



Australian Government

Department of Health



An Australian Government Initiative

Primary Health Network Program

Needs Assessment Reporting Template

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

Name of Primary Health Network

Adelaide PHN

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

Submitted on 29 November 2019

Approved on 20 February 2020

Instructions for using this template

Overview

This template is provided to assist Primary Health Networks (PHNs) to fulfil their reporting requirements for Needs Assessment.

The template includes sections to record needs for:

- General population health of the PHN region
- Primary Mental Health Care
- Indigenous Health (including Indigenous chronic disease)
- Alcohol and Other Drug Treatment Needs

The information provided by PHNs in this report may be used by the Department to inform program and policy development.

Format

The Needs Assessment report template consists of the following:

Section 1 – Narrative

Section 2 – Outcomes of the health needs analysis

Section 3 – Outcomes of the service needs analysis

Section 4 – Opportunities, priorities and options

Section 5 – Checklist

Reporting Period

The Needs Assessment report will be for a three-year period and cover 1 July 2019 to 30 June 2022.

This report has been reviewed and updated for the period 1 July 2019 to 30 June 2020 period.

Priority and Update Status

There has not been significant change requiring an update to the priorities to the Needs Assessment. Only relevant data as per APHN strategic and planning purpose and guidance has been updated accordingly in red.

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SECTION 1 – NARRATIVE

This section provides PHNs with the opportunity to provide brief narratives on the process and key issues relating to the Needs Assessment.

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 Health Priority Network (HPN) (priority interest areas of Mental Health, Aboriginal Health, Consumers and Carers, Disability, Childhood and Youth, Older People and Aged Care, Palliative Care, Alcohol and Other Drugs and Culturally and Linguistically Diverse Communities) 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.

Thus far, PHNs have completed **four** Needs Assessments (NAs) – (1) the Baseline Needs Assessment (BNA), completed in March 2016 and (2) an update to the BNA was completed in November 2016, (3) NA Update in November 2017 and more recently (4) the 2018/19 Adelaide PHN Needs Assessment Report. The latter comprises all sections of General Population Health, the Mental Health and Suicide Prevention and Alcohol and Other Drugs (AOD) plus an additional (new) section for Indigenous Health. It should be noted that the Needs Assessment report was for a three-year period and covers 1 July 2019 to 30 June 2022. All data and priorities are reviewed annually and updated as needed.

This template is called the **2019/20 Adelaide PHN Needs Assessment Report**. In this report, the APHN, reviewed all information from our previous Needs assessment and analysed new data including reflecting the consultation and engagement activities with our communities and stakeholders that have and updated accordingly.

Specifically, between November 2018 and October 2019, the APHN held a series of General Practitioners workshops (3 in total) in the North, South and Central regions respectively and additionally held 3 roundtables (workshops) for Hospital consultants and General Practitioners (in the same regions). The workshops aim was to garner input from these stakeholders about the issues and opportunities for better health outcomes for the APHN community.

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In February 2019, the APHN membership groups' recommendation to the Board was endorsed to further investigate the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) communities' health and wellbeing needs. This report presents the available quantitative data for the region, with results of our consultations with local stakeholders presented in the 2020 Needs Assessment report along with any identified needs for the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) communities in the APHN region.

In May 2019, the APHN conducted a series of workshops with Clinical Councils and Community Advisory Councils seeking feedback and assistance in identifying new or potential opportunities for After Hours (Needs Assessment). Thematic analysis of members themes from the workshop was undertaken to establish whether commonality in after-hours services needs existed across the Adelaide PHN region. A triangulated review of all information (including above membership feedback) reinforced the current service need identified in the Needs Assessment (under General Population Health section). The membership feedback further informed the APHN to take a "deep dive" investigation into opportunities to address the previously identified NA priority – *Lack of community awareness about appropriate after-hours health care services leading to increased potentially preventable hospitalisations*.

Finally, the APHN undertook a series of interviews in October 2019 with General Practice and SAAS participants of the four Priority Care Centres (PCC)¹ trial including General Practitioners, Business Managers, Practice Managers, on-site LHN nurses, SAAS operations staff and crews. Following the findings from the membership consultation on After Hours service needs, the APHN included additional questions to the (evaluation) interviews to specifically investigate the after-hours need (i.e. timing, hours of operation, barriers to service availability, hours of operation of support services (pharmacy, radiology, pathology)). Evaluation is currently undertaken to inform next steps for SA Health and continuation of PCCs.

Additional Data Needs and Gaps

¹ In August 2019, SA Health in partnership with APHN and specific General Practices, established four Priority Care Centres (PCCs) across metropolitan Adelaide. These are located in Hackham, Hindmarsh-Bowden, Para Hills and Elizabeth. The PCCs are "part of a new pilot program that provides community-based healthcare and treatment for eligible patients who would otherwise be seeking a service from a SA Health Emergency Department." The Pilot program of the PCCs will complete in December 2019. The PCCs are "led by General Practitioners with additional support from SA Health hospital staff specially trained in acute assessment and care. They also offer a range of other services that can support care and treatment including access to: (i) Diagnostic tools such as imaging and pathology, (ii) Pharmacy services, and (iii) Community-based health services for follow-up care." Patients are directed to PCCs via SA Ambulance Service (SAAS) or following an assessment of their eligibility at a SA Health Emergency Department. Patients can choose to attend a Centre with no out of pocket expenses or wait for their care to be delivered at an emergency department.

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Most of the data available on the Commonwealth's PHN website provided sufficient base reference for the APHN to analyse the health and service needs of its catchment. Data from the Public Health Information Development Unit (PHIDU) and more recently the Australian Institute of Health and Welfare (AIHW) have provided further evidence into the health, and to a certain extent, service needs of the APHN region.

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.

For any data needs and gaps, the APHN needs assessment process will continue to explore opportunities with research institutions (e.g. AIHW, the National Centre for Education and Training on Addiction (NCETA) and the South Australian Health and Medical Research Institute (SAHMRI)) including consultations with our diverse membership groups to provide further insight and information into identified health and service needs and priorities accordingly.

Additional comments or feedback

There has not been significant change requiring an update to the priorities to the Needs Assessment. Only relevant data as per APHN strategic and planning purpose and guidance has been updated accordingly in red.

Specifically, in the **Health Needs Section**, the following have been updated or included as new:

General Population Health Needs Assessment:

- Child & Youth Health (see pages 23-25)
- Cancer Screening (see pages 36-41)
- Refugees and Culturally and Linguistically Diverse Communities (see pages 46)
- Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) Communities (see pages 46-50) [NEW]
- Sexual Health (see pages 50-54) [NEW]

Primary Mental Health Care (including Psychosocial Support and Suicide Prevention) Health Needs Assessment:

- Child & Youth mental health (see pages 55-58)
- Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) Communities (see pages 65-67) [NEW]

Indigenous Health (including Mental Health and Alcohol and Other Drugs Use) Needs Assessment:

- **Chronic Conditions & Cancer Screening Participation** (see pages 100-101)

In the **Service Needs Section**, the following have been updated or included as new:

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General Population Service Needs Assessment

- Child & Youth (see pages 115-116)
- Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) Communities (see page 117) [NEW]
- Potential Preventable Hospitalisations (see pages 125-129)
- After Hours (see pages 136-142)
- General Practice Support (see pages 143-154)

Primary Mental Health Care (including Psychosocial Support and Suicide Prevention) Service Needs Assessment:

- Trauma (see pages 163-164)
- After Hours (see page 175)

Given this template brings together all previous and or new quantitative and qualitative information into discreet sections – General Population Health, the Mental Health and Suicide Prevention and Alcohol and Other Drugs (AOD) and Indigenous Health, the report is information rich and intensive. Consequently, it may be challenging for the broader general (community) audience.

In the reporting period from 2020 to 2022, the APHN may redesign the Needs Assessment process and/or reporting format to translate needs and priorities (including any new quantitative and qualitative).

SECTION 2 – OUTCOMES OF THE HEALTH NEEDS ANALYSIS

This section summarises the findings of the health needs analysis in the table below.

General Population Health (including After Hours)

Outcomes of the health needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
Chronic conditions			
High rates of chronic conditions and poorer health outcomes in Northern, Western and Southern regions of the APHN.	Variations in prevalence at sub-regional levels and with types of chronic conditions across the APHN region.	<p>Comorbidities are a growing challenge for health professionals and patients in managing their chronic conditions in Australia. Latest (PHN level) data indicates 25% of the APHN population had two or more chronic conditions, and 16% had three or more (BEACH, 2016). Between April 2011 and March 2015 approximately 60% encounters with General Practitioners in APHN were for chronic conditions, a higher rate compared with Other Australian Capital Cities (52%) and the national rate (56%) (BEACH, 2016). No recent PHN data was available for comparison (in addition to types of chronic conditions).</p> <p>A joint Adelaide PHN and Country SA PHN Health Pathways Consumer survey (N=110) targeting consumers (i.e. those with chronic conditions and</p>	<i>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.</i>

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		<p>carers) reported that for APHN participants (n=101), chronic pain, mental health, arthritis, asthma, diabetes and COPD were the top conditions respectively for HealthPathways prioritization. Other conditions reported included Myalgic Encephalomyelitis/Chronic Fatigue Syndrome or ME/CFS, Fibromyalgia, and Hashimoto's Thyroiditis (APHN, 2018a).</p> <p>The survey also reported that majority of the participants had a range of comorbidities. The majority had chronic pain and mental health as comorbidities while those with Chronic pain reported multiple comorbidities (e.g. Mental health, arthritis, and Asthma) while participants with mental health reported chronic pain and asthma as top comorbidities (APHN, 2018a).</p> <p>Over the years, data from the Public Health Information Development Unit (PHIDU), have shown substantial geographical variation within the APHN specifically in the northern, western and southern areas for selected chronic disease prevalence.</p> <p>Recent data from PHIDU (2018), (based on modelled estimates, 2011-2012) have shown similar trends to previous years. But direct comparisons could not be made with previous data. The following information shows; the Aged Standardised Rate (ASR) for each</p>	<p><i>APHN 2018a, Consumer Feedback to HealthPathways SA, October 2018, unpublished.</i></p> <p><i>APHN 2018a, Consumer Feedback to HealthPathways SA, October 2018, unpublished.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2018, Social Health Atlas of Australia.</i></p>
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		<p>chronic disease listed by PHIDU for Australia and the APHN, and top two Population Health Areas (PHAs) in the APHN with highest rates (with the percentage above the APHN rate).</p> <ul style="list-style-type: none"> Respiratory disease – Australia rate: 28.7; APHN 30.7 <ul style="list-style-type: none"> Onkaparinga: 34.4 (12% higher than APHN rate) Playford: 34.2 (11% higher) Asthma – Australia 10.2; APHN 10.1 <ul style="list-style-type: none"> Playford: 11.4 (11% higher) Onkaparinga: 10.9 (7% higher) Chronic Obstructive Pulmonary Disease (COPD) – Australia 2.4; APHN 2.2 <ul style="list-style-type: none"> Playford: 2.7 (23% higher) Port Adelaide Enfield, Marion & Salisbury: 2.3 (all 5% higher) Diabetes – Australia rate: 5.4; APHN 6.8 <ul style="list-style-type: none"> Port Adelaide Enfield: 9.1 (34% higher) Playford & Charles Sturt: 8.0 (18% higher) <p>More recent analysis from Diabetes Australia in 2015 indicate South Australia has the highest rate - 5.8 per cent of the state.</p> Circulatory system disease – Australia rate: 16.9; APHN 16.7 	<p><i>Public Health Information Development Unit (PHIDU), 2018, Social Health Atlas of Australia.</i></p>
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		<ul style="list-style-type: none"> • Playford & Norwood Payneham St Peters: 17.5 (5% higher) • Charles Sturt: 17.3 (4% higher) • High blood cholesterol – Australia rate: 34.7; APHN 34.4 <ul style="list-style-type: none"> • Adelaide & Mitcham: 36.3 (5% higher) • Burnside: 35.9 (4% higher) • Musculoskeletal system disease – Australia rate: 27.7; APHN 27.8 <ul style="list-style-type: none"> • Playford: 30.0 (8% higher) • Salisbury: 29.3 (6% higher) • Arthritis – Australia rate: 15.6; APHN 15.3 <ul style="list-style-type: none"> • Playford: 17.4 (14% higher) • Port Adelaide Enfield: 16.1 (5% higher) • Chronic Kidney disease (note: AIHW 2017a)– Australia rate: 10.0; APHN 7.7 <ul style="list-style-type: none"> • Adelaide: 9.6 (25% higher) • Elizabeth/ Smithfield - Elizabeth North: 9.5 (23% higher) <p>Between July 2014 to June 2016, the SA3s within the APHN region with the highest percentage of chronic disease overall were, Port Adelaide-West followed by West Torrens and Salisbury. In recent data (July 2016 to March 2018), only Port Adelaide-West was in the</p>	<p><i>Public Health Information Development Unit (PHIDU), 2018, Social Health Atlas of Australia.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2017a, Geographical variation in chronic kidney disease prevalence data tables. Canberra: AIHW</i></p>
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		<p>top three, and Adelaide City, followed by Playford were now highest (SA Health, 2018a). For specific chronic diseases (July 2014 to June 2016), the SA3s within the APHN region with the highest percentages were as follows: Diabetes: Marion, Playford and <u>Port Adelaide-West</u>; Asthma: <u>Playford, Marion</u>, Salisbury; COPD: <u>Playford</u>, West Torrens, Campbelltown; Cardio-vascular disease: Norwood - Payneham - St Peters, West Torrens, Marion; Arthritis, West Torrens, Playford, Adelaide City; Osteoporosis: <u>Norwood - Payneham - St Peters</u>, West Torrens, Mitcham; Cancer: West Torrens, <u>Marion, Norwood - Payneham - St Peters</u>. The SA3s in the top three varied between assessment periods for each chronic disease. In recent data (July 2016 to March 2018), the following SA3s were in the top three (if previously in the top three they have been underlined) (SA Health, 2018a).</p> <ul style="list-style-type: none"> • Diabetes: Port Adelaide – East, Salisbury, <u>Port Adelaide – West</u> • Asthma: <u>Playford, Marion</u>, Port Adelaide – West • COPD: <u>Playford</u>, Port Adelaide – East, Salisbury • Cardio-vascular disease: Campbelltown, Playford, Port Adelaide – West • Arthritis: Unley, Port Adelaide – East, Salisbury 	<p><i>SA Health, 2018a, South Australian Monitoring & Surveillance System (SAMSS), South Australian Health and Risk Factor Profile by SA3 regions.</i></p>
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		<ul style="list-style-type: none"> • Osteoporosis: <u>Norwood - Payneham - St Peters</u>, Port Adelaide – East, Onkaparinga • Cancer: <u>Norwood - Payneham - St Peters</u>, Holdfast Bay, <u>Marion</u> <p>For Chronic Pain, the most recent prevalence study in South Australian in 2010 showed that:</p> <ul style="list-style-type: none"> • 17.9% of the overall population have chronic pain. • 5% of people have severe pain that interfered with daily activity. • Chronic pain was associated with older age, living alone, lower income, not being in full-time work and lower educational levels (Currow et al., 2010). <p>This study highlights the high levels of pain with extreme effects on day-to-day life (one in 20 people), the complex inter-relationship of the factors including educational achievement and work status associated with chronic pain, and the impact that these factors have on the people experiencing disabling pain in the longer term. Based on SA population, approximately 250,000 people experience chronic pain, of these approximately 70,000 have severe pain requiring input from a tertiary chronic pain service. Approximately one in ten of these patients experience pain related to</p>	<p><i>SA Health, 2018a, South Australian Monitoring & Surveillance System (SAMSS), South Australian Health and Risk Factor Profile by SA3 regions.</i></p> <p><i>Currow D, Agar M, Plummer JL, Blyth FM and Abernethy AP, 2010. Chronic pain in South Australia: population levels that interfere extremely with activities of daily living. Aust NZ J Public Health 34(3):232-239.</i></p>
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		<p>cancer. There are around 3,000 new cases referred to chronic pain services each year (Currow et al. 2010).</p> <p>As mentioned earlier the dedicated (joint APHN and Country SA PHN) HealthPathways SA survey targeting consumers (i.e. those with chronic conditions and carers) reported that the majority of APHN participants had chronic pain and mental health as comorbidities while those with Chronic pain reported multiple comorbidities (e.g. Mental health, arthritis, and Asthma) while participants with mental health reported chronic pain and asthma as top comorbidities (APHN, 2018a).</p> <p>The key challenges for those with chronic pain included experiences of long waiting lists (3+ years) for LHN pain services, frustration at not being believed or taken seriously by health professionals, and maintaining active lifestyles despite being in pain. Participants found peer support (face to face and online), physiotherapy and mental health services such as CBT, mindfulness and group therapy most beneficial for managing their condition (APHN, 2018a).</p> <p><i>Cancer Incidence</i></p>	<p><i>APHN 2018a, Consumer Feedback to HealthPathways SA, October 2018, unpublished.</i></p> <p><i>APHN 2018a, Consumer Feedback to HealthPathways SA, October 2018, unpublished.</i></p>
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		<p>There are some variations in cancer incidence rates for several cancer types when compared to the national Age-Standardised Rate. Apart from lymphoma (17% higher than national rate), other cancer incidences (i.e. melanoma, head and neck, leukemia, colorectal, lung, ovarian, thyroid) for the APHN was lower than the national rate (AIHW, 2016a).</p> <p>In comparison to the national ASR rate, for cancer incidence by Statistical Area Level 3 in the APHN region, the data shows that Melanoma rates were lower in all SA3s with Salisbury (SA3) at 52% below national rate. However as seen in the geographical variation below, breast, colorectal, lung and prostate cancers incidences are of concern (AIHW, 2016b).</p> <ul style="list-style-type: none"> • Adelaide City: 26% higher for breast cancer for women (all ages) and 39% higher for women aged 50 to 69 years old; 6% higher for prostate cancer • Burnside: 18% higher for breast cancer for women (all ages) and 17 % higher for women aged 50 to 69 years • Campbelltown: 1% higher for breast cancer for women (all ages) • Prospect-Walkerville: 46% higher for breast cancer for women (all ages) and 62% higher 	<p><i>Australian Institute of Health and Welfare (AIHW), 2016a. Cancer Incidence and Mortality Across Regions (CIMAR) books: Primary Health Network (PHN), 2006–2010. Canberra: AIHW.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2016b, Cancer Incidence and Mortality Across Regions (CIMAR) books: Statistical Area Level 3 (SA3), 2006–2010. Canberra: AIHW.</i></p>
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		<p>for women aged 50 to 69 years old; 11% higher for colorectal cancer (all ages); 9% higher for lung cancer</p> <ul style="list-style-type: none"> • Unley: 6% higher breast cancer for women (all ages) • Playford: 5% higher for colorectal cancer (all ages) and 11% higher for people aged 50 to 74 years; 47% higher for lung cancer • Port Adelaide – East: 20% higher for lung cancer • Port Adelaide – West: 13% higher for colorectal cancer (all ages) and 8% higher for people aged 50 to 74 years; 29% higher for lung cancer • Salisbury: 10% higher for colorectal cancer for people aged 50 to 74 years; 16% higher for lung cancer • Holdfast Bay: 8% higher for breast cancer for females aged 50 to 69 years; 8% higher for prostate cancer • Marion: 8% higher for breast cancer for females (all ages) and 5% higher females aged 50 to 69 years; 8% higher for prostate cancer • Onkaparinga: 5% higher for breast cancer for females (all ages) 	<p><i>Australian Institute of Health and Welfare (AIHW), 2016b, Cancer Incidence and Mortality Across Regions (CIMAR) books: Statistical Area Level 3 (SA3), 2006–2010. Canberra: AIHW.</i></p>
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		<ul style="list-style-type: none"> West Torrens: 7% higher for breast cancer for females (all ages) <p><i>Cancer Mortality</i></p> <p>When compared the national ASR rate, the mortality rates for the APHN varied for selected cancers. The APHN mortality rates for leukemia (1%), breast (3%), colorectal for all ages (5%), pancreas (6%), colorectal for 50 to 74 years old (11%) and lymphoma (19%) cancers were above the national rates (AIHW, 2016a).</p> <p>There were geographical variations by mortality by cancer types by SA3's when compared to the national rates. As reported below, mortality rates for breast, colorectal and lung are of concern (similar to incidences rates of these cancers) (AIHW, 2016b).</p> <ul style="list-style-type: none"> Burnside: 14% higher for Melanoma cancer Prospect-Walkerville: 28% higher for breast cancer for females (all ages) and 18% higher for colorectal cancer Playford: 26% higher for breast cancer for females (all ages) and 13% higher for females 50 to 69 years; 20% higher for colorectal cancer (all ages) and 33% higher for people aged 50 to 74 years; 62% higher for lung cancer; 13% higher for prostate cancer 	<p><i>Australian Institute of Health and Welfare (AIHW), 2016a. Cancer Incidence and Mortality Across Regions (CIMAR) books: Primary Health Network (PHN), 2006–2010. Canberra: AIHW.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2016b, Cancer Incidence and Mortality Across Regions (CIMAR) books: Statistical Area Level 3 (SA3), 2006–2010. Canberra: AIHW.</i></p>
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		<ul style="list-style-type: none"> • Port Adelaide – East: 36% higher for breast cancer for females (all ages); 11% for colorectal cancer; 36% higher for colorectal cancer for people aged 50 to 74 years • Port Adelaide – West: 41% higher for colorectal cancer (all ages) and 41% higher for people aged 50 to 74 years; 39% higher for lung cancer • Salisbury: 15% higher for breast cancer for females (all ages) and 33% higher for females aged 50 to 69 years; 11% higher for colorectal cancer (all ages) and 24% higher for people aged 50 to 74 years; 22% higher for lung cancer • Tea Tree Gully: 10% higher for colorectal cancer for people aged 50 to 74 years • Marion: 37% higher for colorectal cancer for people aged 50 to 74 years • Mitcham: 23% higher for breast cancer for females (all ages) • Onkaparinga: 8% higher for breast cancer for females (all ages) and for females aged 50 to 69 years; 9% higher for colorectal cancer for people aged 50 to 74 years; 11% higher for Melanoma • Charles Sturt: 12% higher for breast cancer for females (all ages) and 35% females aged 	<p><i>Australian Institute of Health and Welfare (AIHW), 2016b, Cancer Incidence and Mortality Across Regions (CIMAR) books: Statistical Area Level 3 (SA3), 2006–2010. Canberra: AIHW.</i></p>
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		50 to 69 years; 19% higher for colorectal cancer and 22% higher for people aged 50 to 74 years	<i>Australian Institute of Health and Welfare (AIHW), 2016b, Cancer Incidence and Mortality Across Regions (CIMAR) books: Statistical Area Level 3 (SA3), 2006–2010. Canberra: AIHW.</i>
Child & Youth Health			
Low immunisation rates particularly in SA3s in CALHN and NALHN regions.	Childhood immunisation	<p>As of March 2018 (April 2017 to March 2018 data), the 94% immunisation coverage rates for 1- 5 year old children living in the APHN region were close to reaching the national aspirational immunisation coverage target of 95% (DOH, 2018a). The immunisation coverage for 2-year-olds living in the APHN region was lower, at 90% (DOH, 2018a). These rates were similar to the previous period. However, these coverage rates were not consistent across APHN. <i>Note: Data for Aboriginal and Torres Strait Islander children is reported in the Aboriginal Health section.</i></p> <p>For the period October 2017 to September 2018, 1 year old children immunisation rates were lowest (when compared to APHN rate of 94%) in the SA3s of: Adelaide City (89%), Holdfast Bay (91%), Port Adelaide – West (93%), and Norwood-Payneham-St Peters (93%). However, these SA3s have improved</p>	<p><i>Department of Health (DOH), 2018a, Current PHN immunisation coverage data for all children, Annualised Oct 2017–Sept 2018, Immunise Australia website, accessed October 2018</i></p> <p><i>Department of Health (DOH), 2018b, Current SA3 immunisation coverage data for all children, Annualised Oct 2017–Sept 2018, Immunise Australia website, accessed October 2018</i></p>

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		<p>their rates (all 3% increase) from the previous reporting period (DOH, 2018b). Mitcham (96%), Salisbury (96%), Tea Tree Gully (96%), West Torrens (95%), Prospect-Walkerville (95%), Marion (95%) and Playford (95%) had higher rates than the APHN average rate (DOH, 2018b).</p> <p>For 2-year olds, none of the SA3s in the APHN region had rates higher than the APHN average rate. However, the majority of SA3s saw improvements in their rate when compared to the previous reporting period. The following SA3s had rates lower than 90% but had increment in their rates from previous reporting period: Adelaide City (87% - 11% increase), Charles Sturt (87% - 2% increase), Salisbury (89% - 1% increase), Norwood - Payneham - St Peters (89% - 1% increase), Marion (89% - 2% increase), Playford (87% - 5% increase) (DOH, 2018b).</p> <p>For 5-year olds, immunisation rates had also improved when compared to previous reporting period. The SA3s which had the lowest (in comparison to APHN average rate) were: Adelaide City (84% - 14% increase from reporting period), in Norwood - Payneham - St Peters (91% - 1% increase), Charles Sturt (91% - 2% increase), Salisbury (93% - 2% increase), Playford (93% - 2% increase) (DOH, 2018b).</p>	<p><i>Department of Health (DOH), 2018b, Current SA3 immunisation coverage data for all children, Annualised Oct 2017–Sept 2018, Immunise Australia website, accessed October 2018</i></p> <p><i>Department of Health (DOH), 2018b, Current SA3 immunisation coverage data for all children, Annualised Oct 2017–Sept 2018, <u>Immunise Australia website</u>, accessed October 2018</i></p>
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		<p>Additionally, analysis of the Australian Immunisation Register (AIR) indicates that children from culturally and linguistically diverse backgrounds have lower coverage rates (AIR, 2016). Full detailed data not available.</p>	<p><i>Australian Immunisation Register (AIR), 2016, childhood immunisation records, APHN extracted, unpublished.</i></p>
<p>Higher prevalence of overweight and obese children in NALHN region of the APHN.</p>	<p>Childhood Obesity</p>	<p>Around a quarter (23.0%) of non-Aboriginal children aged 5-17 years in South Australia were overweight or obese, slightly lower the national average of 24.8% (HPCSA, 2018), but still a growing concern given it is above the 2025 target of 21.6% for 5-11 year olds (AHPC, 2017). The AHPC data also indicates a growing concern for young people – nearly one in three (29.5%) are overweight or obese. The 2025 target for 12-17 year olds is 28.3% (AHPC, 2017). <i>Note: Data for Aboriginal and Torres Strait Islander children is reported in the Aboriginal Health section.</i></p> <p>Although the 2014-15 APHN average rate for children or young people aged 2-17 years who are obese or overweight (24.1 per 100 children) is consistent with the Capital Cities rate (26.3 per 100), rates are higher than the APHN average in the northern sub-region of the APHN. The highest rates are in the LGAs of Port Adelaide Enfield (27.0), Playford (26.1) and Salisbury (25.6) (AHPC, 2017). No new data was available for comparison.</p>	<p><i>Health Performance Council of South Australia (HPCSA), 2018, State of Our Health (online report), accessed Oct 2018.</i></p> <p><i>Australian Health Policy Collaboration (AHPC), Australia's Health Tracker by Area, 2017, Children or young people who are obese or overweight.</i></p>

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		<p>The Northern Adelaide Clinical Council raised their concerns on the increasing obesity rates in childhood and the fact that the condition progresses into adulthood. They suggested that education, patterns of behaviour, technology use and not being able to play outside safely were causal factors (APHN, 2016a).</p>	<p><i>APHN, 2016a, Clinical Council priority setting workshops</i></p>
<p>Increasing concern for children and youth presenting at ED (and admissions) with potentially preventable conditions.</p>	<p>Potentially preventable hospital presentations and admissions for children and youth</p>	<p><i>Notes: Data for Aboriginal and Torres Strait Islander children is reported in the Aboriginal Health section while Youth mental health-related presentations to emergency department is reported in the Mental Health section.</i></p> <p>While young people (10-19 years) comprised 12% of the APHN population 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).</p> <p>Analysis of data (2012/13 – 2014/15) from SA health have shown increasing concern for specific potentially preventable conditions - Ear, Nose and Throat infections, Asthma, Dental conditions, Urinary</p>	<p><i>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.</i></p> <p><i>SA Health, 2016a, Potentially Preventable Admissions data, 2012/13 – 2014/15, unpublished.</i></p>

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		<p>tract infections and Diabetes complications, among the child and youth presenting at Emergency Departments in APHN region (SA Health, 2016a). Recent data is not available.</p> <p>Young children have the highest rates of preventable hospitalisation due to dental conditions. More than half (52%) of the almost 24,500 Dental Caries potentially preventable hospitalisations (PPHs) in the past seven years (2007-08 to 2013-14) were for children aged under ten years old (SA Health, 2015a). Between July 2012 and June 2014, a total of 12,037 South Australians were admitted to hospital for acute preventable dental conditions, making dental conditions the leading cause of PPHs in this period. (SA Health, 2015a).</p> <p>In 2017-18 in the APHN, 2.4% of all ED presentations in public hospitals for children and youth (0-17 years) were mental health related (Mental and behavioural disorders (ICD F00-F99)). This was the highest proportion for all PHN's and compared to an average across all PHN's of 1.4% (AIHW, 2019a).</p>	<p><i>SA Health, 2015a, SA Dental Service, Understanding possible preventable hospital separation data for dental, Evaluation and Research Unit, Service Quality & Performance Improvement, August 2015, unpublished.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW) 2019a, Mental Health Services in Australia. Canberra: AIHW.</i></p>
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		<p>It is likely that a significant proportion of youth attending the ED have a diagnosis of Autism Spectrum Disorder (ASD) (ICD code of F84.0 - within the Mental and behavioural disorders (ICD F00-F99) group quoted above), as research (van Steensel et al., 2019) has found ASD has a high comorbidity with mental health disorders, such as anxiety, depression, ADHD and behavioral problems. There is no Australian data available on ED presentations specifically for children with ASD, however a United States (US) study (Deavenport-Saman et al., 2016), found that children with ASD were more likely to visit the ED and for non-urgent reasons.</p> <p>ABS (2015a) estimates the proportion of the population with ASD in South Australia (All ages) to be 0.7% or 16,900 people in 2015. The ABS (2015a) also estimates that approximately 70% of those diagnosed with ASD are under 20 years. In South Australia this is equivalent to approximately 11,730 young persons who have been diagnosed with ASD. (ABS, 2015a). According to the ABS Survey of Disability, Ageing and Carers (SDAC), an estimated 164,000 Australians had autism in 2015 and the number of people with autism in Australia has increased considerably in recent years, from an estimated 64,400 people in 2009 (ABS 2015a). Of those who were estimated to have autism in 2015, 143,900 were identified as also having disability (88%) (ABS 2015a).</p>	<p><i>van Steensel, FJA, Boëgels, SM, de Bruin, EI, 2013. Psychiatric Comorbidity in Children with Autism Spectrum Disorders: A Comparison with Children with ADHD. Child Fam Stud 22: 368-376.</i></p> <p><i>Deavenport-Saman, A, Lu, Y, Smith, K, Yin, L, 2016. Do Children with Autism Overutilize the Emergency Department? Examining Visit Urgency and Subsequent Hospital Admissions Matern Child Health J 20: 306-14.</i></p> <p><i>Australian Bureau of Statistics (ABS). 2015a. Disability, Ageing and Carers, Australia: Summary of Findings, catalogue number. 4430.0.</i></p>
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		<p>Evidence from the US suggests that in addition to more outpatient visits, the population with ASD also have more physician visits and take more prescribed medications (Liptak et al., 2006).</p> <p>Analysis of APHN General Practice data for FY 2018-19 indicates there were 2,174 patients aged 0 to 18 years who visited a general practice and have a coded diagnosis of ASD. This is equivalent to 1.3% of all patients aged 0 to 18 years (APHN, 2019a). Most of these ASD coded diagnoses in this age group are patients visiting practices in the NALHN region (44.7% of the APHN). SALHN and CALHN had 31.3% and 24.0% of the APHN diagnoses coded for ASD respectively.</p>	<p><i>Liptak, GS, Stuart, T, Auinger, P, 2006. Health Care Utilization and Expenditures for Children with Autism: Data from U.S. National Samples. Autism Dev Disord 36: 871-879</i></p> <p><i>APHN, 2019a, Clinical General Practice Data, 2018-2019, unpublished</i></p>
Healthy Ageing			
Older adults living in the APHN region have wide-ranging and complex multi-morbidity, high prevalence of chronic disease and associated risk factors.	Healthy ageing	<p>South Australia has an 'aged' population, with a higher proportion of older people than the national average (Roche et al, 2017a). The Office for the Ageing states that for South Australia over the next 10 years it is expected that the percentage of the population living beyond the age of 65 years will rise from the current figure of 15% to 22% (OFTA, 2014).</p>	<p><i>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.</i></p> <p><i>Office for the Ageing (OFTA), 2014, Prosperity through longevity: South Australia's ageing plan, our vision 2014-2019.</i></p>

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		<p>In the 2016 Census, there were 203,923 people aged 65 years and over, including 31,629 people aged 85 years and over, living in the APHN region (PHIDU, 2017a).</p> <p>A South Australian survey of older people found that 92% of survey respondents selected health and wellbeing as an important aspect of growing older. The results also indicated a decline in self-rated health with age, with approximately 40% of those aged 70-79 years, and more than 50% of those aged over 80 years rated their health as fair or poor. The health issues that most affected daily activities were vision (22%) and mobility (19%) (OFTA, 2014).</p> <p>In the APHN region, there were 27,918 people (14%) aged 65 years and over living in the community with a profound or severe disability, which was lower than the national rate of 16% for other capital cities (PHIDU, 2017a).</p> <p>The risk of developing dementia increases with age (CAHML, 2015). In South Australia, the 2011 estimate of dementia prevalence is 30,500 people (11,400 males, 19,100 females). This is expected to increase to 33,500 people by 2020 (AIHW, 2012). The most common type of dementia is Alzheimer's disease, which accounts for around 75% of all dementia diagnoses. PHN level dementia data not available.</p>	<p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i></p> <p><i>Office for the Ageing (OFTA), 2014, Prosperity through longevity: South Australia's ageing plan, our vision 2014-2019.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i></p> <p><i>Central Adelaide and Hills Medicare Local (CAHML), 2015, Health Profile: a population health needs assessment of the Central Adelaide and Hills region, 2015.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2012, Dementia in Australia. Cat. no. AGE 70. Canberra: AIHW.</i></p>
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		<p>Multimorbidity of chronic conditions increases with age. In South Australia in 2014, 29% of males and 35% of females aged 65-74 years old, and 39% of males and 47% of females aged 75 years and over lived with two or more chronic health conditions (diabetes, asthma, cardiovascular disease, arthritis, osteoporosis and/or a mental health condition). These proportions were double the state averages of 16% for males and 19% females aged 16 years and over (HPCSA, 2016).</p> <p>In 2017, approximately half of all South Australian males (54%) and females (53%) aged 75 years and over were living with two or more of the following health risk factors: high blood pressure, high cholesterol, no physical activity, obesity, smoking, alcohol risk, and/or insufficient consumption of fruit and vegetables. For 65-74-year olds, 59% of males and 60% of females were living with two or more of the health risk factors (HPCSA, 2018).</p> <p>Falls represent a significant health issue among older people, with 2011-12 data showing that across Australia, 96,385 people aged 65 years and over required hospitalisation as a result of a fall. Twice as many women as men were hospitalised for a fall, and the number of falls cases increased with age (CAHML, 2015). In 2012-13, the estimated number of serious</p>	<p><i>Health Performance Council of South Australia (HPCSA), 2016, State of Our Health (online report), accessed April 2016.</i></p> <p><i>Health Performance Council of South Australia (HPCSA), 2018, State of Our Health (online report), accessed Oct 2018.</i></p> <p><i>Central Adelaide and Hills Medicare Local (CAHML), 2015, Health Profile: a population health needs assessment of the Central Adelaide and Hills region, 2015.</i></p>
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		<p>injuries due to falls in people aged 65 and older was 98,704. Females accounted for most of these fall injury cases, and rates of cases were higher for females than for males for all age groups (AIHW, 2017b).</p> <p>Age-standardised rates of hospitalised fall injury cases increased over the 11 years to June 2013 (3% per year). There were more than 24,000 extra fall injury cases for people aged 65 and older in 2012–13 than there would have been if the rate of falls had remained stable since 2002–03 (AIHW, 2017b). In 2014–15, an estimated 111,222 people aged 65 and over were hospitalised due to falls (AIHW, 2018a). Also, for unintentional fall injury deaths: SA recorded the lowest rate (12.2 deaths per 100,000) (AIHW, 2018b).</p> <p>In 2012–13, there were more than 120,000 other fall-related hospital separations (mainly for rehabilitation care) for people aged 65 and older. The length of stay in hospital as a result of an injurious fall takes into account time spent in hospital following transfers after the initial hospitalisation and for fall-related rehabilitation and related care. In total, there were 1.4 million days of patient care over the year, with the average total length of stay per fall injury case estimated to be 14.0 days. Overall, one in every 10</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2017b, Trends in hospitalisations due to falls by older people, Australia 2002–03 to 2012–13. Injury research and statistics series no. 106. Cat. no. INJCAT 182. Canberra: AIHW.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2018a, Trends in hospitalisations due to falls by older people, Australia 2002–03 to 2014–15. Cat. no. INJCAT 191. Canberra: AIHW.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2018b, Trends in injury deaths, Australia, 1999–00 to 2014–15. Injury research and statistics series no. 112. Cat. no. INJCAT 192. Canberra: AIHW.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2017b, Trends in hospitalisations due to falls by older people, Australia 2002–03 to 2012–13. Injury research and statistics series no. 106. Cat. no. INJCAT 182. Canberra: AIHW.</i></p>
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		<p>days spent in hospital by a person aged 65 or older in 2012–13 was attributable to an injurious fall. The days of patient care attributable to fall-related injury rose from 0.8 million patient days in 2002–03 to 1.4 million patient days in 2012–13 (AIHW, 2017b).</p> <p>Around 85% of fall injury cases in 2014–15 were recorded as having occurred in either the home or in residential aged care. The age-standardised rate of falls in the home for older people living in the community was 1,814 per 100,000 population, while the rate of falls for older people living in residential aged care was 10,090 per 100,000 population. These rates are likely to be underestimated because of missing information on the places in which falls occurred (AIHW, 2018b).</p> <p>In addition to the initial hospitalisations for these fall injury cases, there were more than 50,000 other fall-related hospital episodes (mainly for rehabilitation care) for people aged 65 and over in 2014–15. Taken together with the initial hospitalisation for a fall, there were 1.5 million days of patient care over the year, with the average total length of stay per fall injury case estimated to be 13 days. Overall, 1 in every 10 days spent in hospital by a person aged 65 and over in 2014–15 was attributable to an injurious fall. The days of patient care attributable to fall-related</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2017b, Trends in hospitalisations due to falls by older people, Australia 2002–03 to 2012–13. Injury research and statistics series no. 106. Cat. no. INJCAT 182. Canberra: AIHW.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2018b, Trends in injury deaths, Australia, 1999–00 to 2014–15. Injury research and statistics series no. 112. Cat. no. INJCAT 192. Canberra: AIHW.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2018b, Trends in injury deaths, Australia, 1999–00 to 2014–15. Injury research and statistics series no. 112. Cat. no. INJCAT 192. Canberra: AIHW</i></p>
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		injury rose from 0.8 million patient days in 2002–03 to 1.4 million patient days in 2014–15 (AIHW, 2018b).	
Early Intervention and Prevention through Primary Health Care			
Limited understanding of health conditions and navigating the primary health care system	Low levels of health literacy skills	<p>Consultations facilitated with the membership groups of the APHN identified that health literacy was a main issue for community members that required addressing in a coordinated manner (APHN, 2016b).</p> <p>The APHN Clinical Councils identified 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 and reduce unwarranted variation in care by improving health literacy and education (APHN, 2016b).</p> <p>The Community Advisory Councils (APHN, 2016b) prioritised the need for:</p> <ul style="list-style-type: none"> • Better education for consumers and professionals across the health sector to improve and encourage the take-up and application of preventative measures. • Consumers to be empowered and involved in their own care. • Community members and service providers to better inform themselves about services available throughout the primary health care 	<p><i>APHN, 2016b, Membership Groups Priority Setting workshops</i></p> <p><i>APHN, 2016b, Membership Groups Priority Setting workshops</i></p> <p><i>APHN, 2016b, Membership Groups Priority Setting workshops</i></p>

		<p>sector and how to access those services, by improving health literacy and education.</p> <p>The Health Priority Groups overall prioritised the need to invest in early intervention; prevention and education strategies for community and primary health care providers. This will enable community members to make informed decisions; understand health conditions and have awareness where to access appropriate services (APHN, 2016b).</p> <p>Australian research indicates that health literacy is limited in a significant proportion of the general Australian population (Barber et al., 2009). In 2006, 59% of South Australians aged 15-74 years had low health literacy levels indicating they may not have the health literacy skills needed to navigate and understand health information and services (ABS, 2006). While dated, this is the latest health literacy data from the ABS. More recent research by Adams et al. (2009) suggest that 45% of South Australians were 'at risk' or 'of high likelihood' of having low functional health literacy.</p> <p>A 2011-12 ABS (2012) reported in SA, 47% of people (aged 15 to 74) had low literacy (level 1 or 2 literacy score), compared to 44% Australia wide [Note:</p>	<p><i>APHN, 2016b, Membership Groups Priority Setting workshops</i></p> <p><i>Barber MN, Staples M, Osborne RH, Clerehan R, Elder C, Buchbinder, R. (2009). <u>Up to a quarter of the Australian population may have suboptimal health literacy depending upon the measurement tool: Results from a population-based survey.</u> Health Promotion International, 24(3), 252-261.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2006, Adult Literacy and Life Skills Survey, accessed October 2017.</i></p> <p><i>Adams RJ, Appleton SL, Hill CL, Dodd M, Findlay C, Wilson DH. (2009). <u>Risks associated with low functional health literacy in an Australian population.</u> Medical Journal of Australia, 191(10), 530-534.</i></p>
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		literacy scores grouped into six skill levels with Below Level 1 being the lowest level and Level 5 the highest].	<i>Australian Bureau of Statistics (ABS), 2012, Programme for the International Assessment of Adult Competencies, Australia, 2011-12 (cat no. 4228.0).</i>
High prevalence of health risk factors at sub-regional levels, particularly in Local Government Areas (LGAs) of Playford, Salisbury, Port Adelaide Enfield, West Torrens and Onkaparinga.	Management of health risk factors	<p>The APHN membership groups recognise the link between behavioural and lifestyle factors and the effect of these on health. The Southern Community Advisory Council identified that the following lifestyle factors which may impact a person's health: smoking; inadequate nutrition; unemployment; lack of exercise; lack of skills to cook health foods; education level on understanding of good health, healthy lifestyles, impact of junk food (APHN, 2017a). The Northern Adelaide Clinical Council raised concerns about levels of obesity and the impacts on chronic disease and ultimately on use of resources. They expressed concern that obesity was related to choices about behaviour including food choices and exercise. Lack of education was raised as an issue (APHN, 2016a,).</p> <p>Adults living in the Northern Adelaide LHN were more likely to report having at least one risk factor and adults in Central and Southern Adelaide LHN were less likely to report having at least one risk factor in 2015 (SAMSS, 2015). No recent data available for comparison.</p>	<p><i>APHN, 2017a, Community Advisory Council, Results Based Accountability workshops, 2017.</i></p> <p><i>APHN, 2016a, Clinical Council, priority setting workshops.</i></p> <p><i>SAMSS, 2015, Multiple Risk Factors in South Australia, PROS Indicator Report, 2015</i></p>

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		<p><i>Smoking</i></p> <p>Estimates from the 2011-13 Australian Health Survey highlight that when compared to other LGAs in the APHN region, there was a higher proportion of both male and female smokers in the LGAs of Playford, Salisbury, Port Adelaide Enfield and Onkaparinga (PHIDU, 2015).</p> <p>In the two years from 2012 to 2014, the average proportion of females smoking during pregnancy was higher in APHN compared to other Capital Cities, 11.4% compared to 9.3% respectively (PHIDU, 2017a). Rates of smoking during pregnancy were highest in the Local Government Areas of Playford (24%), Salisbury (16%), Onkaparinga (15%), Tea Tree Gully (10%) and Charles Sturt (10%) (PHIDU, 2017a).</p> <p><i>Physical inactivity</i></p> <p>In 2015, approximately half of all South Australians aged between 18-64 years and one-third of South Australians aged 65+ years undertook physical activity in line with recommended national levels, and these proportions have remained unchanged in the thirteen years between January 2003 to December 2015 (SA Health, 2015b). Recent data (between July 2016 and March 2018) also shows similar trends - 46.7% of South Australians undertook physical activity (SA Health, 2018a).</p>	<p><i>Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia</i></p> <p><i>SA Health, 2015b, South Australian Monitoring & Surveillance System (SAMSS), Trends at a glance: Physical Activity trends in South Australian adults, January 2003 to December 2015.</i></p> <p><i>SA Health, 2018a, South Australian Monitoring & Surveillance System (SAMSS), South Australian Health and Risk Factor Profile by SA3 regions.</i></p>
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		<p>Between July 2014 and June 2016, the SA3s within the APHN region with the lowest percentage of physical activity (below State average) were Playford, Port Adelaide – West, West Torrens and Onkaparinga respectively (SA Health, 2018a). However recent data (between July 2016 and March 2018) shows variations in the percentages of physical activity. The SA3s with the lowest percentage of physical activity (below State average) were Playford (0.5% increase from previous period), Port Adelaide – East (6.3% decrease), Salisbury (4.2% decrease), Port Adelaide – West (4.7% increase) and Campbelltown (4.6% decrease) respectively (SA Health, 2018a).</p> <p><i>Unhealthy weight</i></p> <p>In 2015, 6 in every 10 South Australians aged 18 years and over (62%) were overweight or obese (unhealthy weight), and this proportion has increased from 54% since July 2002 (SA Health, 2015d). Recent data (between July 2016 and March 2018) also shows similar trends – 61.4% of South Australians were overweight or obese (SA Health, 2018a).</p> <p>Between July 2014 and June 2016, the SA3s within the APHN region with the highest percentage of people with an unhealthy weight (above State average) were Playford, Salisbury, Port Adelaide – West, Tea Tree Gully and Charles Sturt respectively (SA Health, 2018a). However recent data (between July 2016 and</p>	<p><i>SA Health, 2018a, South Australian Monitoring & Surveillance System (SAMSS), South Australian Health and Risk Factor Profile by SA3 regions.</i></p> <p><i>SA Health, South Australian Monitoring & Surveillance System (SAMSS), 2015d, Trends at a glance: Unhealthy weight trends in South Australian adults, July 2002 to December 2015.</i></p> <p><i>SA Health, 2018a, South Australian Monitoring & Surveillance System (SAMSS), South Australian Health and Risk Factor Profile by SA3 regions.</i></p>
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		<p>March 2018) shows variations in the percentages of physical activity. The SA3s with the highest percentage of people with an unhealthy weight (above State average) were Playford (0.3% increase from previous period), Salisbury (0.3% increase), West Torrens (15.4% increase) and Marion (2.8% increase) respectively (SA Health, 2018a).</p> <p><i>Vegetable consumption</i></p> <p>Between July 2014 and June 2016, the SA3s within the APHN region with the lowest percentage of people consuming the recommend number of serves of vegetables for adults (below State average of 10.3) were Port Adelaide – East, Unley, Prospect-Walkerville, Playford, West Torrens, Port Adelaide – West and Marion respectively (SA Health, 2018a). However recent data (between July 2016 and March 2018) shows variations in the percentages of physical activity. The SA3s with the lowest percentage of people consuming the recommend number of serves of vegetables for adults (below State average of 10.5) were Unley (1.9% decrease from previous period), Port Adelaide – East (2.6% increase), Salisbury (3.7% decrease), Burnside (2.3% decrease), Marion (0.1% decrease), Onkaparinga (1.4% decrease), West Torrens (2.4% increase), Norwood-Payneham-St Peters (7.4% decrease), Port Adelaide – West (1.1%</p>	<p><i>SA Health, 2018a, South Australian Monitoring & Surveillance System (SAMSS), South Australian Health and Risk Factor Profile by SA3 regions.</i></p> <p><i>SA Health, 2018a, South Australian Monitoring & Surveillance System (SAMSS), South Australian Health and Risk Factor Profile by SA3 regions.</i></p>
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		<p>increase) and Mitcham (no change), respectively (SA Health, 2018a).</p> <p><i>Fruit consumption</i></p> <p>Between July 2014 and June 2016, the SA3s within the APHN region with the lowest percentage of people consuming the recommend number of serves of fruits for adults (below State average of 42.8) were Playford, West Torrens, Port Adelaide – West, Unley, Salisbury and Campbelltown respectively (SA Health, 2018). However recent data (between July 2016 and March 2018) shows variations in the percentages of physical activity. The SA3s with the lowest percentage of people consuming the recommend number of serves of fruits for adults (below State average of 42.1) were Burnside (24.9% decrease from previous period), Port Adelaide - West (5.2% decrease), Playford (3.3% increase), Marion (3.3% decrease) and Salisbury (1.2% decrease) respectively (SA Health, 2018a).</p>	<p><i>SA Health, 2018a, South Australian Monitoring & Surveillance System (SAMSS), South Australian Health and Risk Factor Profile by SA3 regions.</i></p>
Cancer Screening			
Lower rates of Breast, Cervix and Bowel screening participation among vulnerable population groups	Breast, Cervix and Bowel screening participation rates	In the April 2019 the Population Health Survey Module System (PHSMS), asked a series of questions about the Cervical and Bowel Screening program in South Australia as well as the Get Screened advertising campaign. The latter campaign was a joint	<p><i>SA Health, 2019a, Screening Report – PHSMS April 2019, Population Health Surveys, Prevention and Population Health Branch, unpublished.</i></p>

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<p>in low socio-economic areas in APHN region</p>		<p>project developed by the APHN with SA Health and Country SA PHN (SA Health 2019a).</p> <p>The cervical screening program encourages women to have a Cervical Screening Test every five years in line with the national policy, and the bowel screening program provides free screening for men and women aged from 50 to 74 years every two years. The PHN co-funded the joint Get Screened advertising campaign - “get screened and get on with living” slogan aimed to encourage South Australians to get screened for cervical, bowel and breast cancer.</p> <p>The Survey showed that two-thirds of respondents reported participation in cervical screening within the last three years (N=1,231) and of these respondents (n=814) reporting participation in cervical screening, over a third (38%) booked an appointment because of a letter from their GP, a quarter (25%) due to a discussion with their GP, nearly a fifth (18%) because of a letter from the Cervical Screening Register and just over 10% after a text message from their GP (SA Health 2019a).</p> <p>For Bowel screening, the Survey showed that 70% of respondents reported participation in bowel screening within the last three years (total respondents=1,128). Of the n=790 respondents reporting participation in bowel screening, over</p>	<p><i>SA Health, 2019a, Screening Report – PHSMS April 2019, Population Health Surveys, Prevention and Population Health Branch, unpublished.</i></p>
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		<p>three-quarters (76%) did so because the kit came in the mail. Other common reasons were; due to recommendation by GP (23%), cancer experience of friends or family (13%), and promotion on TV or radio (8%). Not surprisingly, most of the respondents received their bowel screening kit through the National Bowel Cancer Screening Program (86%), while some respondents received their kit from the GP (10%) and only 1% bought their own. Of the n=329 respondents that did not report participation in bowel screening, over a quarter (29%) reported that they did not participate because they did not have the time or get around to it. The next most common reasons were; that the respondent had a colonoscopy (13%), that they hadn't received the kit in the mail (11%), and that they didn't have symptoms (6%) (SA Health, 2019a).</p> <p>The Survey showed that the majority of respondents (81%) reported seeing or hearing any advertisements about getting screened for breast, bowel or cervical cancer in the past 12 months. The most commonly recalled advertisement was about bowel cancer screening which features footballers and <i>Ita Buttrose</i> (41%). The three advertisements with the "get screened and get on with living" slogan reported similar levels of recollection by respondents (14-15%). Of the n=947 respondents that reported seeing</p>	<p><i>SA Health, 2019a, Screening Report – PHSMS April 2019, Population Health Surveys, Prevention and Population Health Branch, unpublished.</i></p>
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		<p>a cancer screening advertisement with the slogan “get screened and get on with living” (excluding the footballers and <i>Ita Buttrose</i> advert) over three-quarters (77%) saw an advertisement on free-to-air television. Only 12% recalled hearing a screening advertisement on radio, 10% on Facebook and approximately 8% on either websites, catch-up TV or newspapers (SA Health, 2019a).</p> <p>Of the n=433 respondents that recalled a screening advertisement on a medium other than free-to-air television, over half of respondents believed that the main message of the advertisements were that early detection of cancer means a better chance of successful treatment (61%), and that a simple cancer screening test can save your life (60%) (SA Health, 2019a).</p> <p><i>Bowel cancer screening</i></p> <p>In 2016-2017, in comparison to other PHNs, the APHN had the 6th highest rate - 46.0%, of 50-74 year olds participating in the national bowel cancer screening program (AIHW, 2019b). The national rate being 41.3%. The 2016-2017 participation rate for APHN was a slight decrease from the 2015-16 rate of 46.5% (AIHW, 2019b).</p> <p>In 2016-2017, participation in the program varied across the APHN region, with the lowest rates of participation in the SA3's of Playford (37.3%), Port</p>	<p><i>SA Health, 2019a, Screening Report – PHSMS April 2019, Population Health Surveys, Prevention and Population Health Branch, unpublished.</i></p> <p><i>SA Health, 2019a, Screening Report – PHSMS April 2019, Population Health Surveys, Prevention and Population Health Branch, unpublished.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2019b, National cancer screening programs participation data.</i></p>
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		<p>Adelaide-West (40.7%), Adelaide City (41.6%), Salisbury (42.0%) and Port Adelaide-East (43.3%) (AIHW, 2019b).</p> <p>The Northern Adelaide Clinical Council suggested that the lower rates of bowel screening in the northern APHN region are likely attributed to levels of education and literacy (APHN, 2016a).</p> <p><i>Breast cancer screening</i></p> <p>In 2016-2017, the APHN had the 3rd highest rate of participation in the national breast cancer screening program (BreastScreen), at 59.9% of 50-74 year old women, in comparison with other PHNs. The national rate was 55.0 % (AIHW, 2019b). The 2016-2017 participation rate for APHN increased from 59.4% in 2015-2016 (AIHW, 2019b).</p> <p>Participation in the program increased with age, ranging from 53.9% of 50-54 year olds to 65.5% of 65-69 year olds, then declining to 58.0% in 70-74 year olds (AIHW, 2019b).</p> <p>The 2015-2016 participation rates also varied by APHN sub-region. The lowest rates of participation being in the SA3's of Playford (51.7%), Port Adelaide-East (52.4%), Port Adelaide-West (55.7%), and Salisbury (56.5%) (AIHW, 2019b).</p> <p><i>Cervical cancer screening</i></p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2019b, National cancer screening programs participation data.</i></p> <p><i>APHN, 2016a Clinical Council, priority setting workshops</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2019b, National cancer screening programs participation data.</i></p>
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		<p>In 2015-2016, the APHN had the 8th highest rate of participation in the national cervical cancer screening program, at 57.5% of 20-69 year olds, with Country SA PHN 10th highest at 57.0%; the national rate was 55.4% (AIHW, 2019b). The 2015-2016 participation rate for APHN is in line with the 2014-2015 rate of 58.0% (AIHW, 2019b).</p> <p>Participation in the program increased with age, ranging from 42.0% of 20-24 year olds to 63.7% of 50-54 year olds, then declining to 56.9% when 65-74 years of age (AIHW, 2019b).</p> <p>The 2015-2016 participation rates also varied by APHN sub-regions. The lowest rates of participation in the SA3s of Adelaide City (45.0%), Playford (46.8%), Port Adelaide-East (53.6%), West Torrens (54.4%) and Port Adelaide-West (54.5%) (AIHW, 2019b).</p> <p>These patterns of geographical variation across the APHN are consistent with the 2014-15 participation rates in the three national screening programs; residents of the northern, western and city areas of the APHN having much lower participation rates compared to both the APHN and national rates (AIHW, 2019b).</p> <p>There appears to be a correlation between areas of low cancer screening participation and socio-economic status with three of these regions, Playford, Salisbury and Port Adelaide, having the lowest Index</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2019b, National cancer screening programs participation data.</i></p>
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		of Relative Socio-Economic Disadvantage (IRSD) scores in the APHN region (PHIDU, 2017a).	<i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i>
Refugees and Culturally and Linguistically Diverse communities			
High prevalence of health risk factors (including poor nutrition, physical health, diabetes, mental health and AOD)	Refugees and new arrivals and Culturally Diverse Communities' Health and Wellbeing	<p><i>Demographics</i></p> <p>Data from the 2011 Census of Population and Housing indicate that 16% of APHN residents were born in predominately non-English speaking countries (NESC) (PHIDU, 2015); this has increased to 18% based on the 2016 Census data (ABS, 2017a).</p> <p>In 2016, the top 10 birthplaces of people from Non-English Speaking Countries in the APHN were: India, China, Italy, Vietnam, Philippines, Greece, Germany, Malaysia, Afghanistan, and Poland (ABS, 2017a).</p> <p>The largest changes in birthplace countries in the APHN region between 2011 and 2016 were for those born in India (+8,630 persons), China (+8,427 persons), United Kingdom (-5,689 persons) and Afghanistan (+2,856 persons) (ABS, 2017a).</p> <p>The SA3s of Port Adelaide-East (22.1% of the population), Campbelltown (22.0%), Salisbury (17.5%), Charles Sturt (17.2%) and Port Adelaide-West (17.1%) had the highest proportion of people born in NESC and resident for longer than five years (PHIDU, 2017b).</p>	<p><i>Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017a, Census of Population and Housing 2016 (Enumerated), compiled by profile.id and presented in Adelaide Primary Health Network community profile</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017b, Social Health Atlas of Australia: Supplementary Release of 2016 Census Data.</i></p>

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		<p>Whereas the SA3s with the highest proportion of people born in NESC and resident for less than five years (recent arrivals) were Adelaide City (21.9% of the population), Port Adelaide–East (8.5%), West Torrens (7.6%), Norwood-Payneham-St Peters (6.8%), and Burnside (5.9%) (PHIDU, 2017b).</p> <p><i>Language and literacy</i></p> <p>In 2016, the top 10 languages other than English spoken at home for people living in the APHN region were: Mandarin, Italian, Greek, Vietnamese, Persian/Dari, Cantonese, Arabic, Punjabi, Filipino/Tagalog, and Hindi (ABS, 2017a).</p> <p>The SA3s with the highest proportion of people born overseas reporting poor proficiency in English were Port Adelaide-West (6.0%), Port Adelaide-East (5.9%), Salisbury (5.6%), Adelaide City (4.8%), Campbelltown (4.4%) and Charles Sturt (4.3%) (PHIDU, 2017b).</p> <p>Nationally in 2006, of those born overseas in a mainly non-English speaking country, only 26% achieved literacy levels of 3 or above, the 'minimum required for individuals to meet the complex demands of everyday life and work'. Additionally, 74% of those born overseas in a mainly non-English speaking country have less than adequate levels of literacy and</p>	<p><i>Public Health Information Development Unit (PHIDU), 2017b, Social Health Atlas of Australia: Supplementary Release of 2016 Census Data.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017a, Census of Population and Housing 2016 (Enumerated), compiled by profile.id and presented in Adelaide Primary Health Network community profile</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017b, Social Health Atlas of Australia: Supplementary Release of 2016 Census Data.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2006, Adult Literacy and Life Skills Survey, accessed October 2017.</i></p>
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		<p>health literacy. This means that they may not be able to effectively exercise their choice or voice when making healthcare decisions (ABS, 2006). While dated, this is the latest health literacy data from the ABS.</p> <p>A recent report by the ABS reported that for 2011-12 the literacy skills of people born overseas from a non-English speaking country is lower than those born in Australia (i.e. Level 3 and below; Level 1 or below being very basic and Level 5 being the highest) (ABS 2013).</p> <p>The report shows that for Literacy skills of \geq Level 3:</p> <ul style="list-style-type: none"> • If born overseas from a non-English speaking country: 39%; • If born in Australia but 1st language not English: 48.5% • All of SA: 51% <p>And for Literacy level of 1 or below (i.e. lowest level-very basic)</p> <ul style="list-style-type: none"> • If born overseas from a non-English speaking country: 28%; • If born in Australia but 1st language not English: 15% • All of SA: 13% (ABS 2013). <p><i>Inequities in health outcomes and access to services</i></p>	<p><i>Australian Bureau of Statistics (ABS) 2013, Programme for the International Assessment of Adult Competencies, Australia, 2011-12 (cat no. 4228.0)</i></p> <p><i>APHN, 2016a, Clinical Councils, priority setting workshops; APHN,</i></p>
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		<p>Consultations undertaken with APHN's membership groups identified culturally and linguistically diverse (CALD) and new and emerging communities' health as one of the target population groups for the APHN (APHN, 2016a, 2016c, 2016d). Wider community consultations identified that the health needs of CALD communities particularly mental health and AOD should be an area of concern for the APHN (APHN, 2016e).</p> <p>Research by Principe (2015) reported that 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. Older people from CALD backgrounds have a higher risk of mental health issues and tend to present at later stages of illness compared to other older people in Australia. Those who migrated to Australia at an older age or who are from refugee background, face a higher risk of mental and physical health issues. Older migrants, in particular women, are recognised as ageing prematurely and experiencing social isolation (Principe, 2015). Australian research has also identified that CALD communities particularly from Asia and the Pacific are disproportionately affected by Hepatitis B (ASHM, 2015).</p>	<p><i>2016c, Community Advisory Councils, priority setting workshops; APHN, 2016d, Health Priority Groups, priority setting workshops APHN, 2016e, Mental Health and Alcohol and Other Drugs (MHAOD) reform community consultations</i></p> <p><i>Principe, I., 2015, <u>Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds – A Scoping Study for the Health Performance Council SA</u>, assessed February 2016. Australasian Society for HIV Medicine (ASHM), 2015, Hepatitis B Mapping Project: Estimates of chronic hepatitis diagnosis, monitoring and treatment by Medicare Local, 2013/14 – National Report.</i></p>
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		<p>In South Australia, the three population groups with the highest inequality ratio of Quintile 5 (most disadvantaged) to 1 (least disadvantaged), by proportion of the South Australian population, are people born in Vietnam, the Philippines and India (Principe, 2015).</p> <p>A study of women with culturally diverse backgrounds (Lam et al., 2018) found that just 19% identified as "breast aware", and only 27% aged over 40 had participated in annual clinical breast exams.</p>	<p><i>Lam, M, Kwok, C, Lee, MJ, 2018, Prevalence and sociodemographic correlates of routine breast cancer screening practices among migrant-Australian women. Australian and New Zealand Journal of Public Health, 42: 98-103</i></p>
Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) Communities			
Complex physical and mental health challenges for the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) communities (To be further determined in 2020 NA report)	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) Communities health and wellbeing (To be further determined in 2020 NA report)	<p>In February 2019, the APHN Community Advisory Council (CAC) discussed primary health care needs of Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTIQ+) South Australians and recommended that the Adelaide PHN:</p> <ul style="list-style-type: none"> • Adopt LGBTIQ+ communities as a health priority group. • Develop and implement a community consultation and engagement strategy to inform future actions and priorities regarding LGBTIQ+ primary health care needs (APHN, 2019a). <p>Additionally, the APHN membership groups and Board endorsed further investigation on the LGBTIQ+</p>	<p><i>APHN, 2019a, Community Advisory Council, priority setting workshop: The primary health care needs of LGBTIQ+ South Australians – a priority population, February 2019.</i></p>

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		<p>Communities health and wellbeing needs. This report presents on available quantitative data, while currently ongoing stakeholder consultation will be presented in next year's Needs Assessment report along with any identified needs for the LGBTIQ+ communities in the APHN region.</p> <p>Most recent estimates from the ABS indicate that 3% of adults in Australia identify as gay, lesbian or an 'other' sexual orientation. Census data estimates that 0.7% of all couple relationships were recorded as same-sex, while in South Australia this was slightly less at 0.5% (n=1,930) (AIHW, 2018c).</p> <p>The LGBTIQ+ population is disproportionately represented in rates of mental health, sexual health and substance use. A survey by the SA Government in 2014, "South Australian Strategy for the Inclusion of Lesbian, Gay, Bisexual, Transgender, Intersex and Queer People (LGBTIQ) 2014-2016", suggests that the main factors contributing to these health issues are violence, discrimination and homelessness. Reporting on these issues in South Australia and the APHN are limited as there is minimal data available, with the majority being generalised to the Australian population (FFF, 2018).</p> <p>Additionally, a lack of systematic, nuanced research on the health and wellbeing of Australian lesbian,</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2018c, Chapter 5.5 Lesbian, gay, bisexual, transgender and intersex people in Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW</i></p> <p><i>Fay Fuller Foundation (FFF) 2018. Health Needs and Priorities in South Australia report</i></p>
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		<p>bisexual and queer (LBQ) women has been a significant barrier to understanding, recognising and addressing health needs of this group. At worst, LBQ women's health needs have been ignored. At best, they have been synonymous with general women's health (McNair, 2003). While sex between women is considered relatively low risk to health, a range of social, psychological and economic factors mean that this minority group has poorer health outcomes than their heterosexual peers. Stigma, family and community rejection and discrimination can impact on health and wellbeing, the delivery of health services, and women's access to services (Mooney-Somers et al., 2018).</p> <p><i>[Specific mental health-related data is presented in the Primary Mental Health care section]</i></p> <p><i>Substance use</i></p> <p>There is limited data on AOD use in the LGBTIQ+ community (AIHW, 2019c). Data from the AIHW for 2016 from the National Drug Strategy Household Survey (NDSHS), reported that illicit drug use in the previous 12 months was 3 times higher in those identifying as homosexual or bisexual (42%) than the heterosexual population (14%) (AIHW, 2019c).</p>	<p><i>McNair R., 2003, Lesbian health inequalities: A cultural minority issue for health professionals, MJA, Volume 178, pages 643-5.</i></p> <p><i>Mooney-Somers, J. et al. 2018. Women in contact with the Sydney LGBTQ communities: Report of the SWASH Lesbian, Bisexual and Queer Women's Health Survey 2014, 2016, 2018 Sydney: Sydney Health Ethics, University of Sydney.</i></p> <p><i>Australian Institute of Health & Welfare (AIHW) 2019c. People identifying as lesbian, gay, bisexual, transgender, intersex or queer: Alcohol, tobacco and other drugs in Australia.</i></p>
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	<p>Data on specific drug groups indicate even higher rates, with the homosexual/bisexual community being (AIHW 2019c):</p> <ul style="list-style-type: none"> • 5.8 times more likely to use ecstasy • 5.8 times more likely to use meth/amphetamines • 3.7 times more likely use cocaine (and a 4.5% increase in use between 2010 and 2016) • 3.2 times more likely to use cannabis (and a 5% increase in use between 2010 and 2016) • 2.8 times more likely to misuse pharmaceuticals <p>The NDSHS Survey also found that in 2016, those identifying as homosexual or bisexual were more likely to:</p> <ul style="list-style-type: none"> • Consume an average of more than 2 standard alcohol drinks per day (28% vs. 22%). • Exceed lifetime risky drinking guidelines (26% vs. 17.2%) • Exceed single occasion risky drinking guidelines (42% vs. 26%) (AIHW, 2019d). <p>Smoking cigarettes was also found to be more common in those identifying as homosexual or bisexual (35% vs. 29%). However, daily smoking had decreased in the LGBTIQ community between 2010 and 2016 from 28% to 18.7% (AIHW, 2019d).</p>	<p><i>Australian Institute of Health & Welfare (AIHW) 2019c. People identifying as lesbian, gay, bisexual, transgender, intersex or queer: Alcohol, tobacco and other drugs in Australia.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW) 2019d. People identifying as lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ) factsheet.</i></p>
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		<p>There is limited data available on rates of chronic disease in the LGBTIQ+ community in Australia. However, a US study found that LGB adults aged 50 years or older were more likely than heterosexuals to suffer chronic health conditions. In particular, LGB older adults were significantly more likely than heterosexual older adults to have a weakened immune system and lower back or neck pain, and higher rates of disability and mental distress. In addition, sexual minority older women were more likely than their heterosexual counterparts to report having arthritis, asthma, a heart attack, a stroke, a number of chronic conditions, and have poorer general health. Also, sexual minority older men were more likely to report having angina pectoris or cancer (Karen et al. 2017).</p>	<p><i>Karen, I., Kim H-J., Shui C., Bryan A. E.B., 2017, Chronic Health Conditions and Key Health Indicators Among Lesbian, Gay, and Bisexual Older US Adults, 2013–2014. American Journal of Public Health, Volume 107, pages 1332-1338, assessed 13 November 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5508186/</i></p>
Sexual Health			
<p>A growing need in addressing sexual health amongst vulnerable population groups (to be further determined in 2020 NA report)</p>	<p>Sexual health</p>	<p>In 2019, APHN has been working collaboratively with SA Health (Communicable Disease Control Branch) in providing General Practice data to assist in the monitoring and surveillance of recent outbreak of infectious Syphilis among Aboriginal and Torres Strait Islander people living in South Australia. Consequently, APHN is contributing to inform SA Health – Sexually Transmissible Infection (STI) and Blood Borne Virus (BBV) policy and service planning for Aboriginal and Torres Strait Islander people in SA. In 2020, the PHN will work with the CBC Branch to</p>	

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		<p>inform quality improvement initiatives for Adelaide Metropolitan General Practitioners. Furthermore, APHN is a member of the SA Sexually Transmissible Infection and Blood Borne Virus Advisory Committee (SASBAC), a high-level committee, which monitors, BBV and STIs across metro, regional and remote South Australia.</p> <p>In 2018, there were 8,556 new notifications of Sexually Transmitted Infections (STIs) and Blood-Borne Viruses (BBVs) in South Australia (Fearnley et al. 2018). This is a 3% increase in the number of new notifications since 2017. In 2018, there were 6,256 notifications of Chlamydia (<i>Chlamydia trachomatis</i>), making this the most commonly notified STI in South Australia (Fearnley et al. 2018). Data was not available by PHN or lower Statistical Areas within the PHN.</p> <p>SA Health has indicated that sex workers, men who have sex with men, transgender people, Aboriginal and Torres Strait Islander people, Culturally and linguistically diverse people and young people are at risk of getting a STI (SA Health, 2019b).</p> <p>In the Adelaide 2018 Gay Community Periodic Survey (Broady et al. 2019), nearly three-quarters of men</p>	<p><i>Fearnley, E., Tribe I., Waddell R., Solly A., 2018, Surveillance of sexually transmitted infections and blood-borne viruses in South Australia, 2018, Epidemiological report 32, Communicable Disease Control Branch, SA Health</i></p> <p><i>SA Health, 2019b, People at risk of getting a sexually transmitted infection (STI), accessed 13 October 2019,</i> https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/sexual+health+services/adelaide+sexual+health+centre/sexually+transmitted+infections/people+at+risk+of+getting+a+sexually+transmitted+infection</p>
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		<p>who have sex with men (71.3%) reported knowing that post-exposure prophylaxis (PEP) was available. PEP awareness has increased over time, from 59.2% in 2011 to 71.3% in 2018. There has also been a rapid increase in the awareness of pre-exposure prophylaxis (PrEP), from 25.5% in 2014 to 77.7% in 2018. The proportion of non-HIV-positive men who reported taking a prescribed course of PEP in the six months prior to the survey increased from 2.4% in 2014 to 4.9% in 2018. The increase in PrEP use was more dramatic, with the proportion of non-HIV-positive men who reported PrEP use increasing from 0.8% in 2014 to 16.1% in 2018. Among men who reported taking a prescribed course of PrEP in the six months prior to the 2018 survey, more than half obtained PrEP through a trial or study (59.2%) and one in four obtained it from a chemist (25.4%). Men who obtained PrEP from a chemist are assumed to have received a prescription for PrEP from their doctor, reflecting the listing of PrEP on the Pharmaceutical Benefits Scheme in 2018 . The listing of PrEP on the PBS has opportunities for the APHN in providing further support (e.g. education) to General Practitioners in the APHN region.</p> <p>Analysis of APHN General Practice data for 2018 (APHN 2019f), indicates there were a total of 1,029</p>	<p><i>Broady, T., Mao, L., Bavinton, B., Jeffries, D., Barlett, S., Calabretto, H., Narciso, L., Prestage, G., Holt, M., 2019, Gay Community Periodic Survey: Adelaide 2018, Sydney: Centre for Social Research in Health, UNSW Sydney, assessed 13 November 2019,</i> http://unsworks.unsw.edu.au/fapi/datastream/unsworks:58353/binbe9ddc0f-f25b-43fa-a05c-3e07887bf418?view=true</p> <p><i>Adelaide Primary Health Network, 2019f, General Practice data –</i></p>
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		<p>patients who visited a general practice within the time period and have a coded diagnosis for:</p> <ul style="list-style-type: none"> • Chlamydia • Gonorrhea • Trichomoniasis, and • Syphilis. <p>By gender, females tend to be over-represented in the total coded diagnosis for all STIs than males and in particular, for coded diagnosis of Chlamydia. Regardless, Chlamydia had the greatest number of coded diagnosis for all patients who visited a general practice in 2018 (APHN 2019f).</p> <p>By age groups, in both male and female sub-groups, aged 20 to 29 years old, had the greatest number with a coded diagnosis for Chlamydia. The data also shows that there is growing concern for coded diagnosis of STIs for the older age groups of 30 to 49 years old (APHN 2019f).</p> <p>A recent 2019 survey of 2,380 South Australians aged 16–29 years, asked a number of questions related to their sexual health (SAHMRI 2019). [Participant demographics included: 10% of Aboriginal and/or Torres Strait Islander origin; 3% born outside of Australia; 74% identified as heterosexual, 17% bisexual, 2% lesbian, and 4% gay]. Survey participants responded that 43% had ever had a test for STIs. Of</p>	<p><i>Sexually Transmitted Infections, 1st January 2018 to 31 December 2018, unpublished.</i></p> <p><i>South Australian Health & Medical Research Institute (SAHMRI), 2019, “Lets Talk About It” – South Australian Sexual Health Survey Results 2019, assessed 18 November 2019, https://www.sahmriresearch.org/uses/assets/7d8cc013b227045b843ef3</i></p>
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		concern was the lack of knowledge on STIs. For example, only 2 out of 10 youth who participated in the survey were aware there was a medication to cure Hepatitis C, and 45% did not know Chlamydia could lead to a woman becoming infertile. Condom use (in the past 12 months) was also reported to be low, with only 21% of those with regular partners and 36% of those with casual partners, using condoms (SAHMRI 2019).	9a53689c3a5bf86334/lets_talk_about_it_-_survey_report.pdf
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Primary Mental Health Care (including Psychosocial Support and Suicide Prevention)

Outcomes of the health needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
Child and youth living in the APHN region have significant mental health issues	Child and Youth mental health	<p>The report 'A picture of Australia's children' identifies the following as key indicators of child mental health (AIHW, 2012);</p> <ul style="list-style-type: none"> • Proportion of children aged 4–14 years with mental health problems. • Proportion of children aged 6–14 years with mental health disorders (ADHD, depressive disorder, conduct disorder). <p>The report also highlights a gap in representing this data. Consequently, limited data is available to demonstrate the status of mental health and wellbeing in children and adolescents. Data that is available is primarily at the National level, with minimal South Australian and PHN data available.</p> <p>Recent AIHW data (AIHW, 2019a) associated with the above indicators in the 'A picture of Australia's children', report that almost 1 in 7 (13.9%) of children and adolescents (4-17 years) in Australia had a mental health disorder in the 12 months prior to the study. The most common mental disorders in order of prevalence were Attention Deficit Hyperactivity Disorder (ADHD) (7.4% of</p>	<p><i>Australian Institute of Health and Welfare (AIHW) 2012. A picture of Australia's children 2012. Cat. no. PHE 167. Canberra: AIHW</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2019a, Mental Health Services in Australia. Canberra: AIHW.</i></p>

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		<p>all 4–17 year olds, or N= 315,000), Anxiety disorders (6.9% or N= 293,000); Depressive disorder (2.8% or N= 119,000) and Conduct disorder (2.1% or N= 89,000). Furthermore, there was high comorbidity, as 30.0% of those with mental health disorders, or 4.2% of all 4–17 year olds, had 2 or more mental disorders at some time in the previous 12 months (AIHW, 2019a).</p> <p>The demand on mental health services for children also appears to be increasing, as the 2013 ‘National Mental Health Report’ states that there was a three-fold increase in the number of children and young people receiving Medicare-funded primary mental health care services from 2006-07 (79,139) to 2011-12 (337,177) (DoHA, 2013). This represents an increase from 1.1% to 4.6% of children and young people. The increase was most marked for those aged 18-24 (2.2% to 7.5%), followed by those aged 12-17 (1.1% to 5.5%) (DoHA, 2013).</p> <p>Estimates from the National Mental Health Services Planning Framework - Planning Support Tool (the tool) suggest that in 2017 approximately 5,800 people aged 0-17 years in the APhN region are expected to require treatment for a severe mental disorder. A further 9,000 people aged 0-17 years are expected to require treatment for a moderate mental health while 11,300 in the same age group require treatment for mild mental health disorder. The tool also reports that a further 20,300</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2019a, Mental Health Services in Australia. Canberra: AIHW.</i></p> <p><i>Department of Health and Ageing (DoHA) (2013) National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011. Commonwealth of Australia, Canberra</i></p> <p><i>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.</i></p>
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		<p>people aged 0-17 years will experience some indication of mental ill health or risk factors for mental illness in 2017 and would benefit from early intervention and relapse prevention treatment options (DoH, 2016a).</p> <p>The 2015 'The Mental Health of Children and Adolescents' report stated that one in six (17.0%) young people in Australia (4-17 years) with mental disorders had attended a hospital emergency, or outpatient department, or been admitted to hospital due to their emotional or behavioral problems (Lawrence et al., 2015).</p> <p>Recent AIHW data on ED presentations in 2017-18 for Mental and behavioural disorders (ICD F00-F99), listed South Australia as having the highest rate of ED presentations of all States, at 4.8% (for all ages). This was compared to a National rate of 3.6% of all presentations. More than one-quarter (26.3%) of these mental health-related ED presentations were for people aged under 25yrs. More mental health-related ED presentations were for males (51.8%) than females (48.2%) (AIHW, 2019e).</p> <p>In 2017-18, South Australia had the highest proportion of ED presentations (all ages) in public hospitals for 'behavioral and emotional disorders with onset usually</p>	<p><i>Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR (2015) The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2019e, Emergency department care 2017–18: Australian hospital statistics.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW) 2019a Mental Health Services in Australia. Canberra: AIHW.</i></p>
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		<p>occurring in childhood and adolescence (ICD-10-AM-code F90–F98), at 7.2% of all mental health presentations. This was over triple the rate of other states, with a National rate of 2.6% (AIHW, 2019a).</p> <p>It is internationally recognised that early diagnosis and intervention of mental illness in childhood is essential to mitigating the impact of these mental health disorders that persist into adulthood (RACGP, 2013). For example, the WHO (2019) reports that half of all mental illnesses begin before 14 years and three-quarters by mid-20s. The recent Productivity Commission Mental Health – Draft Report, also reiterated the need for early identification of mental health risks in children (PC 2019).</p> <p><i>Mental health-related medicines</i></p> <p>The pattern of mental health-related PBS prescription dispensing for people 17 years and under varied across the APHN region. In 2013-14 the highest rate and number of prescriptions dispensed for antidepressant medications were in Onkaparinga SA3, 3,581 prescriptions equating to a rate of 9,334 prescriptions per 100,000 population (ACSQHC, 2015). The SA3s of Mitcham and Prospect-</p>	<p><i>Royal Australasian College of Physician (RACGP), 2013, Early Intervention for Children with Developmental Disabilities: Position Statement – August 2013, Paediatric & Child Health Division.</i></p> <p><i>World Health Organization (WHO) Child and adolescent mental health, Accessed 21 Oct 2019, https://www.who.int/mental_health/materal-child/child_adolescent/en/</i></p> <p><i>Productivity Commission, 2019, Mental Health, Draft Report, Canberra</i></p> <p><i>Australian Commission on Safety and Quality in Health Care and National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation. Sydney: ACSQHC.</i></p>
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		<p>Walkerville had the next highest rates with 6,588 per 100,000 and 6,584 per 100,000 respectively (ACSQHC, 2015).</p> <p>Rates of dispensing for antipsychotic medication in people aged 17 years and under varied across the APHN, with the highest rates and number of prescriptions dispensed correlated with areas of lower socioeconomic status. In 2013-14 the highest rates were SA3s of Playford (2,916 per 100,000), Onkaparinga (2,524 per 100,000) and Salisbury (2,458 per 100,000) (ACSQHC, 2015).</p> <p>Although rates of PBS dispensing for attention deficit hyperactivity disorder in people 17 years and under were lower in South Australia compared to other states and territories, a wide variation was evident across the APHN. In 2013-14 rates and numbers of ADHD prescriptions were substantially higher in the SA3s of Playford (2,248 prescriptions, a rate of 10,432 per 100,000), Onkaparinga (3,240 prescriptions, 8,541 per 100,000) and Salisbury (2,265 prescriptions, 7,648 per 100,000) (ACSQHC, 2015). The 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.</p> <p>Research indicates that 25% of young people are at risk of serious mental illness, and mental illness risk increases as</p>	<p><i>Australian Commission on Safety and Quality in Health Care and National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation. Sydney: ACSQHC.</i></p> <p><i>Australian Commission on Safety and Quality in Health Care and National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation. Sydney: ACSQHC.</i></p>
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		<p>adolescents age, becoming most prevalent in the older teen years, and even greater for Indigenous young people and young women (Bailey et al., 2016).</p> <p>The APHN Childhood and Youth Health Priority Group (HPG) identified youth mental health as a focus across all their priorities and activities and was concerned about the increased risk of poor mental health for children from families with high levels of social disadvantage, low income or family breakup, unemployment or poor family functioning, or parental mental illness and alcohol and drug use (APHN, 2016d).</p>	<p><i>Bailey, V., Baker, A-M., Cave, L., Fildes, J., Perrens, B., Plummer, J. and Wearing, A. 2016, Mission Australia's 2016 Youth Survey Report, Mission Australia.</i></p> <p><i>APHN, 2016d, Health Priority Group, priority setting workshop</i></p>
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	<p>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, 2017a, based on 2011-12 modelled estimates), and psychological distress 20% higher (PHIDU, 2017a, based on 2014-15 modelled estimates). No recent data available for comparison.</p> <p>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).</p>	<p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i></p> <p><i>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.</i></p>

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		<p>The tool estimates that 38,000 people in the APHN region are expected to require treatment for a severe mental disorder, including 25,600 18-64 year olds and 7,000 people aged 65 years and over, and by 2022 the number of people experiencing a severe mental health disorder and requiring treatment is expected to increase to over 40,000. A further 45,000 people are expected to require treatment for a moderate mental health disorder in 2017 (29,000 aged 18-64 year olds and 6,800 people aged 65 years and over), increasing to 47,000 people by 2022. The tool also reports that approximately 55,600 people are expected to require treatment for a mild mental health disorder (36,300 aged 18-64 year olds and 8,100 people aged 65 years and over), increasing to 58,500 people by 2022. It also reports that a further 68,000 people in the region (44,400 aged 18-64 year olds and 3,300 people aged 65 years and over) will experience some indication of mental ill health or risk factors for mental illness in 2017 and would benefit from early intervention and relapse prevention treatment options. This number is expected to increase to 71,100 people by 2022 (DoH, 2016a).</p>	<p><i>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.</i></p>
Higher prevalence of mental health conditions in Local Government Areas of Playford, Salisbury, Port Adelaide Enfield and Onkaparinga	High prevalence mental health conditions at sub-regional levels	<p>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, 2017a). These findings correlate strongly with socioeconomic status, with these three regions having the</p>	<p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i></p>

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<p>when compared to the APHN averages</p>		<p>lowest Index of Relative Socio-Economic Disadvantage (IRSD) scores in the APHN region. Conversely the lowest rates of psychological distress were in the LGAs of Burnside (7.1 per 100), Unley (9.2 per 100) and Mitcham (9.7 per 100) which had the highest IRSD scores in the region (PHIDU, 2017a). No new data was available for comparison.</p> <p>It is important to note that prevalence of psychological distress varies by the smaller Population Health Areas (PHAs) sub-regions within these LGAs, with rates between 59-98% higher compared to the PHN average in the PHAs of Elizabeth/Smithfield – Elizabeth North, Davoren Park, Elizabeth East and Salisbury/ Salisbury North in the northern LGAs and 50% higher in the southern PHA of Christies Downs/Hackham West – Huntfield Heights (PHIDU, 2017a). No new data was available for comparison.</p> <p>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</p>	<p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.</i></p>
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		<p>Onkaparinga LGA had the highest rates in the southern APHN (PHIDU, 2015). No new data was available for comparison.</p> <p>The Southern Community Advisory Council (CAC) indicated that mental health is a growing concern in the south and needs to be addressed in a holistic manner (APHN, 2016c).</p>	<p><i>APHN, 2016c, Community Advisory Council priority setting workshops</i></p>
Mental health treatment services to consider the mental health issues of vulnerable population groups	Disparity in mental health for specific population groups	<p><i>Note: Data for Aboriginal and Torres Strait Islander people is reported in the Aboriginal Health section while data for people with alcohol and other drugs misuse is reported in Alcohol and Other Drugs section.</i></p> <p><i>People with mental and physical health comorbidities</i></p> <p>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 mortality 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, 2017b).</p> <p>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</p>	<p><i>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.</i></p> <p><i>Australian Bureau of Statistics (ABS) 2017b, Mortality of People Using Mental Health Services and Prescription Medications, Analysis of 2011 data.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2014, Social Health Atlas of Australia.</i></p>

		<p>(ABS, 2014). <i>The ABS defines “core activity limitation” as limitation to self-care, mobility or communication, or were restricted in schooling or employment.</i></p> <p>Of all Australians with psychosocial disability, almost two in five (38.2%) reported profound levels of core activity limitation, and a further one in five (21.7%) reported severe levels of core activity limitation. Of the remaining people with psychosocial disability, 9.7% reported moderate levels of core activity limitation, 17.8% reported mild core activity limitation, and 8.7% reported school or employment restrictions. Just 3.9% of all people with psychosocial disability reported no core activity limitation, schooling or employment restrictions (ABS, 2015a).</p> <p><i>Culturally and linguistically diverse (CALD) communities</i></p> <p>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</p>	<p><i>Australian Bureau of Statistics (ABS), 2014, Disability, Ageing and Carers, Australia: Summary of Findings, 2012.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2015a, Survey of Disability, Ageing and Carers: Summary of Findings.</i></p> <p><i>Principe, I., 2015, Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds – A Scoping Study for the Health Performance Council SA, accessed February 2016.</i></p>
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<p>Mental health treatment services to consider the complex mental health challenges of <i>Lesbian, Gay, Bisexual, Transgender, or Intersex (LGBTI) communities (To be further determined in 2020 NA report)</i></p>	<p>Disparity in mental health for <i>Lesbian, Gay, Bisexual, Transgender, or Intersex (LGBTI) communities (To be further determined in 2020 NA report)</i></p>	<p>particular women, are recognised as ageing prematurely and experiencing social isolation (Principe, 2015).</p> <p>Refugees and new arrival communities are affected by mental health issues and social isolation when adapting to life in a new country (APHN, 2017b).</p> <p><i>Lesbian, Gay, Bisexual, Transgender, or Intersex (LGBTI) communities</i></p> <p>The following mental health issues have been identified in the LGBTIQ+ community:</p> <ul style="list-style-type: none"> • The National LGBTI Health Alliance 2013 reported higher rates of suicidal ideation and depression in this group than any other population in Australia; and, rates were even higher for the transgender population. Data reported from Beyond Blue, showed that LGBTIQ people are 14 times more likely to commit suicide than heterosexual people. Furthermore, Lesbian women were more likely to engage in self harm and attempt suicide than Gay men, but Gay men were more likely to have suicide ideation (Morris, 2016). • The 2016 National Drug Strategy Household Survey found experiencing high or very high psychological distress was more likely to be reported for homosexual or bisexual people (28%), as well as people who were not sure/other 	<p><i>APHN, 2017b, Primary Health Care Service Access (PHCSA) for Refugees And New Arrivals (RANA) Workshop, March 2017.</i></p> <p><i>Morris, S., 2016, 'Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People and Communities'. National LGBTI Health Alliance.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2018c, Chapter 5.5 Lesbian, gay, bisexual, transgender and intersex people in Australia's health</i></p>
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		<p>(23%), compared with heterosexuals (11%) (AIHW, 2018c).</p> <ul style="list-style-type: none"> • The AIHW (2008) reported that the National Survey of Mental Health and Wellbeing (ABS 2008), found people identifying as homosexual/bisexual aged 16 and over had higher rates of anxiety disorder (32% vs. 14.5%) and affective disorder (19% vs. 6%) than heterosexual people. The National LGBTI Health Alliance reported that the LGBTIQ population were twice as likely to be diagnosed with a mental health disorder, with 41.1% aged over 16yrs meeting the criteria for a mental health disorder in the last 12 months (Morris, 2016). • South Australian data on LGBTIQ health available from the Rainbow Survey found that when asked to rate their health, 75% of survey respondents identifying as transgender reported 'very good' or 'good' health. However, no-one rated their health as 'excellent'. Also, 73.5% of the 54 transgender respondents reported seeking psychological or medical help in relation to their transgender status (DCSI, 2017). • The LGBTIQ People Ageing Well 2018 Report found that older LGBTIQ people face challenges associated with social isolation, housing, aged care and health and wellbeing. Mental health challenges such as suicide ideation were linked 	<p>2018. Australia's health series no. 16. AUS 221. Canberra: AIHW</p> <p>Morris, S. 2016, 'Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People and Communities'. National LGBTI Health Alliance.</p> <p>Department for Communities and Social Inclusion (DCSI), 2017, Results of the South Australian Rainbow Survey 2015-16</p> <p>Centre Of The Ageing (COTA) SA and South Australian Rainbow Advocacy</p>
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		<p>with social isolation. This report found that mental health services that target and support older LGBTIQ South Australians are needed (COTA SA & SARAA, 2018).</p> <p>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).</p> <p>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).</p>	<p><i>Alliance (SARAA), 2018, LGBTIQ People Ageing Well – Final Report, July 2018.</i></p> <p><i>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</i></p> <p><i>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</i></p>
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		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 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).	<i>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 in Sex, Health and Society, La Trobe University, Melbourne</i>
People with Severe Mental Illness requiring Psychosocial Support			
Complex and challenging health needs of people with severe mental health disorders requiring psychosocial support	People with severe health disorders requiring psychosocial support	The APHN acknowledges that the (health) needs of the individuals requiring psychosocial support in our region will be unique based on the funding arrangement provided by the Commonwealth – to assist people with severe mental illness resulting in psychosocial disability who are not eligible for the National Disability Insurance Scheme (NDIS). The APHN has worked with the SA Mental Health NDIS implementation working group that consist of sector managers from each LHN, NGOs, DHS, DSS and SA Department of Health to identify opportunities for collaboration and to keep up to date with some of the changes happening in the sector which intersects with APHN commissioned activities. The APHN has also conducted two (online) surveys and a workshop (with clients) in October 2018 – the findings are reported in the Service Needs section.	

		<p>The needs of people with severe mental illness are not homogenous. Some people have episodic illness which can be supported through time-limited clinical services in the primary care setting. Others have more persistent mental illness that requires more acute, hospital based services and a need of some form of social support, ranging from group-based activities delivered through mainstream social services to extensive and individualised disability support (DoH, 2018a).</p> <p>Estimates from the National Mental Health Services Planning Framework - Planning Support Tool (the tool) suggest that in 2018 approximately 6,786 people with severe and complex mental health disorders in APHN region require high intensity adult community support services (DoH, 2018b).</p> <p>Specific data or health needs for people with severe and complex mental health disorders in APHN region requiring psychosocial support is not available but a 2010 (Australian) report on people living with psychotic illness provides some information on the health needs of this cohort of individuals (DoH, 2011).</p> <p><i>Gender and Age Groups</i></p> <p>Nationally, the report estimates that 3.1 cases per 1,000 population aged between 18 and 64 years had a psychotic</p>	<p><i>Department of Health (DoH) 2018a, PHN Primary Mental Health Care Flexible Funding Pool Implementation Guide, http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/\$File/4PHN%20Guidance%20-%20Severe%20mental%20illness.pdf</i></p> <p><i>Department of Health (DoH) 2018b, The Primary Mental Health Service Planning Framework (PMHSPF) Planning Support Tool – developed by the University of Queensland, Brisbane, data extracted October 2018, unpublished.</i></p> <p><i>Department of Health (DoH), 2011, People living with psychotic illness 2010, Canberra, http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/\$file/psych10.pdf</i></p>
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		<p>illness and were in contact with public specialised mental health services. The prevalence of psychotic disorders was higher in males than females (3.7 cases per 1,000 compared to 2.4 per 1,000). Males aged 25-34 years had the highest rates of psychotic illness (5.2 cases per 1,000). The age groups with the next highest prevalence for males were those aged 35-44 and 45-54 years. For females prevalence was more even across age groups at almost 3 cases per 1,000 population in those aged between 25 and 54 years (DoH, 2011).</p> <p><i>Type of disorder</i></p> <p>The most common psychotic disorder was schizophrenia (47.0%), accounting for the majority of males (56.3%) and one third (33.2%) of females, followed by bipolar, mania (17.5%), schizo-affective disorder (17.5%), Severe depression without psychosis (8.7%), Delusional (5.0%), depressive psychosis (4.4%) and other (not classified) (1.4%) (DoH, 2011).</p> <p><i>Nature of Illness</i></p> <p>The report states that one in twelve people (8.1%) had experienced just one episode of psychotic illness, while the majority (61.5%) had experienced multiple episodes with periods of good or partial recovery in between (29.7% and 31.8% respectively). Many people (30.5%) receiving services through the public system have continual chronic illness and one third of these experiences marked</p>	<p><i>Department of Health (DoH), 2011, People living with psychotic illness 2010, Canberra,</i> http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/\$file/psych10.pdf</p> <p><i>Department of Health (DoH), 2011, People living with psychotic illness 2010, Canberra,</i> http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/\$file/psych10.pdf</p> <p><i>Department of Health (DoH), 2011, People living with psychotic illness 2010,</i></p>
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		<p>deterioration over time. The most common symptoms of psychotic illness are delusions and hallucinations A range of other symptoms, some of which are associated with other mental disorders, such as depression and anxiety, are also commonly experienced by people with psychotic illness (DoH, 2011).</p> <p><i>Functioning</i></p> <p>Most people (90.4%) reported deterioration of functioning after illness onset. One third (32.3%) were assessed as having a significant level of impairment in their ability to care for themselves in the previous 4 weeks and almost one-fifth (18.4%) was unable to complete a simple chore such as cleaning their room. Two thirds (63.2%) were assessed as having a significant level of dysfunction in their capacity to socialise over the past year (DoH, 2011).</p> <p><i>Literacy Skills</i></p> <p>Almost one in five (18.4%) people with a psychotic illness reported difficulty with reading and/or writing (DoH, 2011).</p> <p><i>Physical conditions</i></p> <p>Chronic back, neck or other pain were common (31.8%) amongst people with psychotic illness, followed closely by above average asthma rates (30.1% compared to 20.2%</p>	<p>Canberra, http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/\$file/psych10.pdf</p> <p>Department of Health (DoH), 2011, People living with psychotic illness 2010, Canberra, http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/\$file/psych10.pdf</p> <p>Department of Health (DoH), 2011, People living with psychotic illness 2010, Canberra, http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/\$file/psych10.pdf</p> <p>Department of Health (DoH), 2011, People living with psychotic illness 2010,</p>
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		<p>for the general population) and heart or circulatory conditions (26.8% compared to 16.3% for the general population. One quarter (24.0%) of people with psychosis were at high risk of cardiovascular disease. Almost half (45.1%) of people with psychotic illness were obese. Physical activity levels were far lower in people with psychosis, with 96.4% classified as either sedentary or undertaking low levels of exercise in the previous week compared to 72.0% for the general population (DoH, 2011).</p> <p><i>Smoking, alcohol and drug use</i></p> <p>Two thirds (66.1%) of people with psychosis smoke, smoking on average 21 cigarettes per day. Alcohol abuse was high, with 58.3% of males and 38.9% of females assessed by interviewers as consuming alcohol at levels that constitute abuse or dependence at some point in their lifetime. Rates of lifetime use of cannabis or other illicit drugs were very high, with 63.2% of males and 41.7% of females assessed by interviewers as using at levels that constitute abuse or dependence. Only 12.9% of people with psychotic illness were participating in drug and alcohol treatment programs (DoH, 2011).</p> <p><i>Suicide ideation</i></p> <p>Just over one-tenth (11.5%) of people reported that they were thinking about suicide at the time of interview and two thirds (67.0%) had done so in their lifetime. Half (49.5%) reported they had attempted suicide at some</p>	<p>Canberra, http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/\$file/psych10.pdf</p> <p>Department of Health (DoH), 2011, <i>People living with psychotic illness 2010</i>, Canberra, http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/\$file/psych10.pdf</p> <p>Department of Health (DoH), 2011, <i>People living with psychotic illness 2010</i>, Canberra,</p>
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		point in their lifetime. This compares to only 3.7% in the general population. Females were more likely to have attempted suicide than males (57.5% and 44.2% respectively) (DoH, 2011).	http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/\$file/psych10.pdf
Suicide Prevention			
Suicide prevention efforts to target vulnerable population groups	Higher prevalence of suicide ideation, mental health conditions and deaths in vulnerable population groups	<p><i>Note: Data for Aboriginal and Torres Strait Islander people is reported in the Aboriginal Health section</i></p> <p><i>Gender and age</i></p> <p>In South Australia, the rates of deaths from intentional self-harm in 2016 were almost three times higher for males than females across the 15-44 year age groups and twice the rate for 45-54 year olds (ABS, 2017c).</p> <p>In 2016, intentional self-harm was the leading cause of death for South Australians aged 15-24 years old (28 deaths), 25-34 years old (43 deaths) and 35-44 years old (38 deaths), and the third-leading cause for 45-54 year olds (41 deaths) (ABS, 2017c). In Greater Adelaide between 2012-2016, 18 children aged 5-17 years old died from intentional self-harm, 12 males and six females (ABS, 2017a).</p> <p>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-</p>	<p><i>Australian Bureau of Statistics (ABS), 2017c, 3303.0 Causes of Death, Australia, 2016.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017c, 3303.0 Causes of Death, Australia, 2016.</i></p> <p><i>Nock, M., Borges, G., Bromet, E. et al., 2008, Suicide and suicidal behaviour. Epidemiological Reviews, 30(1). 133-154</i></p>

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		<p>17 years old potentially experiencing suicidal ideation in the past 12 months (ABS, 2017a).</p> <p><i>LGBTI communities (information on mental health needs are also reflected in General Population Health and Primary Mental Health Care sections)</i></p> <p>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).</p>	<p><i>Population estimates: Australian Bureau of Statistics (ABS), 2017a, Census of Population and Housing 2016 (Enumerated), compiled by profile.id and presented in Adelaide Primary Health Network community profile</i></p> <p><i>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.</i></p> <p><i>McNeil, J., Bailey, L., Ellis, S., Morton, J. & Regan, M., 2012, Trans Mental Health Study 2012, Scottish Transgender Alliance, Scotland</i></p> <p><i>Jones, T., Carpenter, M., Hart, B., Ansara, G., Leonard, W. and Lucke, J., 2016, Intersex: Stories and Statistics from Australia. Open Book Publishers: London.</i></p>
Suicide prevention efforts to target specific sub-regional areas, specifically in Local Government Areas of Playford, Adelaide City,	Higher prevalence of suicide ideation, mental health conditions and deaths at a sub-regional level	<p><i>Suicide ideation</i></p> <p>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</p>	<p><i>SA Health, 2016, Suicidal ideation: Adults July 2003 to December 2015.</i></p> <p><i>Population estimates: Australian Bureau of Statistics (ABS), 2017a, Census of</i></p>

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<p>Onkaparinga, Marion, Norwood and Mitcham</p>		<p>and over in the APHN region had experienced suicidal ideation in the past year (ABS, 2017a). The overall prevalence of suicidal ideation has remained constant at the State-level over the past ten years (SA Health, 2016).</p> <p>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, 2017a).</p> <p><i>Hospitalisations from intentional self-harm</i></p> <p>In 2015-16 Playford Statistical Area Level 3 (SA3) had the highest rate of hospitalisations due to intentional self-harm with 35 hospitalisations per 10,000 population (AIHW, 2018d). Rates were also high, and higher than the APHN average of 19 hospitalisations per 10,000 in the SA3s of Adelaide City (25), Salisbury (20), Marion (24) and Onkaparinga (23) (AIHW, 2017c).</p> <p>Within the APHN region between 2013-14 and 2014-15, Mitcham SA3 had the largest increase in hospitalisations due to intentional self-harm, 8 hospitalisations in 2013-14 (AIHW, 2016c) to 13 hospitalisations in 2014-15 (AIHW, 2017c). But Mitcham was down to 15 per 10,000 people in 2015-2016.</p>	<p><i>Population and Housing 2016 (Enumerated), compiled by profile.id and presented in Adelaide Primary Health Network community profile</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2018d, MyHealthyCommunities: Hospitalisations for mental health conditions and intentional self-harm in 2015–16</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2017c, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014–15.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2016c, Healthy Communities: Hospitalisations for</i></p>
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		<p><i>Deaths from intentional self-harm</i></p> <p>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, 2017c). In 2016, deaths from suicide and self-inflicted injuries were 33% higher in Greater Adelaide compared to the average rate for all other Australian capital cities (ABS, 2017c).</p> <p>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).</p> <p>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</p>	<p><i>mental health conditions and intentional self-harm in 2013–14.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017c, 3303.0 Causes of Death, Australia, 2016.</i></p> <p><i>Australian Health Policy Collaboration (AHPC), 2017, Australia' Health Tracker Atlas.</i></p> <p><i>Australian Health Policy Collaboration (AHPC), 2017, Australia' Health Tracker Atlas.</i></p>
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		death from suicides and self-inflicted injuries compared to the Greater Adelaide average (AHPC, 2017).	
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Alcohol and Other Drug Treatment Needs

Outcomes of the health needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
Young people in the southern and western APHN regions have higher rates of drinking at risky level when compared to APHN and State averages.	Alcohol consumption	<p>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 prevalence rate of Adelaide-West SA4 region 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). Localised data from the 2016 Survey was not available for comparison.</p> <p>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). Recent data not available for comparison.</p> <p>The Southern Community Advisory Council identified that there is a high level of substance abuse (alcohol and drugs, in particular methamphetamine) in the southern region of Adelaide requiring timely services and education for young people (APHN, 2016c).</p>	<p><i>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.</i></p> <p><i>Drug and Alcohol Services South Australia (DASSA), 2013, Alcohol consumption and related harm in South Australia.</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops</i></p>

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<p>Young people across the APHN region have significant rates of illicit drug use</p>	<p>Illicit drug use</p>	<p>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). Recent data not available for comparison.</p> <p>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). Recent data not available for comparison.</p> <p>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 secondary analysis, 2016).</p>	<p><i>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.</i></p> <p><i>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.</i></p> <p><i>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.</i></p>
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		The Southern Community Advisory Council identified that there is a high level of substance abuse (alcohol and drugs, in particular methamphetamine) in the southern region of Adelaide requiring timely services and education for young people (APHN, 2016c).	<i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i>
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	<p>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).</p> <p>From the recent 2016 Household Survey, people (aged more than 14yrs) in South Australia reported slight but non-significant declines in the rates of risky alcohol consumption (both lifetime and single occasion risk) between 2013 and 2016. But people in their 50s were the most likely to be lifetime risky drinkers and across all of Australia people in their 20s were more likely to drink 5 or more standard drinks at least once a month (AIHW 2017). Lifetime risky drinking was highest in the SA4 of Adelaide – South and West, and single occasion risky drinking was highest in Adelaide –West (AIHW, 2017d).</p>	<p><i>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.</i></p> <p><i>Drug and Alcohol Services South Australia (DASSA), 2013, Alcohol consumption and related harm in South Australia.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW) 2017d. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW.</i></p>

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		<p>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). Recent 2014-15 estimates however show that the rates were highest in LGAs of Adelaide, Holdfast Bay and Walkerville (PHIDU 2018). The risk levels were defined here as modelled estimates of alcohol consumption of more than two standard drinks per day on average (PHIDU, 2015).</p> <p>At Statistical Area Level 3 (SA3) areas, monthly risky drinking ranged from 18% (Unley) to 37% (Port Adelaide-West). In addition to Port Adelaide-West, Holdfast Bay (32%), Charles 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).</p> <p>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).</p>	<p><i>Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2018, Social Health Atlas of Australia.</i></p> <p><i>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.</i></p>
Cumulatively, use of cannabis, methamphetamine and opioids/painkillers was	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	<i>Australian Institute of Health and Welfare (AIHW), 2014, National Drug Strategy Household Survey detailed</i>

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<p>consistently higher in the Southern areas when compared with than other areas in APHN region.</p>		<p>opioid/painkiller use are 2.2% and 2.1% respectively among persons aged 18 years and over (AIHW, 2014).</p> <p>From the recent 2016 Household Survey In 2016, South Australia (1.9%) reported higher rates than the national average of 1.4% in recent meth/amphetamine use. People in South Australia also reported a significant decline in the proportion that had used ecstasy in the previous 12 months (from 2.8% in 2013 to 1.6% in 2016). South Australians were more likely to misuse pain-killers/opiates (4.3%) than people in any other state or territory. Recent ecstasy use significantly declined in South Australia (from 2.8% to 1.6%). Compared with 2010, the proportion of people reporting that ice was their main form of meth/amphetamine used in the previous 12 months has increased South Australia (AIHW, 2017d).</p> <p>Detailed 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).</p> <p>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</p>	<p><i>report 2013, Drug statistics series no. 28, Cat. No. PHE 183, Canberra, AIHW.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2017d. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW.</i></p> <p><i>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.</i></p>
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		<p>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).</p> <p>However, a recent DASSA report indicated that in South Australia amphetamines are the most common drug of concern after 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).</p> <p>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).</p> <p>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</p>	<p><i>Drug and Alcohol Services South Australia (DASSA), 2016, Identifying the Gaps: Report on South Australian Drug and Alcohol Service Planning, unpublished.</i></p> <p><i>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.</i></p>
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		<p>ranged from 13% (Adelaide-Central) to 24% (Adelaide-South) (Roche et al., 2016). In 2016, recent Illicit drug use was higher than the national rate in both Adelaide – South and West (AIHW, 2017d).</p> <p>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).</p> <p>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 (APHN, 2016c).</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2017d. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW.</i></p> <p><i>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.</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops</i></p>
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	<p>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).</p>	<p><i>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</i></p>

		<p>The latest 2017 South Australian Drug Trends Report identifies over two-fifths of the sample (41%) self-reported mental health problems in the six months preceding interview (Karlsson, 2018). The report also shows that:</p> <ul style="list-style-type: none"> • Among those who had suffered from a mental health problem, depression and anxiety continued to be the most commonly reported disorders. • Forty-eight per cent of the IDRS sample was assessed as having 'high' to 'very high' levels of psychological distress, much higher than general population norms (11%). <p><i>Alcohol use</i></p> <p>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).</p> <p>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</p>	<p><i>and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales.</i></p> <p><i>Karlsson (2018) South Australian Drug Trends 2017. Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trends Series No. 186. Sydney: National Drug & Alcohol Research Centre, UNSW Australia</i></p> <p><i>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.</i></p>
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		<p>for people with very high psychological distress compared to those with low psychological distress (Roche et al., 2017a).</p> <p><i>Tobacco use</i></p> <p>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).</p> <p><i>Illicit drug use</i></p> <p>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., 2017a).</p> <p>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).</p>	<p><i>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.</i></p>
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		<p>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).</p> <p><i>Illicit use of licit drugs</i></p> <p>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.</p> <p>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).</p> <p>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-</p>	<p><i>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.</i></p> <p><i>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.</i></p> <p><i>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.</i></p> <p><i>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.</i></p>
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		<p>related deaths involved people with a history of mental illness (Pilgrim et al., 2015).</p> <p>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).</p>	<p><i>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.</i></p>
<p>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</p>	<p>Varying patterns & prevalence of alcohol consumption and other drugs use by gender and age groups</p>	<p>Alcohol consumption in APHN region by gender:</p> <ul style="list-style-type: none"> • 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). <p>Alcohol consumption in APHN region by age groups:</p> <ul style="list-style-type: none"> • 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- 	<p><i>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.</i></p>

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		<p>59 year olds and 20% among persons aged 60 years; and</p> <ul style="list-style-type: none"> • 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). <p>Other Drugs use in APHN region by gender:</p> <ul style="list-style-type: none"> • 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). <p>Other Drugs use in APHN region by age groups:</p> <ul style="list-style-type: none"> • 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 	<p><i>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.</i></p>
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		<ul style="list-style-type: none"> 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). 	
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	<p>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.</p> <p>Young people (12-24 years including school students):</p> <ul style="list-style-type: none"> Alcohol (APHN) Cannabis (APHN) Non-opioid analgesics <p>Older people:</p> <ul style="list-style-type: none"> Alcohol (APHN) Opioids Analgesics Anxiolytics, particularly benzodiazepines (APHN, SA) Cannabis (estimates) <p>Employed people:</p> <ul style="list-style-type: none"> Alcohol (all employees; mining, public administration/safety, retail, agriculture, administration industries at higher risk) Tobacco (construction, transport, mining and agriculture industries) 	<p><i>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.</i></p>

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		<ul style="list-style-type: none"> • Cannabis (all employees; construction, transport, agriculture, manufacturing, administration, financial, scientific/professional industries at higher risk) • Methamphetamine (construction industry) • Painkillers (construction industry) <p>Unemployed people:</p> <ul style="list-style-type: none"> • Tobacco • Cannabis • Methamphetamine • Ecstasy <p>Single people:</p> <ul style="list-style-type: none"> • Alcohol • Tobacco • Cannabis • Methamphetamine • Ecstasy <p>People identifying as Lesbian, Gay, Bisexual, Transgender and/or Intersex (LGBTI):</p> <ul style="list-style-type: none"> • Alcohol • Tobacco • Illicit drug use in general • Opioids • Cannabis • Methamphetamine • Heroin 	<p><i>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.</i></p>
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		<p>People in contact with the criminal justice system:</p> <ul style="list-style-type: none"> • Alcohol • Tobacco • Illicit drug use in general • Opioids • Cannabis • Methamphetamine • Heroin <p>People with mental health conditions:</p> <ul style="list-style-type: none"> • Alcohol • Tobacco • Illicit drug use in general • Cannabis • Methamphetamine • Pharmaceuticals, painkillers/analgesics/opioids 	<p><i>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.</i></p>
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	<p><i>Alcohol use</i></p> <p>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).</p> <p>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</p>	<p><i>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.</i></p>

		<p>compared to those with low psychological distress (Roche et al., 2017a).</p> <p><i>Tobacco use</i></p> <p>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 been treated for or diagnosed with a mental illness (Roche et al., 2017a).</p> <p><i>Illicit drug use</i></p> <p>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., 2017a).</p> <p>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</p>	<p><i>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.</i></p> <p><i>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.</i></p>
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		<p>psychological distress (13% South Australia; 12% nationally) (Roche et al., 2017a).</p> <p>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).</p> <p>Based on literature reviews and secondary analysis of various data sets, Roche et al., 2017a has reported the main drugs of concern for people with mental health conditions are alcohol, tobacco, illicit drug use in general, cannabis, methamphetamine, pharmaceuticals, and painkillers/analgesics/opioids (Roche et al., 2017a).</p> <p><i>Illicit use of licit drugs</i></p> <p>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.</p> <p>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%</p>	<p><i>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.</i></p>
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		<p>respectively. The rate of use for South Australians with very high psychological distress was also twice the national rate (12%) (Roche et al., 2017a).</p> <p>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).</p> <p>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 (APHN, 2016d).</p> <p>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 (APHN, 2016c).</p>	<p><i>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.</i></p> <p><i>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.</i></p> <p><i>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.</i></p> <p><i>APHN, 2016d, Health Priority Group, priority setting workshops.</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p>
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Indigenous Health (including Mental Health and Alcohol and Other Drugs use)

Outcomes of the health needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
Chronic Conditions & Cancer Screening Participation			
Aboriginal and Torres Strait Islander South Australians have higher prevalence of nearly all health conditions, compared to non-Aboriginal South Australians.	Health inequalities in health and wellbeing of Aboriginal people	<p>The recently released <i>Aboriginal and Torres Strait Islander Health Performance Framework 2017</i> report for South Australia lists the following concerns for the State (AIHW 2017e):</p> <ul style="list-style-type: none"> • The age-standardised proportion of Indigenous women that smoked during pregnancy was 48%, this was 3 times the rate for non-Indigenous women (15%) in 2014; • A smaller proportion of Indigenous women accessed antenatal care services in the first trimester of pregnancy (53%) compared with for non-Indigenous women (78%) in 2014; • Age-standardised death rates for some chronic diseases in 2011–2015 were higher for Indigenous Australians than for non-Indigenous Australians: more than 4 times as high for diabetes (74 compared with 18 per 100,000); and twice as high for digestive diseases (46 compared with 21 per 100,000); • The incidence rate for Indigenous Australians with end-stage kidney disease increased from 24 per 100,000 in 1997, to 40 per 100,000 in 2014; and • Indigenous Australians had a higher age-standardised rate of hospitalisation for injury from 	<i>Australian Institute of Health and Welfare (AIHW), 2017e, Aboriginal and Torres Strait Islander Health Framework 2017 report: South Australia, AIHW, Canberra.</i>

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		<p>July 2013 to June 2015 compared with non-Indigenous Australians (47 compared with 24 per 1,000). The most common injuries resulting in hospitalisation were: assaults (22%), falls (19%), and complications of medical and surgical care (14%) of all hospitalisations.</p> <p>Recent analysis of health conditions, health-related behaviours and social determinants undertaken by Gibson et al. (2017a) identified that Aboriginal and Torres Strait Islander South Australians have higher prevalence of nearly all health conditions, compared to non-Aboriginal South Australians.</p> <p>The Aboriginal Health HPG reported that people are presenting late with cancer, leading to high mortality rates and there is a lack of early detection of cancer. The HPG also reported that social determinants of health such as affordable housing, available transport, financial barriers as impacting on health outcomes (APHN, 2016d).</p> <p>The Northern Adelaide Clinical Council reported that accessible services and transport were issues for the delivery of effective Aboriginal health services in the north. The Council also raised the importance of</p>	<p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017a. South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017. Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>APHN, 2016d, Health Priority Group, priority setting workshops.</i></p> <p><i>APHN, 2016a, Clinical Council priority setting workshops.</i></p>
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		<p>delivering services in a manner that is culturally safe. The Southern Adelaide Clinical Council reported that health services in its area were limited in their cultural sensitivity. The Southern Council also reported that transport was an issue for their communities with the nearest clinic being in the city (APHN, 2016a).</p> <p>The prevalence of self-reported asthma among Aboriginal children aged 0-14 years was 1.8 times higher than among non-Aboriginal 0-14 year olds; Aboriginal children were also more likely to be hospitalised (Gibson et al, 2017a).</p> <p>Infant mortality rates were also substantially higher, with 7.6 deaths per 1,000 live births from 2012-2014 for Aboriginal and Torres Strait Islander populations in South Australia, compared to 2.6 deaths per 1,000 live births for the state as a whole (ABS, 2015). In 2017 in SA the Infant mortality rate (calculated per 1,000 live births) was 4.7 for the Indigenous community, and 3.0 for the non-Indigenous. Indigenous infant mortality has decreased since 2014, when it was 7.2 (ABS, 2017d).</p>	<p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017a. South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017.</i></p> <p><i>Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2015, Infant mortality rates, Indigenous status, Selected states and territories-2002-2004 to 2012-2014.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017d, Deaths, Australia, 2017 (cat. no. 3302.0)</i></p>
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		<p><i>Health risk factors, health status & outcomes</i></p> <p>Aboriginal and Torres Strait Islander population smoking rates in metropolitan Adelaide are three times those of the non-Indigenous residents, 37% compared to 12% in 2014-15 (ABS, 2016a).</p> <p>The prevalence rates for a number of chronic conditions are substantially higher for Aboriginal and Torres Strait Islander people in South Australia compared to the prevalence for all persons. For example, in 2012-13, asthma rates were almost double (19.7% compared to 10.8%), as were rates of diabetes (8.9% compared to 4.6%). Cardiovascular disease rates were also substantially higher, 12.5% compared to 4.5% (HPCSA, 2016).</p> <p>In 2012-13, 35.7% of Aboriginal people in South Australia reported living with three or more long-term health conditions. This was higher than the national rate of 32.7% for Aboriginal people. However, it was lower than the 40.5% all-person rate for South Australia recorded in 2011-12 (40.5%). Age-standardised rates for diabetes were almost six times the non-Indigenous rate, chronic lower respiratory was three times, and intentional self-harm was twice the non-Indigenous rate (ABS, 2016a).</p>	<p><i>Australian Bureau of Statistics (ABS), 2016a, National Aboriginal and Torres Strait Islander Social Survey, 2014–15.</i></p> <p><i>Health Performance Council of South Australia (HPCSA), 2016, State of Our Health Report, (based on ABS 2013, Australian Aboriginal and Torres Strait Islander health survey: 2012-13).</i></p> <p><i>Australian Bureau of Statistics (ABS), 2016a, National Aboriginal and Torres Strait Islander Social Survey, 2014–15.</i></p>
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		<p>The all-cause mortality rate was also higher for Aboriginal and Torres Strait Islander populations in South Australia compared to the population as a whole, 9.2 deaths per 1,000 population compared to a rate of 6 deaths per 1,000 from 2010-2014 (ABS, 2016a). Data on the underlying causes of death for Aboriginal and Torres Strait Islander populations in APHN are currently not available; however the 6 leading causes of death for Aboriginal and Torres Strait Islander people in SA in 2013-17 are:</p> <ul style="list-style-type: none"> • Ischaemic heart diseases • Diabetes mellitus 61 • Malignant neoplasm of trachea, bronchus and lung • Chronic lower respiratory diseases) • Intentional self-harm) • Cirrhosis and other liver diseases (ABS, 2018). <p><i>Cancer Screening Participation</i> The SA3s of Playford, Salisbury, Port Adelaide – West, Port Adelaide – East, West Torrens and Adelaide City, have higher proportions of both Aboriginal and Torres Strait Islander and culturally and linguistically diverse populations in the target screening age groups compared to other regions of the APHN (AIHW, 2018e). Lower rates of participation in breast and bowel cancer screening are recorded in Indigenous Australians.</p>	<p><i>Australian Bureau of Statistics (ABS), 2016a, National Aboriginal and Torres Strait Islander Social Survey, 2014–15.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2018, Causes of Death, Australia, 2017 (cat. no. 3303.0)</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2018e, Cancer in Aboriginal & Torres Strait Islander people of Australia. Cat. no. CAN 109. Canberra: AIHW.</i></p>
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		<p>Screening rates for indigenous vs. non-indigenous populations in Australia are as follows:</p> <ul style="list-style-type: none"> Breast cancer: 37.3% vs. 53.2% Bowel cancer: 23.5% vs. 40% (AIHW, 2018e). <p>Information is not available on Indigenous participation in the National Cervical Screening Program.</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2018e, Cancer in Aboriginal & Torres Strait Islander people of Australia. Cat. no. CAN 109. Canberra: AIHW.</i></p>
Child & Youth Health			
Access to services and management of conditions influencing Aboriginal and Torres Strait Islander children and youth presenting at ED and admissions with potentially preventable conditions.	Timely access and equity to health services and care	<p>Analysis of data (2012/13 – 2014/15) from SA health have shown increasing concern for specific potentially preventable conditions - Ear, Nose and Throat infections, Asthma, Dental conditions, Urinary tract infections and Diabetes complications, among the child and youth presenting at Emergency Departments in APHN region (SA Health, 2016a). Recent data not available.</p> <p>The burden of poor oral health is not evenly distributed across the population with Aboriginal children experiencing more than 50 per cent tooth decay than non-Aboriginal children. Furthermore, children in the lowest socio-economic areas have 50 to 70 per cent more tooth decay compared to those in the highest socio-economic areas, and untreated tooth decay is 70 per cent more prevalent in the most disadvantaged children. However, 18 to 27 per cent of children in the highest socio-economic groups also had untreated</p>	<p><i>SA Health, 2016a, Potentially Preventable Admissions data, 2012/13 – 2014/15, unpublished.</i></p> <p><i>SA Health, 2015a, SA Dental Service, Understanding possible preventable hospital separation data for dental, Evaluation and Research Unit, Service Quality & Performance Improvement, August 2015, unpublished.</i></p>

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		tooth decay (SA Health, 2015a). Aboriginal children experience approximately 70 per cent more dental caries than non-Aboriginal people and they have more teeth with untreated dental decay. The rate of decay is the major cause for hospital admissions (SA Health, 2010).	<i>SA Health, 2010, Aboriginal Health Care Plan 2010-2016, South Australia, Department of Health, Statewide Service Strategy Division.</i>
Increase immunisation coverage rates across the APHN region for children 5 year and under, particularly for Aboriginal and Torres Strait Islander children.	Childhood immunisation	<p>Although the immunisation rates for Aboriginal and Torres Strait Islander children living in the APHN region have significantly increased since 2013-14, Aboriginal and/or Torres Strait Islander children still have a lower rate of fully immunised children at 1-, and 2-years of age, compared to non- Aboriginal and/or Torres Strait Islander children in the region (NHPA, 2015a). As of June 2017, immunisation coverage rates for 5-year old for Aboriginal and Torres Strait Islander children living in the APHN region were at 95%, which is in line with the national target (DOH, 2017c).</p> <p>The Aboriginal Health Health Priority Group identified immunisation as an issue within maternal, child and youth health (APHN, 2016d).</p>	<p><i>National Health Performance Authority (NHPA), 2015a, Australian Childhood Immunisation Register statistics 2014–15.</i></p> <p><i>Department of Health (DOH), 2017c, Current PHN immunisation coverage data for Aboriginal and Torres Strait Islander children, Current quarter: June 2017, <u>Immunise Australia website</u>, accessed October 2017</i></p> <p><i>APHN, 2016d, Health Priority Group, priority setting workshops.</i></p>
Rates of obesity and overweight are higher for Aboriginal children compared to non-Aboriginal children	Childhood Obesity	For Aboriginal children, over a third (37.6%) aged 5-17 years in South Australia were overweight or obese. This percentage is higher when compared to non-Aboriginal children and to the national average for Aboriginal children (32.8%) (HPCSA, 2018). Compared to other states and territories, South Australia is ranked second highest (HPCSA, 2016). The AHPC national data	<p><i>Health Performance Council of South Australia (HPCSA), 2018, State of Our Health (online report), accessed Oct 2018.</i></p> <p><i>Health Performance Council of South Australia (HPCSA), 2016,</i></p>

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		<p>indicated that unhealthy weight in childhood is a significant issue for Aboriginal children and young people (AHPC, 2017).</p> <p>The Aboriginal Health HPG identified the need to focus on prevention of obesity, as it can contribute to health issues such as diabetes and hypertension (APHN, 2016d).</p>	<p><i>State of Our Health Report, (based on ABS 2013, Australian Aboriginal and Torres Strait Islander health survey: 2012-13).</i></p> <p><i>APHN, 2016d, Health Priority Group, priority setting workshops.</i></p>
Mental Health (including Suicide Ideation)			
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	<p>The Aboriginal Health Health 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 (APHN, 2016d).</p> <p>Aboriginal people living in the Central Adelaide Local Health Network (CALHN) were hospitalised for mental health-related conditions at 4.5 times the age-standardised rate of non-Aboriginal people (54 per 1,000 people compared to 12 per 1,000 people). This equated to 42 extra Aboriginal hospitalisations per 1,000 people. While the age-standardised rate of mental health hospitalisation in non-Aboriginal people in CALHN was slightly lower than the state rate, Aboriginal people in CALHN had a higher rate of</p>	<p><i>APHN, 2016d, Health Priority Group, priority setting workshops.</i></p> <p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017b. South Australian Aboriginal Health Needs and Gaps Report: Central Adelaide Local Health Network, 2017, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p>

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		<p>hospitalisation than the state rate (Gibson et al., 2017b).</p> <p>Aboriginal people living in Northern Adelaide Local Health Network (NALHN) were hospitalised for mental health-related conditions at 5.2 times the age-standardised rate of non-Aboriginal people (54.9 per 1,000 compared to 10.6 per 1,000 population). This equated to 44 extra Aboriginal hospitalisations per 1,000 population. While the age-standardised rate of mental health hospitalisation in non-Aboriginal people in NALHN was slightly lower than the state rate of 12.4 per 1,000 population, Aboriginal people in NALHN had a higher rate of hospitalisation than the state rate of 48.5 per 1,000 population. This difference between NALHN and the state was driven by higher rates for Aboriginal females in NALHN compared to their state counterparts. Between 2011 and 2015, mental health separations for Aboriginal people declined in both NALHN and the wider state (Gibson et al., 2017c).</p> <p>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</p>	<p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017c. South Australian Aboriginal Health Needs and Gaps Report: Northern Adelaide Local Health Network, 2017, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017d. South Australian Aboriginal Health Needs and Gaps Report: Southern Adelaide Local Health Network, 2017, Wardliparingga Aboriginal</i></p>
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		<p>lower rate of hospitalisation (34.4 per 1,000) than the state rate of 48.5 per 1,000 population. This difference between SALHN and the state was driven by higher rates for Aboriginal females in SALHN compared to their state counterparts. Between 2011 and 2015, mental health separation rates for Aboriginal people declined in both SALHN and the wider state (Gibson et al., 2017d).</p> <p>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).</p> <p><i>Psychological Distress</i></p> <p>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).</p> <p>Most common admission type was for 'Injury, poisoning and other external causes', then 'pregnancy, childbirth and the puerperium', then 'mental health related</p>	<p><i>Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>Health Performance Council of South Australia (HPCSA), 2016, State of Our Health Report, (based on ABS 2013, Australian Aboriginal and Torres Strait Islander health survey: 2012-13).</i></p> <p><i>Australian Bureau of Statistics (ABS), 2016, National Aboriginal and Torres Strait Islander Social Survey, Australia, 2014–15</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2016, Aboriginal and Torres Strait Islander Social Health Atlas of Australia.</i></p>
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		conditions'. Greater Adelaide was above the rate for the rest of Australia (for Aboriginal persons) for 'mental health related conditions' by 31% and 'All cancers' by 16% (ABS 2016).	<i>Australian Bureau of Statistics (ABS), 2016, National Aboriginal and Torres Strait Islander Social Survey, Australia, 2014–15</i>
Suicide prevention efforts to specifically target Aboriginal and Torres Strait Islander people	Higher prevalence of suicide ideation, mental health conditions and deaths in Aboriginal and Torres Strait Islander population	<p>Suicide accounted for a higher proportion of deaths among Aboriginal and Torres Strait Islanders populations, 4.2%, compared to non-Indigenous South Australians, 1.6% of deaths (ABS, 2016a). Intentional self-harm [suicide] was the 5th ranked cause of death for ATSI but ranked 13th for non-indigenous population (ABS, 2017c).</p> <p>Furthermore, the 2012-2016 age-standardised death rate from intentional self-harm for Aboriginal and Torres Strait Islander South Australians was 70% higher compared to the rates for non-Indigenous South Australian, 21.3 deaths per 100,000 population and 12.6 deaths per 100,000 population respectively (ABS, 2017c).</p> <p>The four reports by Gibson et al. (2017a) 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</p>	<p><i>Australian Bureau of Statistics (ABS), 2016a, National Aboriginal and Torres Strait Islander Social Survey, Australia, 2014–15</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017c, 3303.0 Causes of Death, Australia, 2016</i></p> <p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017a. South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017. Wardliparingga Aboriginal</i></p>

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		<p>age group (3.8 per 10,000 population). For non-Aboriginal people, the highest rate was in the 35–44 age group (2.0 per 10,000 population). The 15–24 age group had the lowest rate for non-Aboriginal people (0.9 per 10,000 population) (Gibson et al., 2017a).</p> <p>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., 2017b).</p> <p>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., 2017c).</p> <p>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 were in the 35–44</p>	<p><i>Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017b. South Australian Aboriginal Health Needs and Gaps Report: Central Adelaide Local Health Network, 2017, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017c. South Australian Aboriginal Health Needs and Gaps Report: Northern Adelaide Local Health Network, 2017, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p>
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		age group (2.1 per 10,000 population) (Gibson et al., 2017d).	<i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017d. South Australian Aboriginal Health Needs and Gaps Report: Southern Adelaide Local Health Network, 2017, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i>
Alcohol and Other Drugs (AOD) (The APHN is currently reviewing data for Indigenous AOD treatment needs and will be further determined in the 2020 NA report)			
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	<p>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.</p> <p>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).</p>	<p>Commonwealth of Australia (Department of Health) 2017, <i>National Drug Strategy 2017-2026, Canberra, Commonwealth of Australia.</i></p> <p><i>Drug and Alcohol Services South Australia (DASSA), 2017, South Australian Alcohol and Other Drug Strategy 2017-2021, Adelaide, Government of South Australia.</i></p> <p><i>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</i></p>

		<p>Alcohol</p> <p>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).</p> <p>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, 2017e). Data was not available for APHN region. [There were also no significant changes in drug use among Indigenous Australians between 2013 and 2016 but changes are difficult to detect among Indigenous people in the NDSHS due to the small Indigenous sample (AIHW, 2017d)]</p> <p>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, 2017e).</p> <p>Previous data in 2012-13, reported that for Adelaide 55% and 23% of Aboriginal people aged 15+ years in South Australia exceeded the single occasion risk (past year) and lifetime risk guidelines, respectively. For</p>	<p><i>University, Adelaide, South Australia, unpublished.</i></p> <p><i>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.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2017e, Aboriginal and Torres Strait Islander Health Performance Framework: 2017 report, Catalogue number IHW 181, Canberra.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW) 2017d. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW.</i></p>
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		<p>South Australia, it was 51% and 21% respectively (Roche et al., 2017a).</p> <p>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).</p> <p>Tobacco</p> <p>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).</p> <p>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, 2017e).</p> <p>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-</p>	<p><i>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.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2017e, Aboriginal and Torres Strait Islander Health Performance Framework: 2017 report, Catalogue number IHW 181, Canberra.</i></p>
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		<p>Indigenous Australians (40% compared with 14%). This is consistent with national rates (AIHW, 2017e).</p> <p>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, 2017e).</p> <p>Illicit Drugs use</p> <p>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, 2017e). Data was not available for APHN region.</p> <p>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, 2017e). Data was not available for APHN region.</p> <p>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, 2017e).</p> <p>Previous data in 2012-13, reported that 48% and 27% of Aboriginal people aged 15+ years in Adelaide had used</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2017e, Aboriginal and Torres Strait Islander Health Performance Framework: 2017 report, Catalogue number IHW 181, Canberra.</i></p>
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		<p>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).</p> <p>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).</p> <p>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).</p>	<p><i>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.</i></p> <p><i>Drug and Alcohol Services South Australia (DASSA), 2016, Identifying the Gaps: Report on South Australian Drug and Alcohol Service Planning, unpublished.</i></p>
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SECTION 3 – OUTCOMES OF THE SERVICE NEEDS ANALYSIS

This section summarises the findings of the service needs analysis in the table below. The needs for General Practice Support is detailed in the General Population Health section while the needs for the Psychosocial Support Measure is reported in the Primary Mental Health section accordingly.

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

Outcomes of the service needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
Accessing appropriate primary health care services for vulnerable population groups	Timely access and equity to primary health care services and care	<p><i>Clinical Councils</i></p> <p>Priority setting workshops with the Southern Adelaide Clinical Council (CC) prioritised the importance of improving and increasing timely access to health services (APHN, 2016a).</p> <p>During the priority setting workshops, the Central Adelaide CC prioritised the need to map and coordinate implementation of current strategies and develop solutions to current gaps for End of life care (APHN, 2016a).</p> <p>The Northern Adelaide CC prioritised the need to improve coordination and access to primary health care services and programs and build the capacity of the primary health care workforce (incl. GPs) to meet the needs of at risk and vulnerable people. They also identified a need for better pathways for consumers to enable navigation through the primary health care system (particularly for the socially isolated, at risk families, mental health, and vulnerable populations) (APHN, 2016a).</p>	APHN, 2016a, Clinical Council, priority setting workshops.

		<p><i>Community Advisory Councils</i></p> <p>The Central Community Advisory Council (CAC) prioritised that the importance to identify the barriers including cost to accessing health services despite the availability of quality and quantity of chronic disease services. Additionally, the Council identified access and affordability as important as health literacy, coordination and facilitation of care and mental health and comorbidity (APHN, 2016c).</p> <p>During the priority setting workshops, the Northern CAC prioritised that health service providers need to inform themselves to address and cater for the needs of vulnerable individuals – Aboriginal and Torres Strait Islander people, CALD, elderly, youth, and others. 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, 2016c).</p> <p><i>Health Priority Groups</i></p> <p>The Disability HPG prioritised the need to review the current provision of disability health services to maintain and enable access to primary health services across disability, health and community (APHN, 2016d).</p> <p>The Childhood & Youth HPG prioritised the need to build the capacity of families using sound community development practices which empower minority groups and build trust. Services need to be accessible, appropriate and timely (APHN, 2016d).</p>	<p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
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		<p>The Mental Health HPG prioritised the need to ensure a coordinated approach between services that focuses on the whole person and their circumstances, including coexisting physical health needs and complex social factors which interact with mental health (APHN, 2016d).</p> <p>In the priority setting workshops, our Palliative Care HPG prioritised that capacity needs (to be built) at the primary care level to maximise care and support for people in the community when they are dying. They emphasised that GPs and palliative care nurses are critical to the whole system working (APHN, 2016d).</p> <p>In a Position Statement on the 'Early Intervention for Children with Developmental Disabilities' (RACGP, 2013), the RACGP emphasized that access to early intervention support services for children with Developmental disabilities, including Autism Spectrum Disorders (ASD), maximises positive life-long outcomes. A recent Productivity Commission Draft Report on Mental Health also reiterates the need for early identification of mental health risks in children (PC, 2019). Although ASD is not considered a mental health disorder by the Productivity Commission, ASD has a high comorbidity with other disorders.</p> <p>Early intervention can be highly dependent on obtaining a diagnosis. Diagnosis of ASD in South Australia is impeded by long wait lists, particularly at public hospitals, and significant costs of private assessment services, which can be upwards of a thousand dollars (Taylor et al. 2016).</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>Royal Australasian College of Physician (RACGP) Paediatric & Child Health Division. 2013. Early Intervention for Children with Developmental Disabilities: Position Statement.</i></p> <p><i>Productivity Commission (PC), 2019, Mental Health, Draft Report, Canberra, accessed 15 October 2019, https://www.pc.gov.au/inquiries/current/mental-health/draft</i></p> <p><i>Taylor, L., Brown, P., Eapen, V., Midford, S., Paynter, J., Quarmby, L., Smith, T., Maybery, M., Williams, K. and</i></p>
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		<p>In South Australia, Autism SA reported that wait times in public hospitals vary between 8 – 14 months (Autism SA 2010).</p> <p>In 2018 (January to December), the Women’s and Children’s Hospital (WCH) Child Development Unit (CDU) reported there were a total of 1,104 referrals received for Autism Diagnostic Assessments and 417 patient assessments conducted (WCH, 2019a). Of these assessments, 89.7% were diagnosed with ASD (WCH 2019a) with the WCH website indicating a waiting time of approximately 14–18 months (WCH, 2019b).</p> <p>In 2019, according to NALHN CDU (to date/October 2019), there were a total of 419 young people on the wait list for assessments. Of these, 351 are for Autism Diagnostic Assessments and as of October 2019, the wait time was 25 months (NALHN 2019).</p>	<p><i>Whitehouse, A. (2016). Autism Spectrum Disorder Diagnosis in Australia: Are we meeting Best Practice Standards? Autism Co-operative Research Centre, Brisbane</i></p> <p><i>Autism SA 2010. Autism Spectrum Disorders in South Australia; Submission to the Productivity Commission on Disability Care and Support.</i></p> <p><i>Women’s and Children’s Hospital (WCH), 2019a, Child Development Unit (CDU) email correspondence, unpublished.</i></p> <p><i>Women’s and Children’s Hospital (WCH), 2019b, Child Development Unit (CDU), assessed 21 October 2019, http://www.wch.sa.gov.au/services/az/other/allied/childdev/index.html</i></p> <p><i>Northern Adelaide Local Health Network (NALHN), 2019, Child Development Unit (CDU) email correspondence, unpublished.</i></p>
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Accessing appropriate primary health care services for LGBTIQ+ communities (To be further determined in 2020 NA report*)	Appropriate and equity access to primary health care services and care for vulnerable population groups (To be further determined in 2020 NA report*)	<p>*Further information on APHN Stakeholder consultation for the LGBTIQ+ communities will be presented in the 2020 NA report</p> <p><i>Accessing Services</i></p> <p>Use of crisis support services (CSS) by the LGBTIQ+ community has been found to be poor, with a survey by the Australian Research Centre in Sex, Health and Society finding that over 71% of respondents chose not to use a CSS during their most recent personal or mental health crises (Waling et al., 2019).</p> <p>The 2019 South Australian Rainbow Advocacy Alliance (SARAA) Survey found that only 60% of respondents felt comfortable disclosing their gender and/or their sexual orientation when accessing services. This not only raises concern over why this community feels uncomfortable reporting this, but also suggests that data on health service use by the LGBTIQ+ community is extremely unreliable. Furthermore, when accessing services, 37.7% of respondents felt that they didn't receive enough or meaningful information to inform decision making. Also, 64% felt that the current level of LGBTIQ+ specific services did not adequately meet their needs (SARAA, 2019).</p>	<p><i>Waling, A., Lim, G., Dhalla, S., Lyons, A., & Bourne, A. (2019). Understanding LGBTI+ Lives in Crisis. Bundoora, VIC & Canberra, ACT: Australian Research Centre in Sex, Health and Society, La Trobe University & Lifeline Australia. Monograph 112.</i></p> <p><i>South Australian Rainbow Advocacy Alliance (SARAA), LGBTIQ+ Community Survey 2019.</i></p>
Improve access to culturally appropriate health services for refugees and new arrivals, and culturally diverse communities	Refugees and new arrivals and diverse communities timely access to primary health care services	<p>Consultations undertaken with APHN's membership groups identified Culturally and Linguistically Diverse (CALD) and new and emerging communities' health as one of the target population groups for the APHN (APHN, 2016a, 2016c, 2016d).</p> <p>The service needs of CALD communities were raised as areas of concern particularly their ability to access mental health,</p>	<p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016a, Clinical Council, priority setting workshops.</i></p>

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		<p>alcohol and other drug and primary health care services in our region (APHN, 2016b, 2016d).</p> <p>Research undertaken by the Health Performance Council SA identified people from CALD backgrounds are among the population groups missing out on accessing suitable services or gaining equitable health care outcomes (Principe, 2015). Analysis of patient data between 2011-15 reported that 8.2% of patients visiting General Practices were of CALD backgrounds in the APHN region when compared to 13.2% for other capital cities and 8.9 nationally (BEACH, 2016).</p> <p>The CALD Scoping Study for the Health Performance Council SA have identified: inclusion and empowerment; access and equity; quality and capacity building as key principles of care for persons from CALD backgrounds arising from consultations and other relevant research (Principe, 2015).</p> <p>The APHN conducted a number of RANA consultations with key stakeholders representing the multicultural sector, primary</p>	<p>APHN, 2016d, <i>Health Priority Groups (HPG), priority setting workshops</i></p> <p>APHN, 2016b, <i>Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p> <p><u>Principe I., 2015, <i>Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds – A Scoping Study for the Health Performance Council SA</i>, assessed February 2016.</u></p> <p><i>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.</i></p>
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		<p>health care and research which identified the following areas required addressing:</p> <ul style="list-style-type: none"> • health literacy for refugees and new arrivals to make informed decisions about their health and health care. Refugee and new arrival populations have limited understanding of the Australian health system and access to appropriate and timely primary health care services (APHN, 2017c) • capacity building for primary health workers supporting the health of refugees and new arrivals. Primary health care providers, including general practice don't have the support, training and capacity to deliver culturally safe and culturally appropriate services to refugee and new arrival populations (APHN, 2017c) • system integration of primary health care services for refugees and new arrivals. The migrant health sector and primary health care services are not integrated due to the lack of formalised partnerships and referral pathways that increase and improve access and delivery of culturally appropriate and sensitive primary care services to new arrival and refugee populations (APHN, 2017c). 	<p><i>APHN, 2017c, Refugees and New arrivals (RANA) consultation and co-design workshops, August 2017.</i></p>
Increase the health workforce capacity to work with vulnerable population groups with high health needs to improve access to	Health Workforce	<p><i>Clinical Councils</i></p> <p>The priority setting workshops with the Northern Adelaide 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</p>	<p><i>APHN, 2016a, Clinical Council, priority setting workshops.</i></p>

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<p>primary health care services and health literacy</p>		<p>families, mental health, health ownership, advanced care planning and vulnerable populations) (APHN, 2016a).</p> <p>The Southern Adelaide CC prioritised the need to reduce unwarranted variation in care by improving health literacy and education (APHN, 2016a).</p> <p>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 is specific national priorities including opiate and antibiotic prescribing by improving health literacy and education (APHN, 2016a).</p> <p><i>Community Advisory Councils</i></p> <p>The Northern CAC prioritised the need better education for consumers and professionals across the health sector to improve and encourage the take-up and application of preventative measures (APHN, 2016c).</p> <p>The Central CAC prioritised the need for consumers to be empowered and involved in their own care, to use plain language, access to transparent information about fees and reasons for particular referral pathways, enable more online patient reviews of primary health services, and for general practices to have up to date and accessible websites (APHN, 2016c).</p> <p>The Southern CAC prioritised that community members and service providers need to better inform themselves about services available throughout the primary health care sector</p>	<p><i>APHN, 2016a, Clinical Council, priority setting workshops.</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p>
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		<p>and how to access those services, by improving health literacy and education (APHN, 2016c).</p> <p><i>Health Priority Groups</i></p> <p>The Older People & Aged Care HPG prioritised the need for awareness of services and case coordination for those who do not have access or skills to use the internet. They also identified the need for advocacy for older people by health professionals. The Older People & Aged Care HPG also stressed the importance of building the capacity of health professionals and GPs to undertake mental health assessments, support older people with advance care and palliative care needs better and address overprescribing of medications (falls risk) by providing support, training and education (APHN, 2016d).</p> <p>The Palliative Care HPG prioritised the need to promote end-of-life and advanced care planning in primary care; encourage and support GPs with an interest in the field, and expand the GP shared care model. They also identified the need to raise awareness in the community, and recognise the role the aged care sector can play in providing palliative care (APHN, 2016d).</p> <p>The Childhood and Youth HPG prioritised health literacy of the community in relation to healthy child development and developmental behaviours; whilst upskilling practitioners in the impacts of trauma on children's health and development was a priority. There was also concern that there is a lack of knowledge by primary health practitioners (including GPs) in paediatrics; especially developmental and behavioural issues (APHN, 2016d).</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
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		<p>The Mental Health HPG prioritised the need to invest in early intervention and prevention with inclusive criteria which facilitates access to services. 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 (APHN, 2016d).</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
<p>Lack of integration, pathways and care coordination along the health continuum for people in our community and particularly vulnerable population groups.</p>	<p>Care coordination, integration and navigation</p>	<p><i>Clinical Councils</i></p> <p>The priority setting workshops with our Central Adelaide CC identified system integration (–development of improved and standardised access and integration processes between primary care and both public and private hospital services), as a priority need for (improving) care coordination, integration and navigation (APHN, 2016a). The Southern Adelaide CC prioritised increasing integration through coordination and communication between services and practitioners (APHN, 2016a). Similarly, the Northern Adelaide CC prioritised integrated approach as the key need for (improving) care coordination, integration and navigation (APHN, 2016a). The Northern Adelaide Clinical Council reported that there was limited knowledge of what services are available for people experiencing chronic pain. They also reported a lack of coordination and integration of these services (APHN, 2016a).</p>	<p><i>APHN, 2016a, Clinical Council, priority setting workshops.</i></p> <p><i>APHN, 2016a, Clinical Council, priority setting workshops.</i></p>

		<p><i>Community Advisory Councils</i></p> <p>In the workshops, the Central CAC 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 (APHN, 2016c). The Northern CAC prioritised the need to coordinate pathways to primary health care. Additionally, they reported that the health system is way too complex for consumers and users in navigate it properly – consequently the inability to access information or programs pertinent to them (APHN, 2016c). 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, 2016c).</p> <p><i>Health Priority Groups</i></p> <p>The Disability HPG prioritised the need for a primary health care service model for people with disabilities which is interagency and interdisciplinary (APHN, 2016d).</p> <p>During the priority setting workshops, the Palliative Care HPG prioritised the need to shift focus from the acute system to the role of GPs and the navigation issues from the perspective of consumer, clinician and service provider. Additionally, they identified that pathways need to be simple and easy to access – a stepped model of care that is responsive and timely with one person, a case manager / coordinator, to help sort care</p>	<p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
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		<p>when needed will improve care coordination, integration and navigation (APHN, 2016d).</p> <p>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 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 (APHN, 2016d).</p> <p>The Childhood & Youth HPG prioritised the need to improve the (current) disjointed service delivery models which present multiple barriers to the provision of services being child-focused. The HPG also reported there is a lack of identified care coordinators for families with complex needs and a lack of funding / workforce/ quality which affects the level of care coordination and collaboration (APHN, 2016d).</p> <p>The Older People & Aged Care HPG prioritised the need to improve case management, care coordination and advocacy on behalf of consumers by health professionals, and increase incentives to encourage collaboration and integration across aged care, acute and primary care sectors (APHN, 2016d).</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
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		The Mental Health HPG prioritised the need to improve the experience of entry to and navigation of the stepped care and broader service system (APHN, 2016d).	APHN, 2016d, Health Priority Groups (HPG), priority setting workshops
Access to appropriate and timely health care services are pivotal in reducing specific PPH (conditions) in specific areas of the APHN.	High rates of preventable hospitalisations by sub-regional levels and age groups in APHN region	<p><i>Geographic and temporal persistence of PPHs across APHN</i></p> <p>Following the work by Duckett and Griffiths (2016) published as “Perils of Place: identifying hotspots of health inequalities”, a recent PHIDU analysis on PPH provides another framework to identify the existence of areas with persistently high PPH rates over time. It utilises two measures; (i) “hotspots” or the degree of temporal persistence of PPHs over time and (ii) difference in PPH (ASR) rates, with the Australian rates via heatmaps. APHN regards this new PHIDU work as another suite of evidence to highlight areas where interventions can be targeted.</p> <p>The below PHAs are regarded as “hot” with rates of 50% more than the Australian average for the period 2012/13 - 2016/17 for specified PPHs categories (i.e. PPH rates consistently over specific Australian rate in recent four out of five years) (PHIDU, 2019):</p> <ol style="list-style-type: none"> 1. Total separations all PPHs (categories) – 2 PHAs: <ol style="list-style-type: none"> I. Davoren Park (Northern Adelaide Local Health Network (NALHN) region); and II. Elizabeth/Smithfield-Elizabeth North (NALHN). 2. Overnight separations all PPHs – 3 PHAs: <ol style="list-style-type: none"> I. Davoren Park (NALHN); 	Public Health Information Development Unit (PHIDU), 2019, Potentially Preventable Hospitalisations: A Geographic and Temporal Analysis, Data by Population Health Area, Published 2019: September 2019.

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		<p>II. Elizabeth/ Smithfield-Elizabeth North (NALHN); and</p> <p>III. Christie Downs/ Hackham West – Huntfield Heights (SALHN).</p> <p>3. Total Acute PPHs – 1 PHA:</p> <p>I. Elizabeth/ Smithfield-Elizabeth North (NALHN).</p> <p>4. Same-day separations Acute PPHs – 1 PHA:</p> <p>I. Hope Valley – Modbury (NALHN).</p> <p>5. Overnight separations Acute PPHs – 2 PHAs:</p> <p>I. Davoren Park (Northern Adelaide Local Health Network (NALHN) region); and</p> <p>II. Elizabeth/Smithfield-Elizabeth North (NALHN).</p> <p>6. Total Chronic PPHs – 3 PHAs:</p> <p>I. Davoren Park (NALHN);</p> <p>II. Elizabeth/ Smithfield-Elizabeth North (NALHN); and</p> <p>III. Christie Downs/ Hackham West – Huntfield Heights (SALHN).</p> <p>7. Overnight separations Chronic PPHs – 5 PHAs:</p> <p>I. Davoren Park (NALHN);</p> <p>II. Elizabeth East (NALHN);</p> <p>III. Elizabeth/ Smithfield-Elizabeth North (NALHN);</p> <p>IV. Salisbury/ Salisbury North (NALHN); and</p> <p>V. Christie Downs/ Hackham West – Huntfield Heights (SALHN).</p> <p>8. Total Vaccine-preventable conditions PPHs – 6 PHAs:</p> <p>I. Davoren Park (NALHN);</p>	<p><i>Public Health Information Development Unit (PHIDU), 2019, Potentially Preventable Hospitalisations: A Geographic and Temporal Analysis, Data by Population Health Area, Published 2019: September 2019.</i></p>
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		<p>II. Elizabeth/ Smithfield-Elizabeth North (NALHN);</p> <p>III. Enfield-Blair Athol (NALHN);</p> <p>IV. Christie Downs/ Hackham West – Huntfield Heights (SALHN);</p> <p>V. Charles Sturt-North West (CALHN); and</p> <p>VI. Dry Creek-South/ Port Adelaide/ The Parks (CALHN).</p> <p>9. Overnight Vaccine-preventable conditions PPHs – 8 PHAs:</p> <p>I. Davoren Park (NALHN);</p> <p>II. Elizabeth/ Smithfield-Elizabeth North (NALHN);</p> <p>III. Parafield/ Parafield Gardens/ Paralowie (NALHN);</p> <p>IV. Salisbury/ Salisbury North (NALHN);</p> <p>V. Christie Downs/ Hackham West – Huntfield Heights (SALHN);</p> <p>VI. Charles Sturt-North West (CALHN);</p> <p>VII. Dry Creek-South/ Port Adelaide/ The Parks (CALHN); and</p> <p>VIII. Richmond (CALHN).</p> <p>Overall observation of the data shows the following 3 PHAs have continued temporal persistence of PPHs over time and significant rates above the Australian average:</p> <p>1. Davoren Park (NALHN);</p> <p>2. Elizabeth/ Smithfield-Elizabeth North (NALHN); and</p>	<p><i>Public Health Information Development Unit (PHIDU), 2019, Potentially Preventable Hospitalisations: A Geographic and Temporal Analysis, Data by Population Health Area, Published 2019: September 2019.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2019, Potentially Preventable</i></p>
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		<p>3. Christie Downs/ Hackham West – Huntfield Heights (SALHN). (PHIDU, 2019)</p> <p>Recent analysis of AIHW data of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), for period 2015–16, 2016–17 and 2017–18 for ED presentation for lower urgency care showed variations in age-standardised rates (per 1,000 population) for All hours, In-hours and After-hours in APHN region (by SA3s and LHNs) (AIHW, 2019g). In 2017-18 the lower urgency ED rates for all persons by LHNs were:</p> <table border="1"> <thead> <tr> <th>Geography</th><th>All hours (% difference with APHN)</th><th>In-hours (% difference with APHN)</th><th>After-hours (% difference with APHN)</th></tr> </thead> <tbody> <tr> <td>APHN</td><td>85.7</td><td>43.6</td><td>42.1</td></tr> <tr> <td>NALHN</td><td>91.5 (6.8%)</td><td>46.3 (6.1%)</td><td>45.2 (7.3%)</td></tr> <tr> <td>CALHN</td><td>71.9 (-16.2%)</td><td>34.3 (-21.3%)</td><td>37.5 (-10.9%)</td></tr> <tr> <td>SALHN</td><td>96.9 (13.1%)</td><td>52.4 (20.3%)</td><td>44.5 (5.6%)</td></tr> </tbody> </table> <p>(AIHW, 2019g)</p> <p>The following SA3s had the highest lower urgency ED per 1,000 population rates across All hours, In-hours <u>and</u> After-hours for all persons when compared to the APHN rates:</p> <ol style="list-style-type: none"> 1. Onkaparinga (SALHN) 2. Charles Sturt (CALHN) 	Geography	All hours (% difference with APHN)	In-hours (% difference with APHN)	After-hours (% difference with APHN)	APHN	85.7	43.6	42.1	NALHN	91.5 (6.8%)	46.3 (6.1%)	45.2 (7.3%)	CALHN	71.9 (-16.2%)	34.3 (-21.3%)	37.5 (-10.9%)	SALHN	96.9 (13.1%)	52.4 (20.3%)	44.5 (5.6%)	<p><i>Hospitalisations: A Geographic and Temporal Analysis, Data by Population Health Area, Published 2019: September 2019.</i></p> <p><i>Australian Institute of Health & welfare (AIHW) 2019g, Use of emergency departments for lower urgency care: 2015-16 to 2017-18, Cat. No. HSE 231</i></p> <p><i>Australian Institute of Health & welfare (AIHW) 2019g, Use of emergency departments for lower urgency care: 2015-16 to 2017-18, Cat. No. HSE 231</i></p>
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		<p>3. Port Adelaide-West (CALHN)</p> <p>4. Playford (NALHN) (AIHW, 2019g)</p> <p>In 2013-14 the age-standardised rate of potentially preventable hospitalisations (PPH) in the APHN was 2,446 hospitalisations per 100,000 people, consistent with the Australian average rate (NPHA, 2015b). The most recent 2016-17 reported that the PPH rate for the APHN had slightly increased to 2,653 per 100,000 people (note: is similar to the national rate for 2016-17) (AIHW, 2018f).</p> <p>In 2013-14, approximately six percent (6%) of hospitalisations were for vaccine preventable conditions. Acute conditions, primarily dental conditions, kidney and urinary tract infections, cellulitis and ear, nose and throat infections, accounted for 47% of PPH. Chronic conditions also accounted for 47% of PPH, with the highest rates for chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes complications, iron deficiency anaemia and angina (NPHA, 2015b). In 2016-17, the majority of PPH hospitalisations in the APHN were for chronic (42%) and acute conditions (49%), with vaccine-preventable conditions accounting for 9%. This was analogous to national trends. The highest PPH for acute conditions and chronic conditions were similar to the 2013-14 trends with pneumonia and influenza the highest for vaccine preventable conditions for both reporting periods (AIHW, 2018f).</p>	<p><i>National Health Performance Authority (NHPA), 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14. Australian Institute of Health and Welfare (AIHW), 2018f. Potentially preventable hospitalisations in Australia by small geographic areas. Cat. No. HPF 36. Canberra: AIHW. National Health Performance Authority (NHPA), 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14. Australian Institute of Health and Welfare (AIHW), 2018f. Potentially preventable hospitalisations in Australia by small geographic areas. Cat. No. HPF 36. Canberra: AIHW.</i></p>
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		<p>In 2013-14, the top five conditions (out of 22 conditions) contributed to approximately half of the total PPH in the region and almost two-thirds of total bed days. Heart failure contributed to the highest proportion of bed days with 16.3% (and 9.1% of PPH), followed by COPD, 14.8% bed days (10.7% of PPH), kidney and urinary tract infections 13.1% (11.7% of PPH), diabetes complications 10.1% bed days (7.2% of PPH) and cellulitis 9.7% of bed days (8.9% of PPH) (NHPA, 2015b). This trend was similar for the 2016-17 data (AIHW, 2018f).</p> <p>In 2013-14, age-standardised rates of PPH varied across the APHN region (NHPA, 2015b). Rates for Total PPH were highest in the north and north-west areas of the APHN, specifically the Statistical Area Level 3s of Playford, Port Adelaide – West, Salisbury and Port Adelaide – East. Rates were lowest in Burnside, Unley and Prospect – Walkerville. For 2016-17, the same SA3s had the highest (and increased) PPHs although the rates for Port Adelaide-West has somewhat reduced. The SA3 of Playford had the highest PPH rate of 3,941 hospitalisations per 100,000 people in APHN. (AIHW, 2018f).</p> <p>In 2013-14, the four SA3s (i.e. Playford, Port Adelaide – West, Salisbury and Port Adelaide – East) as well as Onkaparinga in APHN's south, had the highest rates of PPH for Chronic conditions respectively (NHPA, 2015b). In 2016-17, the trends</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2018f. Potentially preventable hospitalisations in Australia by small geographic areas. Cat. No. HPF 36. Canberra: AIHW.</i></p> <p><i>National Health Performance Authority (NHPA), 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14. Australian Institute of Health and Welfare (AIHW), 2018f. Potentially preventable hospitalisations in Australia by small geographic areas. Cat. No. HPF 36. Canberra: AIHW.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2018f. Potentially preventable hospitalisations in Australia by small geographic areas. Cat. No. HPF 36. Canberra: AIHW.</i></p>
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		<p>were similar although Prospect – Walkerville is now 4th highest instead of SA3 of Port Adelaide-East (AHIW, 2018f).</p> <p>There was less variation in the PPH rates for Acute and Vaccine-preventable across the region, but they were highest in the SA3s of Playford, Adelaide City, Port Adelaide – East, Salisbury, Tea Tree Gully, Marion and West Torrens respectively (NHPA, 2015b).</p>	<p><i>National Health Performance Authority (NHPA), 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14.</i></p>
<p>Improve access to and effectiveness of primary health care services for older persons including quality use of medications.</p>	<p>Healthy ageing</p>	<p>The Older Persons & Aged Care HPG identified the following issues as priority needs for the HPG:</p> <ul style="list-style-type: none"> • loneliness (social isolation), • quality use of medications leading to increased mortality, morbidity and falls, • lack of access to primary mental health care services (for older people), • Lack of care coordination and pathways between acute, primary health care and aged/social care services, • raising awareness of health professionals to the early warning signs of dementia, and • palliative care (e.g. communication of end of life transition, knowledge in workforce about palliative care referral pathways, use of Advanced Care Plans). (APHN, 2016d) <p>The Central Adelaide Clinical Council reported that there are currently no palliative care beds in the South Australian community. They reported a lack of standardised</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>

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		<p>documentation of clinical instructions, a lack of knowledge of health care providers available, poor understanding and lack of access to palliative medicines and a lack of out-of-hours continuity of care (APHN, 2016a).</p> <p>The Northern Adelaide Clinical Council also reported that there was a need for good palliative care for people with comorbidities and mental health support (APHN, 2016a).</p> <p><i>Mental health-related medication</i></p> <p>In 2013-14, for people aged 65+ years, the highest rates of dispensing of antidepressant medications in the APHN region was in the Statistical Area Level 3 (SA3) of Playford with 244,017 prescriptions per 100,000 people; the South Australian rate was 206,606 per 100,000 (ACSQHC, 2015). Rates for antidepressant dispensing were also high in Onkaparinga (217,803), Tea Tree Gully (217,739), Salisbury (216,313), and Norwood-Payneham-St Peters (216,138) (ACSQHC, 2015).</p> <p>Playford SA3 had the 2nd highest rate of PBS prescriptions dispensed for anxiolytic (anti-anxiety) medicines in Australia for people aged 65 years and over with 74,380 per 100,000 people, twice the Australian rate (ACSQHC, 2015). Rates for anxiolytic dispensing were also high in Port Adelaide - West (59,011), Salisbury (58,342), Tea Tree Gully (54,215), and Marion (52,324) (ACSQHC, 2015).</p> <p>The highest rates of antipsychotic medicines dispensing for people aged 65 years and over occurred in the SA3s of Port Adelaide - West (33,404), Norwood-Payneham-St Peters</p>	<p><i>APHN, 2016a, Clinical Council, priority setting workshops.</i></p> <p><i>Australian Commission of Safety and Quality in Health Care (ACSQHC) and the National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation.</i></p> <p><i>Australian Commission of Safety and Quality in Health Care (ACSQHC) and the National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation.</i></p>
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		<p>(32,932), Adelaide City (31,730), Playford (31,364), and Unley (31,002) (ACSQHC, 2015).</p> <p>Rates of PBS prescriptions dispensed for anticholinesterase medicines, which are used to treat Alzheimer's, in people aged 65 years and over were notably higher in the SA3s of Charles Sturt (21,369), Port Adelaide - West (19,923), Adelaide City (18,004), and Playford (17,666) compared to the Australian rate, 12,650 prescriptions per 100,000 people (ACSQHC, 2015).</p> <p>While there is a correlation between areas of lower socioeconomic status particularly in the north of the APHN region, and higher rates of mental health-related PBS prescriptions dispensing to people aged 65 years, the patterns may also reflect the distribution of older residents and the density of aged care facilities across the APHN region. The APHN also notes that based on the available data, it is not possible to determine the extent to which antidepressant and antipsychotic medicines were prescribed for conditions other than mental health.</p> <p><i>Hospitalisations</i></p> <p>In South Australia, people aged 65 years and over take up a disproportionately large amount of overnight stays in hospital, with people aged between 65-75 years of age twice as likely as the rest of the population to be admitted to hospital. In particular, despite being only 4.9% of the population, people aged 80 and over take up more than 25% of overnights stays, with those aged over 85 years are more than five times as likely to be admitted to hospital (OFTA, 2014).</p>	<p><i>Australian Commission of Safety and Quality in Health Care (ACSQHC) and the National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation.</i></p> <p><i>Office for the Ageing (OFTA), 2014, Prosperity through longevity: South Australia's ageing plan, our vision 2014-2019.</i></p>
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		<p>In 2015-16 people aged 65+ years and living in the APHN region made up 48% of potentially preventable hospitalisations in South Australian hospitals; people aged 85 years and over made up 14% (SA Health, 2017). This remained consistent at 48% through 2016-17 and 2017-18 (SA Health, 2018b). The rates of potentially preventable hospitalisations in the region generally increased with age, with people 80 years and older with the highest rates each year. In 2015/16 the four most common conditions leading to a 'potentially preventable' hospitalisation in people aged 65 years and older were chronic obstructive pulmonary disease, congestive cardiac failure, urinary tract infections, and diabetes complications (SA Health, 2017). This trend continued in 2017-18 - the most frequent acute conditions for PPH in those over 65 years were urinary tract infections and cellulitis, and chronic conditions were chronic obstructive pulmonary disease, congestive cardiac failure, diabetes complications, and angina (SA Health, 2018b).</p> <p>Feedback from the Central Adelaide Clinical Council reported that one in four people over age 75 have an unplanned hospital admission due to a medication related problem (APHN, 2016a).</p> <p>At the APHN level, older people residing in APHN accounted for 9% of AOD-related hospital separations. However, they comprised higher proportions of separations for alcohol (15%) and opioids (16%) (Roche et al., 2017a).</p>	<p><i>SA Health, 2017, PPA Data for Adelaide Primary Health Network (PHN), unpublished</i></p> <p><i>SA Health, 2018b, Potentially Preventable Admissions (PPA) Data for Adelaide Primary Health Network (PHN) (data compiled for the PHN, unpublished)</i></p> <p><i>APHN, 2016a, Clinical Council, priority setting workshops.</i></p> <p><i>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</i></p>
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		<p>The number of fentanyl-related deaths in Australia increased between 2002/03 and 2010/11. While fentanyl prescriptions were most prevalent among females over 80 years, fentanyl-related deaths most commonly occurred among males aged 30-49 years (Roxburgh et al., 2011).</p> <p><i>Primary health care services</i></p> <p>Community consultations conducted by the former Medicare Locals in the APHN region reported a number of issues for older adults including access to transport, social isolation, coordination of health and social services, capacity to navigate the health system and coordination of end of life and palliative care (CAHML, 2015; SAFKIML 2015; NAML 2015).</p> <p>Barriers to access, particularly for older CALD communities include language, the reliance on online information and registration for services, and changes to and within community support agencies (Principe, 2015).</p>	<p><i>University, Adelaide, South Australia, unpublished.</i></p> <p><i>Roxburgh, A., Bruno, R., Larance, B., & Burns, L. (2011). Prescription of opioid analgesics and related harms in Australia. Medical Journal of Australia, 195(5), 280-284.</i></p> <p><i>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.</i></p> <p><i>Principe, I., 2015, <u>Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse</u></i></p>
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			<u>Backgrounds – A Scoping Study for the Health Performance Council SA, assessed February 2016.</u>
After-Hours			
Continue to raise awareness amongst both the community and healthcare providers about the after-hours services particularly in the SA3s of Playford, Salisbury, Tea Tree Gully, Port Adelaide-East, Port Adelaide-West, Charles Sturt, Marion, Onkaparinga and Adelaide City.	Variations in after-hours service use and access	<p>PHN analysis of SA Health data indicated that approximately two-fifths of all unplanned Emergency Department (ED) presentations in the 2013/14 and 2014/15 financial years occurred in the after-hours period, and two-fifths of these presentations were triaged as semi-urgent or non-urgent (SA Health, 2015d). Approximately two-thirds of these presentation were self-, relative- or friend-referrals. The Local Government Areas of Playford, Onkaparinga, Adelaide City and Walkerville had the highest presentation rates in this period. Approximately 1 out of every 10 presentations was for a potentially preventable-type condition. Ear, Nose, Throat infections, Cellulitis, Urinary Tract infections, Dental conditions and Asthma are potentially preventable conditions presenting at EDs in the after-hours period in APHN region especially the LGAs of Playford and Onkaparinga (SA Health, 2015d).</p> <p>Data provided by the National Health Performance Agency (NHPA, 2017) indicate that in the 2013/14 financial year, the SA3s with the highest average number of unplanned, non-urgent, semi-urgent and urgent after-hours ED attendances in the APHN region were SA3s of Playford (135 attendances per 1,000 people), Onkaparinga (125 attendances) and Adelaide</p>	<p>SA Health, 2015d, Emergency Department Presentations, 2013/14 – 2014/15, unpublished analysis undertaken by APHN.</p> <p>SA Health, 2015d, Emergency Department Presentations, 2013/14 – 2014/15, unpublished analysis undertaken by APHN.</p> <p>National Health Performance Authority (NHPA), 2017a, Healthy Communities: Use of</p>

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		<p>City (102 attendances). Other SA3s of Salisbury (101 attendances), Port Adelaide-East (96 attendances), and Charles Sturt (97 attendances) had rates higher than the APHN average of 93 attendances per 1,000 people (NHPA, 2017a).</p> <p>Recent NHPA data reports that for 2015/16, there were 90 after-hours ED attendances per 1,000 people for the APHN region. The 2015-16 data shows the following SA3s had higher after-hours ED attendances when compared to the APHN average: Playford (132 attendances), Onkaparinga (117), Port Adelaide-West (101), Salisbury (97), Charles Sturt (95) and Adelaide City (94) (NHPA, 2017b).</p> <p>Between 2012/13 and 2014/15, non-urgent after-hours attendances by general practitioners increased by 23%, and urgent after-hours attendances by 26% in the same period (DOH, 2015). Recent trend data by the National Health Performance Agency (NHPA, 2017a) indicates that the after-hours GP attendances has increased from 0.53 attendances per person (age-standardised) in 2013/14 to 0.65 attendances in 2016-17. In 2013/14, the SA3s of Playford, Port Adelaide-West and Charles Sturt had the highest rates after-hours GP attendances per person respectively (NHPA 2017b). These SA3s still had the highest rates in 2015-16. However, in 2016-17, the following SA3s had the highest rates of after-hours GP attendances respectively: Playford, Port Adelaide-West, Port Adelaide-East and Salisbury (note: rates has increased from</p>	<p><i>emergency department and GP services in 2013-14 to 2016-17.</i></p> <p><i>National Health Performance Authority (NHPA), 2017b, Healthy Communities: Use of emergency department and GP services in 2013-14 to 2015-16.</i></p> <p><i>Department of Health (DOH), 2015, Medicare Benefits Schedule, 2013/14 – 2014/15, analysis undertaken by APHN, unpublished.</i></p> <p><i>National Health Performance Authority (NHPA), 2017b, Healthy Communities: Use of emergency department and GP services in 2013-14 to 2015-16.</i></p>
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		<p>previous reporting periods) (NHPA, 2017b). This data will also be reported in General Practice Support section.</p> <p>The rate of use of GP services use in the after-hours period is higher in APHN compared to rates for all metropolitan PHNs (grouped) and the National rate (AIHW, 2019h). Rates of GP after-hours activity in the APHN have increased by 19% in over the five years from 2013-14 to 2017-18 with rates of use remaining consistent for last 3 years.</p> <p>In 2017-18, 29% of APHN residents, approximately 360,000 people, had used an After-Hours GP service, with 25% using a non-urgent service and nine percent an urgent service. Over 800,800 services were delivered in the after-hours period in 2017-18 equivalent to an ASR of 65 services per 100 people (AIHW, 2019h).</p> <p>Almost one out of every ten people (9.1%) in APHN had used an urgent GP after-hours service in 2017-18. This equates to a rate of 15.0 services per 100 people, more than twice the national rate of 6.3 services per 100 people (AIHW, 2019h).</p> <p>Use of After-hours GP services was highest amongst children aged 0-14 years and older adults aged 80+ years for non-urgent, urgent and total service types (AIHW, 2019h). The rate of GP after-hour services provided to people aged 80+ years was three times the rate for APHN residents aged 15-24, 45-64, and 65-79 years, and twice the rate for people aged 25-44 and 0-14 years (AIHW, 2019h).</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2019h, Medicare-subsidised GP, allied health and specialist health care across local areas, 2013–14 to 2017–18.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2019h, Medicare-subsidised GP, allied health and specialist health care across local areas, 2013–14 to 2017–18.</i></p>
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		<p><i>Use of Healthdirect helpline</i></p> <p>In 2016 there were 82,567 calls to the <i>HealthDirect</i> helpline (Nurse Triage) while in 2017, there were 87, 008 calls. In 2017, residents living in the postcodes in LGAs of Playford, Salisbury, Tea Tree Gully, Onkaparinga and Adelaide City made the most call episodes to the <i>HealthDirect</i> helpline (Nurse Triage) (HealthDirect Australia, 2018). In the 2016 and 2017 approximately 4% of all calls made by APHN residents to the Nurse (Triage) Helpline were triaged to the After-Hours GP Helpline (HealthDirect Australia, 2018). This data will also be reported in General Practice Support section.</p> <p>Analysis of the <i>HealthDirect</i> Australia data shows that for 2016 there were 3,345 calls made to the After-Hours GP Helpline while in 2017, there were slightly higher or 3,363 calls to the Helpline. In 2017, residents living in the postcodes in LGAs of Playford, Salisbury, Tea Tree Gully, Marion and Onkaparinga made the most call episodes to the After-Hours GP Helpline (HealthDirect Australia, 2018). This data will also be reported in General Practice Support section.</p> <p>Recent data shows that for 2018, 36% of the 3,980 calls made to the After-Hours GP Helpline concerned children, with 1,120 calls for patients aged 0-4 years old (HealthDirect Australia, 2019).</p>	<p><i>HealthDirect Australia, 2018, HealthMap data 2016/17, accessed November 2018, unpublished.</i></p> <p><i>HealthDirect Australia, 2018, HealthMap data 2016/17, accessed November 2018, unpublished.</i></p> <p><i>HealthDirect Australia, 2019, HealthMap data 2017/18, accessed August 2019, unpublished.</i></p>
Provide specific primary care services for the community during the	Availability and awareness of urgent primary health care services	While there are currently a number of Medical Deputising Services operating in the after-hours period across the APHN, analysis of their service boundaries show that there are pockets	Adelaide Primary Health Network (APHN), 2016f, analysis of Medical deputising

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<p>after-hours period to reduce unnecessary urgent triage 4 and 5 presentations to Emergency Departments</p>		<p>within in the north of the Playford LGA, and south-eastern region of the Onkaparinga LGA that are not being serviced (APHN, 2016f). No new data available for analysis.</p> <p>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 (CAHML, 2015; SAFKIML, 2015; NAML, 2015).</p> <p>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).</p> <p>In 2019, the APHN membership groups (CAC and CC's) raised the need to improve awareness of after-hours services among the community and providers. The Central CC commented on the need for greater promotion of after-hours services in primary health care to ensure community uptake, particularly in culturally and linguistically diverse communities. The</p>	<p>service provider websites (National Home Doctor Service, MedVisit, Australian Family Home Doctor, Doctor To You, Call The Doctor, Western Suburbs After Hours, My Doctor Now), unpublished, assessed August 2016.</p> <p>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.</p> <p>APHN, 2019b, Clinical and Community Advisory Councils, After Hours consultation, May 2019.</p>
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		<p>northern CAC raised the need for GP's to improve the promotion of after-hours services to their patients. The Northern CC commented that GPs are referring patients to ED rather than after-hours services and greater awareness is needed among GPs in order to avoid this (APHN, 2019b).</p> <p>The Southern Adelaide Clinical Council reported during a planning workshop that young people in crisis do not always receive help in a timely manner. The Central Adelaide Clinical Council also reported that there is a lack of available psychiatric services and the Northern Adelaide Clinical Council raised the issue that mental health services were 9 to 5 and an extended hour 'walk in clinic' was needed in the North (APHN, 2016a).</p> <p>The 2019 consultations with APHN membership groups (CAC and CC's) established that access to and awareness of after-hours services was still an issue in the APHN region (APHN, 2019b).</p> <p>Members also considered there to be a lack of after-hours mental health services to address the needs of children and youth, people with AOD issues, Aboriginal and Torres Strait Islander populations, and the LGBTIQ community. Members also identified that more after-hours services are required for other vulnerable population groups including people experiencing homelessness, those with low incomes, and the elderly (APHN, 2019b).</p> <p>As well as mental health services, members suggested that after-hours services for pharmacy, dental health, sexual health, and domestic violence support were also lacking across in the</p>	<p><i>APHN, 2016a, Clinical Council, priority setting workshops.</i></p> <p><i>APHN, 2019b, Clinical and Community Advisory Councils, After Hours consultation, May 2019.</i></p> <p><i>APHN, 2019b, Clinical and Community Advisory Councils, After Hours consultation, May 2019.</i></p> <p><i>APHN, 2019b, Clinical and Community Advisory Councils, After Hours consultation, May 2019.</i></p>
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		<p>region. Council members also suggested that more phone services, counselling, allied health and nursing specialists, and community related services such as those associated with community centres and lived experience support were needed in the after-hours period (APHN, 2019b).</p> <p>Feedback gained from the workforce (GPs, Business and Practice Managers, SA Ambulance Service staff, and LHN Nurses) participating in the Priority Care Centre (PCCs) trial identified several accessibility barriers that limit the service ability in the after-hours. These included access to support services such as pharmacy, radiology and pathology due to restricted operating hours; GP recruitment issues in the after-hours period; current operating hours of PCCs (in-hours) mismatch high demand times in emergency departments (sociable after-hours) (APHN, 2019c).</p>	<p><i>APHN, 2019c, Perceptions of Priority Care Centres Trial, October 2019, unpublished.</i></p>
<p>General Practice Support</p> <p><i>The APHN has: 327 General Practices, 1,617 General Practitioners and 447 Practice Nurses, in our region.</i></p> <p>Following the findings from the APHN General Practice Support Survey (reported in the previous NA report), the APHN consulted further (directly) with General Practitioners between November 2018 and May 2019. A total of 36 General Practitioners in the region were consulted through workshops on the Issues and</p>			

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Opportunities to achieve a successful and productive working relationship between APHN and GP's, for better health outcomes for the community in the region. Findings from this workshop are reported in this section, referenced as "GP's Roundtable Workshops". The consolidated Pareto chart of themes (from the workshop) shows that approximately 50% of the total weight is coming from three Issues and Opportunities: (1) Lack of collaboration and poor relationships between primary and acute; (2) Education, training and business support for GP practices; and (3) Difficulty accessing mental health services and other specialised services. These are addressed in the NA report.

Following feedback from the GP's Roundtable Workshops, between June 2019 and October 2019, the APHN consulted with Local Health Networks on the issues and opportunities to achieve a successful and productive working relationship between APHN, the Local Health Networks (CALHN / SALHN / NALHN), General Practitioners and Hospital Consultants for better health outcomes for the community in the region. Findings from this workshop are reported in this section, referenced as "LHN/GP/Hospital Workshops". The consolidated Pareto chart of themes (from the workshop) shows that approximately 50% of the total weight is coming from two Issues and Opportunities: (1) Improved clinical communication (interpersonal) and (2) Functional, integrated technology that facilitates clinical communications. These are addressed in the NA report.

Appropriate access to quality primary care including mental health and other specialised services	Access to primary health care and other specialised services	In the most recent South Australian Monitoring & Surveillance System (SAMSS) Survey, between July 2016 to March 2018, 87.7% of the participants in the State reported visiting a general practitioner in the past 12 months at least once (SAMSS, 2018a). The top three SA3s with the highest proportion of participants visiting a general practitioner (in the past 12 months) were: Port Adelaide-West (95.0%), Adelaide City (94.0%), Norwood-Payneham-St Peters (92.8%) respectively (SAMSS, 2018). For the same reporting period, 31.4% of participants indicated visiting a general practitioner in the past four weeks (SAMSS, 2018). The top three SA3s with the highest proportion of participants visiting a general practitioner (in the past four weeks) were: West Torrens (52.8%), Port Adelaide-East (39.4%) and Tea Tree Gully (38.9%) (SAMSS, 2018).	SA Health, 2018a, South Australian Monitoring & Surveillance System (SAMSS), South Australian Health and Risk Factor Profile by SA3 regions.
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		<p>Between 2012/13 and 2014/15, non-urgent after-hours attendances by general practitioners increased by 23%, and urgent after-hours attendances by 26% in the same period (DOH, 2015). Recent trend data by the National Health Performance Agency (NHPA, 2017) indicates that the after-hours GP attendances has increased from 0.53 attendances per person (age-standardised) in 2013/14 to 0.65 attendances in 2016-17. In 2013/14, the SA3s of Playford, Port Adelaide-West and Charles Sturt had the highest rates after-hours GP attendances per person respectively (NHPA, 2017). These SA3s still had the highest rates in 2015-16. However, in 2016-27, the following SA3s had the highest rates of after-hours GP attendances respectively: Playford, Port Adelaide-West, Port Adelaide-East and Salisbury (note: rates has increased from previous reporting periods) (NHPA, 2017).</p> <p>Analysis of the <i>HealthDirect</i> Australia data shows that for 2016 there were 3,345 calls made to the After-Hours GP Helpline while in 2017, there were slightly higher or 3,363 calls to the Helpline. In 2017, residents living in the postcodes in LGAs of Playford, Salisbury, Tea Tree Gully, Marion and Onkaparinga made the most call episodes to the After-Hours GP Helpline (HealthDirect Australia, 2018).</p> <p>For calls to the <i>HealthDirect</i> helpline (Nurse Triage) in 2016 there were 82,567 calls while in 2017, there were 87, 008 calls. In 2017, residents living in the postcodes in LGAs of Playford, Salisbury, Tea Tree Gully, Onkaparinga and Adelaide City made the most call episodes to the <i>HealthDirect</i> helpline (Nurse</p>	<p><i>Department of Health (DOH), 2015, Medicare Benefits Schedule, 2013/14 – 2014/15, analysis undertaken by APHN, unpublished.</i></p> <p><i>National Health Performance Authority (NHPA), 2017, Healthy Communities: Use of emergency department and GP services in 2013-14 to 2016-17.</i></p> <p><i>HealthDirect Australia, 2018, HealthMap data 2016/17, accessed November 2018, unpublished.</i></p> <p><i>HealthDirect Australia, 2018, HealthMap data 2016/17, accessed November 2018, unpublished.</i></p>
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		<p>Triage) (HealthDirect Australia 2018). Therefore, in the 2016 and 2017 approximately 4% of all calls made by APHN residents to triaged to the Nurse (Triage) Helpline went to the After-Hours GP Helpline (HealthDirect Australia, 2018).</p> <p>Findings from the GP's Roundtable Workshops reported that difficulty in accessing mental health services and other specialised services is the third most important issues and opportunities for the participants (APHN, 2019).</p> <p>The below is summary of themes from the workshops (difficulty in accessing mental health services and other specialised services):</p> <ul style="list-style-type: none"> • Person-centred care <p>GPs identified that a range of people in the APHN region cannot access services that meet their needs. This includes services for underserved groups and populations as well as overall preventive care and condition management.</p> <ul style="list-style-type: none"> • Navigation <p>Access to services is hampered by challenging pathways and referral processes, including eligibility criteria, lack of clear processes and follow-up.</p> <ul style="list-style-type: none"> • Timely access <p>GPs mentioned that urgent mental health care was difficult to access and that there were often long waiting times for other mental health services, including commissioned ones (APHN, 2019d).</p>	<p><i>Adelaide Primary Health Network (APHN), 2019d, GP's Roundtable Workshops, November 2018 to May 2019, unpublished.</i></p>
Work collaboratively to assist in accreditation	Accreditation	<p>The APHN General Practice Support Survey found that 85% of General Practices are accredited. While 15% of the Practices reported that they were not accredited, 7% (n=77, 4th most</p>	<p><i>APHN 2018b, Adelaide PHN General Practice Support Survey</i></p>

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		common response) indicated requiring support from the APHN for accreditation (APHN, 2018b).	<i>2018, October 2018, unpublished.</i>
Increase awareness and uptake of digital health systems and benefits for patients	Digital Health	<ul style="list-style-type: none"> Nearly three quarters or 74% of the practices reported that they are actively uploading and viewing patient My Health Records while 12% reported that they are aware of My Health Record but are not planning to use it. Two percentage (2%) of the practices indicated they are not aware how the Record can benefit their work and their patients. Only 5% (n=49, 11th most common response) selected requiring assistance from the APHN in using My Health Record (APHN, 2018b). Fax service and postal services were the top two responses/choices for more than half (53%) of the practices surveyed to receive/send patient/client information to other health professionals. Health Link, Argus and Email were the other most common choices by the practices. Six percentage (6%) (n=61, 9th most common response) of the practices indicated requiring assistance from the APHN in the utilisation of secure messaging services to receive/send patient/client information to other health professionals (APHN, 2018b). 	<i>APHN 2018b, Adelaide PHN General Practice Support Survey 2018, October 2018, unpublished.</i>
Targeted support to increase awareness and utilisation of HealthPathways SA and specific pathways for patients	HealthPathways SA	More than half or 67% of the practices reported that they are not aware of HealthPathways SA and a majority of those who are aware of it have indicated that the general practitioners in the practice have not utilised it. Additionally, 13% (n=132, the (first) most common response) indicated requiring assistance from the APHN with HealthPathways SA (APHN, 2018b).	<i>APHN 2018b, Adelaide PHN General Practice Support Survey 2018, October 2018, unpublished.</i>

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		<p>A dedicated (joint APHN and Country SA PHN) survey (N=110) directed to consumers (i.e. those with chronic conditions and carers) reported that for APHN participants (n=101), chronic pain, mental health, arthritis, asthma, diabetes and COPD were the top conditions respectively for HealthPathways prioritization. Other conditions reported included Myalgic Encephalomyelitis/Chronic Fatigue Syndrome or ME/CFS, Fibromyalgia, and Hashimoto's Thyroiditis (APHN, 2018a).</p> <p>The survey also reported that majority of the participants had a range of comorbidities. The majority had chronic pain and mental health as comorbidities while those with Chronic pain reported multiple comorbidities (e.g. Mental health, arthritis, and Asthma) while participants with mental health reported chronic pain and asthma as top comorbidities (APHN 2018a).</p>	<p><i>APHN 2018a, Consumer Feedback to HealthPathways SA, October 2018, unpublished.</i></p>
Promote and targeted support to adopt best practice in utilisation of clinical softwares or technology to improve patient care and quality improvement activities	Health information management systems	<ul style="list-style-type: none"> Although all of the practices use a clinical extraction tool to analyse data, devise the necessary strategies to improve patient care and report on quality improvement activities, 27% reported that they do not actively code their clinical data (APHN, 2018b); <ul style="list-style-type: none"> PENCAT was the most common data extraction tool used by the practices (APHN, 2018b). With regards to the frequency in actively cleaning uncoded clinical data, more than half (59%) of the practices frequently or occasionally undertake this process. The rest (n=83) either never or rarely or unfrequently clean uncoded clinical data (APHN, 2018b). 	<p><i>APHN 2018b, Adelaide PHN General Practice Support Survey 2018, October 2018, unpublished.</i></p> <p><i>APHN 2018b, Adelaide PHN General Practice Support Survey 2018, October 2018, unpublished.</i></p>

		<ul style="list-style-type: none"> • Assistance from the APHN with data extraction tools and data coding and or cleaning of un-coded data were the second (n=89) and third (n=81) most common responses by the practices (APHN, 2018b). • More than ninety percentage (93%) of the practice indicated that they are computerised with <i>Best Practice</i> the most common clinical software and billing package used (APHN, 2018b). <ul style="list-style-type: none"> ○ It should be noted that 1% of the practices reported that they were <u>not</u> computerised (i.e. not using any clinical software) while another 5% indicated using both paper documentation and computers for their operation/organisation (APHN, 2018b). <p>Findings from the LHN/GP/Hospital Workshops identified functional, integrated technology that facilitates clinical communication as the second most issue/opportunity for the participants (APHN 2019e). It is also identified as a new need for General Practice Support for this NA report.</p> <p>The below are summary of themes from the workshops:</p> <ul style="list-style-type: none"> • Interoperability <p>The biggest issue identified was the inability of the large variety of software platforms to communicate with one another. There is no current functionality that allows the flow of information directly between the software of the acute system and that being used in primary care.</p> <p>Other themes that was identified were:</p>	<p><i>APHN 2018b, Adelaide PHN General Practice Support Survey 2018, October 2018, unpublished.</i></p> <p><i>Adelaide Primary Health Network (APHN), 2019e, LHN/GP/Hospital Workshops, November 2018 to May 2019, unpublished.</i></p> <p><i>Adelaide Primary Health Network (APHN), 2019e, LHN/GP/Hospital Workshops, November 2018 to May 2019, unpublished.</i></p>
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		<ul style="list-style-type: none"> Choose to use (Implementing and getting people to use available tech) Administrative, and Access (APHN 2019e). 	
Enhance capacity of practices to specific quality improvement activities to improve health outcomes for patients	Quality Care	<ul style="list-style-type: none"> Although 24% reported that they have patients with approved plans, 28% of the practices indicated that they were not aware how the National Disability Insurance Scheme (NDIS) works. Another 15% reported that they have used the Access Request Form but have no approved plans in place with patients (APHN, 2018b). More than half or 67% of the practices reported that they are not aware of HealthPathways SA and a majority of those who are aware of it have indicated that the general practitioners in the practice have not utilised it. Additionally, 13% (n=132, the (first) most common response) indicated requiring assistance from the APHN with HealthPathways SA (APHN, 2018b). Although 24% reported that they have patients with approved plans, 28% of the practices indicated that they were not aware how the National Disability Insurance Scheme (NDIS) works. Another 15% reported that they have used the Access Request Form but have no approved plans in place with patients (APHN, 2018b). More than three quarters (82%) of the practices were currently participating in the Practice Incentives Program (PIP) which are aimed at supporting general practice activities that encourage continuing improvements and 	<p><i>APHN 2018b, Adelaide PHN General Practice Support Survey 2018, October 2018, unpublished.</i></p> <p><i>APHN 2018b, Adelaide PHN General Practice Support Survey 2018, October 2018, unpublished.</i></p>

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		<p>quality care, enhance capacity and improve access and health outcomes for patients (APHN, 2018b).</p> <ul style="list-style-type: none"> ○ eHealth, Diabetes, Asthma, Cervical and After Hours are the top five PI programs respectively. ○ Challenges in participation (in PIP) including administration and understanding the process were the top key challenges for practices. ○ Quality improvement and PIP were 6th (n=69) and 7th (n=67) most common response respectively selected by practices requiring assistance from the APHN (APHN, 2018b). <ul style="list-style-type: none"> • Thematic analysis of the responses to the health and wellbeing priorities or concerns of their patients indicated (1) Mental health, (2) Chronic conditions (includes diabetes and its management, chronic condition management and cycles of care) and (3) Aged care (includes aged care access, health checks and healthy ageing), as the top three main priorities or concerns of their patients. Access to health care was a close fourth priority or concern for the practices (APHN, 2018b). ○ Practices selected mental health (including support for low-intensity mental health), immunisation and alcohol and other drugs as 5th (n=74), 8th (n=62) and 10th (n=50) most common responses requiring assistance from the APHN (APHN, 2018b). 	<p><i>APHN 2018b, Adelaide PHN General Practice Support Survey 2018, October 2018, unpublished.</i></p>
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		<ul style="list-style-type: none"> • Flexible methods On both sides (primary and acute), medical professionals agreed that there needs to be more flexibility and variety in the methods used to communicate with each other. Depending on the requirements of the situation, medical professionals felt that there should be options available – emails, phone calls, hot lines, formal letters, web portal access – that suit the identified needs. Within this there was also a sub-theme around a need for automation and interoperability of clinical software. • Quality The quality of communications between the sectors was noted to be of high importance to all medical professionals. Accuracy, respect, relevance, consistency and patient need were identified as key factors in high quality communication, particularly when communicating clinical information. • Inclusive GPs requested to be included in communications and discussions about their patients’ care during and after a hospital admission or presentation. Access to current hospital information, through software access, being able to identify and contact those providing care in the hospital and involvement in multi-disciplinary discussions was seen to be a path to better patient care. • Easy Both parties identified a need for streamlined and seamless two-way communication without barriers such as unclear pathways. Single point of access was mentioned – such as a 	<p><i>Adelaide Primary Health Network (APHN), 2019e, LHN/GP/Hospital Workshops, November 2018 to May 2019, unpublished.</i></p>
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		<p>contact person within the hospital, dedicated phone numbers or a web-enabled access point.</p> <ul style="list-style-type: none"> • Timely <p>The timing of communication was noted as another area for improvement. Having available options for urgent contact, as well as improving timelines for 'non-urgent' communication, such as discharge summaries, referrals etc. (APHN 2019e).</p>	
General practitioners require education, training, and business support for them and their practices and team	Workforce support	<p>Findings from the GP's Roundtable Workshops reported that education, training and business support for General Practitioners and practices was identified as the second most important issues/opportunities for the participants (APHN, 2019d). It is also identified as a new need for General Practice Support for this NA report.</p> <p>The below are summary of workforce support themes from the workshops:</p> <ul style="list-style-type: none"> • Professional development <p>GPs clearly expressed a desire for Adelaide PHN to provide a range of professional development opportunities. Of particular note, was the request for training and development opportunities for their staff.</p> <ul style="list-style-type: none"> • Business support <p>GPs are also interested in receiving support from Adelaide PHN around matters pertaining to the ongoing improvement of their practices. This includes mentoring and networking opportunities and information and training about business sustainability and improvement.</p> <ul style="list-style-type: none"> • Face to face support <p>Face to face support is still seen as a vital part of developing the relationship between Adelaide PHN and the GPs working in our region (APHN, 2019d).</p>	<p><i>Adelaide Primary Health Network (APHN), 2019d, GP's Roundtable Workshops, November 2018 to May 2019, unpublished.</i></p> <p><i>Adelaide Primary Health Network (APHN), 2019d, GP's Roundtable Workshops, November 2018 to May 2019, unpublished.</i></p>

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

Outcomes of the service needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
There is an inequitable distribution of mental health and suicide prevention 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	<p><i>Note: Data for Aboriginal and Torres Strait Islander people is reported in the Aboriginal Health section.</i></p> <p><i>Primary mental health care services</i></p> <p>Service mapping undertaken by APHN still identifies a concentration of providers of psychological and psychiatry services in the centre of the APHN region (APHN, 2017d). Previous service mapping identified that approximately two-thirds of providers of psychological services, and two-thirds of mental health services are in the centre of the APHN region (NHSD, 2015).</p> <p>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).</p> <p>Three aspects of psychological management were reported by the Bettering the Evaluation and Care of Health (BEACH) study. Firstly, the APHN had significantly</p>	<p><i>APHN, 2017d, CRM records, APHN analysis, September 2017, unpublished.</i></p> <p><i>National Health Services Directory (NHSD), APHN analysis, November 2015, unpublished.</i></p> <p><i>Department of Health (DoH), 2016b, Medicare Benefits Schedule data by Statistical Area Level 3 2014/15, APHN analysis, unpublished.</i></p>

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		<p>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).</p> <p>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).</p> <p>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</p>	<p><i>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.</i></p> <p><i>Australian Commission of Safety and Quality in Health Care (ACSQHC) and the National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation.</i></p>
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		<p>65 years and over (ACSQHC, 2015). High rates of anti-psychotic medicines dispensing occurred in the Playford, Salisbury, Adelaide City, Onkaparinga, Port Adelaide-West and Norwood-Payneham-St Peters across varying age groups (ACSQHC, 2015). Onkaparinga, Playford and Salisbury had highest rates of dispensing for attention deficit hyperactivity disorder medicines for people aged 17 years and under in 2013-14 (ACSQHC, 2015). The 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.</p> <p>Between July 2014 to June 2016, the SA3s within the APHN region with the highest proportion of people who used a mental health service (in the past four weeks) were, Burnside followed by Walkerville and Playford. The SA3s with the greatest proportions of mental health service use varied between reporting periods. In the recent data (July 2016 to March 2018), the following SA3s were in the top three, Norwood- Payneham-St Peters, followed by Holdfast Bay and Charles Sturt/Adelaide City (SA Health, 2018a).</p> <p><i>Acute mental health services</i></p> <p>The most recent 2015-16 APHN average age-standardised rate of mental health hospitalisations of 106 hospitalisations per 10,000 people was consistent with the</p>	<p><i>Australian Commission of Safety and Quality in Health Care (ACSQHC) and the National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation.</i></p> <p><i>SA Health, 2018a, South Australian Monitoring & Surveillance System (SAMSS), South Australian Health and Risk Factor Profile by SA3 regions.</i></p>
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		<p>national average (102 per 10,000 people). However, this (2015-16) rate is higher than the previous reporting periods of 2014-15 (92 per 10,000) and 2013-14 (84 per 10,000 people) (AIHW, 2017c).</p> <p>Some areas of the APHN region had exceptionally high rates of mental health hospitalisations (AIHW 2017c). Trend data shows that the SA3 of Adelaide City had the highest and increased rate in APHN and Australia when compared with previous reporting periods with 224 hospitalisations per 10,000 people in 2015-16 when compared to 200 per 10,000 in 2014-15 and 187 per 10,000 in 2013-14. Marion, Playford, Port Adelaide – East, Onkaparinga SA3s had the remaining top five highest mental health hospitalisation rates respectively in 2015-16 (AIHW, 2017c). It should be noted that the mental health hospitalisation rates for all SA3s in the APHN region has increased over reporting period years.</p> <p>There have been changes between the three reporting periods by primary groups of mental health condition for mental health hospitalisations. In 2013-14, Schizophrenia and delusional disorders, intentional self-harm, and bipolar and mood disorders were the top three primary groups of conditions. The top three mental health conditions were the same in 2014-15 with anxiety and stress episodes and drug and alcohol episodes sharing equal third. In 2015-16, Schizophrenia and delusional</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2017c, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm, 2013–14 to 2015-16</i></p>
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		<p>disorders, intentional self-harm, and drug and alcohol episodes were the top three primary groups of conditions (AIHW, 2017c).</p> <p>There was no change in hospitalisation due to intentional self-harm for the APHN's average rate (15 hospitalisations per 10,000 people) for the periods 2013-14 and 2014-15. However, for 2015-16 the average APHN rate increased to 19 hospitalisations per 10,000 people. There were however geographical variations and changes for the most recent reporting period (AIHW 2018). In 2015-16, Playford (35 hospitalisations per 10,000 people), Adelaide City (25) and Marion (24) had the top three highest hospitalisation due to intentional self-harm, respectively (AIHW, 2017c). Within the APHN region between the three reporting periods of 2013-14 , 2014-15, and 2015-16, Playford had the highest increase (21 in 2013-14, 22 in 2014-15 and 35 in 2015-16) followed by Adelaide City (21 in 2013-14, 19 in 2014-15 and 24 in 2015-16) (AIHW, 2017c).</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2017c, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm, 2013–14 to 2015-16</i></p>
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	<p>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 (APHN, 2016c).</p>	<p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p>

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		<p>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 (APHN, 2016c).</p> <p>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 (APHN, 2016d). The 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 (APHN, 2016d).</p> <p>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</p>	<p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
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		<p>needs of people accessing both mental health and alcohol and other drug treatment services (Roche et al., 2017).</p> <p>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).</p> <p>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).</p> <p>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).</p> <p>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</p>	<p><i>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.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2015c, National Health</i></p>
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		<p>likely to be unemployed, have a lower level of educational attainment, and be living in a lone-person household compared with those with physical health conditions only (ABS, 2015c). No new data available for comparison.</p> <p>People with a mental and behavioural condition were almost twice as likely than those without a mental and behavioural condition to report having diabetes (8.1% compared with 4.5%), almost three times as likely to report chronic obstructive pulmonary disease (COPD) (5.7% compared with 2.0%) and around twice as likely to report osteoporosis (6.3% compared with 2.9%) (ABS, 2015c). For South Australia, 8.8% of people with a mental and behavioural condition reported having diabetes while 5.8% are likely to report COPD. Compared to other States and national rates, South Australians with a mental and behavioural conditions reported having higher rates of heart, stroke and vascular disease (ABS, 2015c).</p> <p>People with two or more mental and behavioural conditions only were 5 times as likely as the general adult population to report high or very high levels of psychological distress, 55.9% compared with 11.7% (ABS, 2015c). No new data available for comparison.</p> <p>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</p>	<p><i>Survey: Mental Health and co-existing physical health conditions, Australia, 2014–15.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2015c, National Health Survey: Mental Health and co-existing physical health conditions, Australia, 2014–15.</i></p> <p><i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p>
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		<p>system for consideration. Listed below are three elements which related to integrated and holistic health services:</p> <ul style="list-style-type: none"> • 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 (APHN, 2016b). <p>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 (APHN, 2016c).</p>	<p><i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p>
Increase the availability of culturally safe and appropriate services, and services targeted to vulnerable population groups	Importance of providing culturally appropriate services	<p><i>Note: Data for Aboriginal and Torres Strait Islander people reported in Indigenous Health section.</i></p> <p>Providing (culturally) appropriate mental health services for high risk communities like new arrivals in Australia from refugee backgrounds, culturally and linguistically diverse (CALD) and minority groups (including transgendered people) was prioritised by the Mental Health HPG (APHN, 2016d).</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
Difficulty in accessing appropriate mental health services for vulnerable population groups.	Timely access and equity to health services and care	<p>Australian and Overseas studies have identified the estimated prevalence of trauma exposure in childhood to be approximately 31% (Price-Robertson et al. 2010; Douglas & Wodak 2016; Lewis et al. 2019). If applying this</p>	<p>Price-Robertson R, Bromfield L, and Vassallo S, 2010, The prevalence of child abuse and neglect, Australian Institute of</p>

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		<p>proportion to the APHN population, it indicates that 82,075 people under 18 years old may be at risk of trauma exposure. Taking into consideration of adult trauma and PTSD amongst for example Aboriginal and Torres Strait Islanders and veterans would require accessing specialised mental health treatment services.</p> <p>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 (APHN, 2016e).</p>	<p>Family Studies, Factsheet, April 2010.</p> <p>Douglas B, Wodak J, 2016, Trauma-related stress in Australia – Essays by leading Australian thinkers and researchers, Australia21 Ltd, ACT.</p> <p>Stephanie J Lewis, Louise Arseneault, Avshalom Caspi, Helen L Fisher, Timothy Matthews, Terrie E Moffitt, Candice L Odgers, Daniel Stahl, Jia Ying Teng, Andrea Danese, 2019, The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales, Lancet Psychiatry, Vol 6, March 2019, pp 247-56.</p> <p><i>APHN, 2016e, Mental Health and Alcohol and Other Drugs (MHAOD) reform community consultations</i></p>
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		<p>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 (APHN, 2016a, 2016c, 2016d) . 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 (APHN, 2016c). The Southern CC prioritised the importance of improving pathways, and increasing timely access to mental health services (in the south) (APHN, 2016a).</p> <p>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, 2016a, 2016c).</p>	<p><i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p> <p><i>APHN, 2016c Community Advisory Councils, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups, priority setting workshops.</i></p> <p><i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p> <p><i>APHN, 2016c Community Advisory Councils, priority setting workshops.</i></p>
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		<p>The importance of having timely access to oral care for people with mental health was raised by the Consumers and Carers HPG (APHN, 2016d).</p> <p>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 (APHN, 2016a, 2016d). 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 (APHN, 2016c). 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, 2016c).</p> <p>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</p>	<p><i>APHN, 2016d, Health Priority Groups, priority setting workshops.</i></p> <p><i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p> <p><i>APHN, 2016c Community Advisory Councils, priority setting workshops.</i></p> <p><i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p>
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		improving the appropriateness of services through carer involvement as part of the treating team and improved carer support (APHN, 2016b).	<i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i>
Increase awareness of mental health services by improving the health literacy of community and carers.	Community and carers health literacy	<p>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).</p> <p>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.</p> <p>The importance of increasing knowledge and skills to facilitate improved access to available services was raised by both the clinical and community representatives of the APHN membership groups (APHN, 2016a, 2016c).</p> <p>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 (APHN, 2016c).</p> <p>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,</p>	<p><i>Australian Bureau of Statistics (ABS), 2006, Adult Literacy and Life Skills Survey, accessed October 2017.</i></p> <p><i>Adams RJ, Appleton SL, Hill CL, Dodd M, Findlay C, Wilson DH. (2009). <u>Risks associated with low functional health literacy in an Australian population</u>. Medical Journal of Australia, 191(10), 530-534.</i></p> <p><i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p> <p><i>APHN, 2016c Community Advisory Councils, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups, priority setting workshops.</i></p>

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		<p>and for general practices to have up to date and accessible websites (APHN, 2016c).</p> <p>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, 2016d).</p> <p>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 (APHN, 2016b).</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p>
<p>Increase the capacity of service providers to deliver:</p> <ul style="list-style-type: none"> • culturally safe and appropriate services • Integrated service • Services that enable navigation and 	<p>Training and education for health professionals</p>	<p>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 (APHN, 2016a).</p> <p>The Older People & Aged Care HPG also stressed the importance to build the capacity of health professionals</p>	<p><i>APHN, 2016a Clinical Councils, priority setting workshops</i></p>

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pathways to appropriate care		<p>and GPs to understand the issues for older people by providing support, training and education (APHN, 2016d). 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 (APHN, 2016d).</p> <p>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 (APHN, 2016a).</p> <p>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, two of which related to workforce:</p> <ul style="list-style-type: none"> • Service size, structure and workforce balanced to be expert and also local • Accountability mechanisms for health outcomes (APHN, 2016b). 	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016a Clinical Councils, priority setting workshops</i></p> <p><i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p>
Increase awareness and promotion of early intervention and low	Promotion of early intervention and low	The Central Clinical Council (CC) prioritised early intervention of childhood mental health disorders and prevention of relapse/adult development of serious and	<i>APHN, 2016a Clinical Councils, priority setting workshops.</i>

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<p>intensity services for vulnerable population groups</p>	<p>intensity programs by health professionals</p>	<p>more chronic mental health issues and crises (APHN, 2016a).</p> <p>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 (APHN, 2016a).</p> <p>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 (APHN, 2016d). 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 (APHN, 2016d).</p> <p>The need for better education for consumers and professionals across the health sector to focus on early intervention and improve and encourage the take-up and application of preventative measures was an issue raised</p>	<p><i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
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		by both the Northern Community Advisory Council (CAC) and Aboriginal Health HPG (APHN, 2016c, 2016d). 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 (APHN, 2016d).	<i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i> <i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i>
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	<p>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 (APHN, 2016a, 2016c, 2016d).</p> <p>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 (APHN, 2016d).</p> <p>The Older People & Aged Care HPG prioritised the need to improve case management, care coordination and integration for non-acute mental health issues including</p>	<p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i> <i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops.</i> <i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>

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		<p>management of medication for older people (APHN, 2016d).</p> <p>The Disability HPG prioritised the need for a primary health care service model for people with disabilities which is interagency and interdisciplinary (APHN, 2016d).</p> <p>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 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 (APHN, 2016d).</p> <p>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 (APHN, 2016d).</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
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		<p>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 (APHN, 2016a). 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 (APHN, 2016a).</p> <p>The Central Community Advisory Council (CAC) prioritised the importance in the simplification of mental health services and integration with drug and alcohol services (APHN, 2016c). 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 (APHN, 2016c).</p> <p>The Northern CAC prioritised the need to coordinate pathways to primary health care. Additionally, they reported that the health system is way too complex for consumers and users in navigate it properly – consequently inability to access information or programs pertinent to them (APHN, 2016c).</p>	<p><i>APHN, 2016a Clinical Councils, priority setting workshops;</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p>
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		<p>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, 2016c).</p> <p>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:</p> <ul style="list-style-type: none"> • Simple system access, referral and treatment for consumers and providers • Care navigation – enabled by formal agreements • Clinical handover mechanisms across services (APHN, 2016b). 	<p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p>
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 (APHN, 2016d).	<i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i>

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		<p>Consultation with Community Advisory Councils received feedback that a lack of available after-hours mental health services for this age group was leading to more ED visits. This was particularly commented upon for the outer northern and southern APHN suburbs (APHN, 2019b).</p> <p>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).</p>	<p><i>APHN, 2019b, Clinical and Community Advisory Councils, After Hours consultation, May 2019.</i></p> <p><i>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.</i></p>
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<p>People with Severe Mental Illness requiring Psychosocial Support</p> <p><i>The APHN acknowledges that the (service) needs of the individuals requiring psychosocial support in our region will be unique based on the funding arrangement provided by the Commonwealth – to assist people with severe mental illness resulting in psychosocial disability who are not eligible for the National Disability Insurance Scheme (NDIS).</i></p> <p><i>The APHN has conducted two (online) surveys and a consultation workshop (with clients) in October 2018. The online survey targeted existing service providers providing psychosocial support services in the APHN region with 16 organisations (note: one consisting of 7 consortium agencies) participating in the survey. The other online survey targeted a wider audience ranging from health professionals, support workers, carers and the general community with a total of 96 people completing the survey. The (client) consultation consisted of two face-to-face workshops (Northern and Southern regions) with total of 25 existing clients of service providers providing psychosocial support services. The findings below summarises themes, issues, challenges and opportunities from respective surveys/consultations.</i></p>			
<p>Prioritise services especially in the high need areas of Northern, Western and Southern APHN regions</p>	<p>Distribution of services according to need</p>	<p>Service mapping undertaken by the APHN shows that the majority of current services providing psychosocial support services have footprints in the LGAs of Adelaide City, Onkaparinga, Port Adelaide Enfield, Playford, Salisbury and Charles Sturt and West Torrens (APHN, 2018f).</p> <p><i>Service Provider Survey</i> More than three quarters, 86.7% of the service providers who participated in the online survey indicated being concerned for vulnerable individuals in specific circumstances who may not be eligible for services through the NDIS or psychosocial services (APHN, 2018c).</p> <p>Although all LGAs in the APHN region have a service footprint, the LGAs of Port Adelaide Enfield, Salisbury, Charles Sturt, Prospect, Adelaide, Playford, Tea Tree Gully and West Torrens have the most coverage by existing service providers of psychosocial support services (APHN, 2018c).</p>	<p><i>APHN 2018f, Psychosocial support service provider mapping, unpublished.</i></p> <p><i>APHN 2018c, Adelaide PHN National Psychosocial Support Measure – Service Provider Survey, October 2018, unpublished.</i></p>

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		<p>As reported in the health and service needs of Primary Mental Health sections, there is a higher need of supporting people with mental health conditions in Local Government Areas of Playford, Salisbury, Port Adelaide Enfield and Onkaparinga in the APHN region.</p> <p><i>Community Survey</i> When participants were asked which best describes them or their role, case manager/care coordinator was the most common response followed by allied mental health professional, support workers and mental health clinicians. One in ten were clients of current services while four percent were family members of those require psychosocial support services (APHN, 2018e). Adelaide, Port Adelaide Enfield, Playford, Charles Sturt and Onkaparinga were the top five LGAs where participants live or work (APHN, 2018e).</p>	<p><i>APHN 2018e, Adelaide PHN National Psychosocial Support Measure – Community Survey, October 2018, unpublished.</i></p>
Access to appropriate psychosocial support services for people with severe mental health conditions	Timely access to services	<p><i>Client consultations</i> Clients of existing psychosocial support services identified lack of timely, responsive services that met their needs, lack of empathy understanding and respect and underfunded programs and services as the top 3 irritants from their experience of service use (APHN, 2018d). Conversely, clients valued services tailored to (their) specific needs, skilled relatable knowledgeable support staff and suitable transport as their top 3 opportunities for experiencing good services (APHN, 2018d).</p>	<p><i>APHN 2018d, Adelaide PHN Community Engagement – National Psychosocial Support Measure, October 2018, unpublished.</i></p>

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		<p>Respondents in the community survey indicated: Housing support, making connections (e.g. group support, with community) and independent living skills (e.g. housing, budgeting and employment) as the three most important things to consider when designing a new psychosocial support (services) for people with complex mental health issues (who are not eligible for the NDIS) (APHN, 2018e).</p> <p><i>Service Provider Survey</i> Service providers provide a range of psychosocial support services and/or programs to clients. Coordination and liaison (provided by 81.3% of service providers), social skills and social inclusion (81.3%), independent living skills (62.5%) and other broad services (such as carer respite and support, counselling, group activities) were common (psychosocial support) services provided to clients with severe mental health conditions (APHN, 2018c). Providers also indicated their clients, who are not eligible for the NDIS, will continue to need these services (i.e. coordination and liaison, social skills and social inclusion, independent living skills) (APHN, 2018c).</p> <p>Service providers reported a range of challenges for their clients when participating in psychosocial support services. Social skills and isolation due to mental health conditions was a major barrier to their clients being able to participate in services. They also reported that lack of flexible and response service which adapts to client needs was a challenge to client participation. Although transport challenges were highlighted (including during client</p>	<p><i>APHN 2018e, Adelaide PHN National Psychosocial Support Measure – Community Survey, October 2018, unpublished.</i></p> <p><i>APHN 2018c, Adelaide PHN National Psychosocial Support Measure – Service Provider Survey, October 2018, unpublished.</i></p> <p><i>APHN 2018d, Adelaide PHN Community Engagement – National Psychosocial Support Measure, October 2018, unpublished.</i></p> <p><i>APHN 2018c, Adelaide PHN National Psychosocial Support Measure – Service Provider Survey, October 2018, unpublished.</i></p>
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		<p>consultations (APHN, 2018d)), the episodic nature of (client population) mental conditions, effects of medication and anxiety were associated to this barrier than cost (although plays a contributing role given majority of clients are not in full time employment) (APHN, 2018c,d).</p> <p><i>Community Survey</i> When asked what psychosocial support services or programs participants are aware of in the APHN region for people with severe mental health illness, majority of the them indicated being aware of: Partners in Recovery (PIR) (81.5%), Personal helpers and mentors (81.5%), and Carer respite programs (67.4%). Individual Psychosocial Rehabilitation Support Services (IPRSS) were the most common response for “Others” (APHN, 2018e).</p> <p>Participants rated the following current availability and accessibility of services and supports as “Poor” or “Very Poor” (Top three respectively):</p> <ul style="list-style-type: none"> • Finding and maintaining a home • Social skills • Friendships and family connections <p>While reported the housing and accommodation, social skills and social inclusion and independent living skills as the top 3 psychosocial support gaps and unmet needs for people with severe mental illness (APHN, 2018e).</p>	<p><i>APHN 2018e, Adelaide PHN National Psychosocial Support Measure – Community Survey, October 2018, unpublished.</i></p> <p><i>APHN 2018e, Adelaide PHN National Psychosocial Support Measure – Community Survey, October 2018, unpublished.</i></p> <p><i>APHN 2018e, Adelaide PHN National Psychosocial Support Measure – Community Survey, October 2018, unpublished.</i></p> <p><i>APHN 2018e, Adelaide PHN National Psychosocial Support Measure – Community Survey, October 2018, unpublished.</i></p>
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		<p>Conversely, the following current availability and accessibility of services and supports as “Good” or “Very Good” (Top three respectively):</p> <ul style="list-style-type: none"> • Managing drug and alcohol addictions • Mental health literacy and education • Physical health and wellbeing (APHN, 2018e). <p>More than half (64.2%) indicated that people with severe mental health illness require on average between 1 to 4 hours of psychosocial support services during the week (APHN, 2018e). However, more than one quarter or 35.8% of respondents response indicated that support should be varied based on needs regardless of time of day. This aspect of support (needs base) was also voiced during the client consultation workshops (APHN, 2018d).</p>	<p><i>Measure – Community Survey, October 2018, unpublished.</i></p> <p><i>APHN 2018d, Adelaide PHN Community Engagement – National Psychosocial Support Measure, October 2018, unpublished.</i></p>
Increase awareness and promotion services for people with severe mental health conditions	Awareness of available services	<p>Similar to identified needs highlighted in this NA report, clients and service providers highlighted the importance in easy access of information on services for people (with severe mental health conditions). During the client consultations, participants selected information about service (that are) easily available as the fifth most important value and indicated the importance of knowing someone to call who knows them when they need them as the next most importance as the factor for experiencing good service (APHN, 2018c).</p>	<p><i>APHN 2018c, Adelaide PHN National Psychosocial Support Measure – Service Provider Survey, October 2018, unpublished.</i></p>
Increase the health workforce capacity to provide appropriate care to people with severe mental health conditions	Workforce capacity to provide appropriate care	<p><i>Client consultations</i></p> <p>Clients of existing psychosocial support services identified lack of timely, responsive services that met their needs, lack of empathy understanding and respect and underfunded programs and services as the top 3 irritants</p>	<p><i>APHN 2018d, Adelaide PHN Community Engagement – National Psychosocial Support</i></p>

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		from their experience of service use (APHN 2018d). Conversely, clients valued services tailored to (their) specific needs, skilled relatable knowledgeable support staff and suitable transport as their top 3 opportunities for experiencing good services (APHN ,2018d).	<i>Measure, October 2018, unpublished.</i>
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Alcohol and Other Drug Treatment Needs

Outcomes of the service needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
Need for AOD services to focus on targeted population groups	AOD treatment services for population groups	<p>Gender and age groups</p> <p>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).</p> <p>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).</p> <p>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).</p>	<p><i>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.</i></p>

		<p>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).</p> <p>Young people</p> <p>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).</p> <p>For APHN region in 2016 by main drug of concern, young people accounted for:</p> <ul style="list-style-type: none"> • 44% of non-opioid analgesics ED presentations with Adelaide-North SA4 having the highest ED presentations, 	<p><i>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.</i></p> <p><i>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.</i></p>
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		<ul style="list-style-type: none"> • 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). <p>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 both treatment episodes (66%) and ADIS calls (32%) (Roche et al., 2017a).</p> <p>Older people</p> <p>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).</p> <p>For APHN region in 2016 by main drug of concern, older people accounted for:</p>	<p><i>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.</i></p>
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		<ul style="list-style-type: none"> • 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). <p>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).</p> <p>Employed people</p> <p>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%); and counselling (3%) were the most commonly used forms of treatment by employed South Australians (Roche et al., 2017a).</p> <p>Unemployed people</p> <p>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).</p>	<p><i>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.</i></p>
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		<p>Single people</p> <p>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).</p> <p>People identifying as Lesbian, Gay, Bisexual, Transgender and/or Intersex (LGBTI)</p> <p>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).</p> <p>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.</p> <p>Lack of inclusion of LGBTI-specific issues (e.g. opportunity to identify as LGBTI, addressing stigma and AOD use</p>	<p><i>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.</i></p> <p><i>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</i></p>
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		<p>relationship) within AOD services may impact willingness to access such treatment services (Eliason, 2001; Eliason & Schope, 2001).</p> <p>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).</p> <p>People in contact with the criminal justice system</p> <p>No data on treatment utilisation but post-release, discharges 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).</p>	<p>(LGBT) community, <i>Substance Use & Misuse</i>, 52(8), 1027-1038.</p> <p>Eliason, M., 2001, <i>Substance abuse counselor's attitudes regarding lesbian, gay, bisexual, and transgendered clients</i>, <i>Journal of Substance Abuse</i>, 12(4), 311-328.</p> <p>Eliason, M., & Schope, R., 2001, <i>Does "don't ask don't tell" apply to health care? Lesbian, gay, and bisexual people's disclosure to health care providers</i>, <i>Journal of the Gay and Lesbian Medical Association</i>, 5(4), 125-134.</p> <p>Kinner, S., Preen, D., Kariminia, A., Butler, T., Andrews, J., Stooze, M., & Law, M. (2011). <i>Counting the cost: Estimating the number of deaths among recently released prisoners in Australia</i>. <i>The Medical Journal of Australia</i>, 195(2), 64-68.</p> <p>Merrall, E., Kariminia, A., Binswanger, I., Hobbs, M., Farrell, M., Marsden, J., Bird, S.M. (2010). <i>Meta-analysis of drug-related deaths soon after release from prison</i>. <i>Addiction</i>, 105(9), 1545-1554.</p>
Higher use of AOD treatment services,	Variations in specialist and non-	Emergency Department (ED) Presentations	<p>Roche, A.M., McEntee, A., Fischer, J., Duraisingam, V., Kostadinov, V., 2017b,</p>

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<p>particularly for alcohol, cannabis and illicit drugs, and in Adelaide-North, Adelaide-Central and Adelaide-South SA4 regions.</p>	<p>specialist healthcare services for AOD problems</p>	<p>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).</p> <p>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).</p> <p>Alcohol (57%) was the most common AOD ED presentation with Adelaide-North SA4 having the most presentations for alcohol (Roche et al., 2017b).</p> <p>Hospital Separations</p> <p>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).</p>	<p><i>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.</i></p> <p><i>Roche, A.M., McEntee, A., Fischer, J., Duraisingam, V., Kostadinov, V., 2017b,</i></p>
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		<p>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).</p> <p>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 AOD separation while for stimulants, it was Adelaide-Central and Adelaide-West SA4s (Roche et al., 2017b).</p> <p>AOD Treatment (from the AOD Treatment Services National Minimum Data Set (AODTS-NMDS))</p> <p>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).</p> <p>The following services were provided in the APHN region, in descending order of prevalence:</p> <ul style="list-style-type: none"> • Amphetamines (31%) • Alcohol (28%) • Cannabis (17%) • Heroin (8%) • Pharmaceuticals (8%) • other drugs (7%) (Roche et al., 2017b). 	<p><i>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.</i></p> <p><i>Roche, A.M., McEntee, A., Fischer, J., Duraisingam, V., Kostadinov, V., 2017b,</i></p>
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		<p>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).</p> <p>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 30-39 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).</p> <p>For clients from APHN region, the majority being treated for amphetamines (57%), cannabis (55%) and all other drugs (89%) received Assessment Only treatment. Withdrawal</p>	<p><i>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.</i></p> <p><i>Roche, A.M., McEntee, A., Fischer, J., Duraisingam, V., Kostadinov, V., 2017b,</i></p>
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		<p>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).</p> <p>Alcohol and Drug Information Service (ADIS) South Australia</p> <p>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).</p> <p>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).</p> <p>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 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).</p>	<p><i>Utilisation of Specialist and Non-Specialist Healthcare Services for Alcohol and Other Drug Problems in South Australia.</i></p> <p><i>National Centre for Education and Training on Addiction, Flinders University, Adelaide South Australia, unpublished.</i></p> <p><i>Roche, A.M., McEntee, A., Fischer, J., Duraisingam, V., Kostadinov, V., 2017b, Utilisation of Specialist and Non-Specialist</i></p>
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		<p>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).</p> <p>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).</p> <p>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).</p>	<p><i>Healthcare Services for Alcohol and Other Drug Problems in South Australia.</i></p> <p><i>National Centre for Education and Training on Addiction, Flinders University, Adelaide South Australia, unpublished.</i></p>
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<p>Need for targeted approaches to address over prescriptions of opioids and anxiolytics in specific sub-regional areas and population groups</p>	<p>Quality use of medicines</p>	<p>There is a lack of General Practice data on the proportion of patients reporting AOD issues in general and referrals to AOD services.</p> <p>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).</p> <p>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).</p> <p>Prescribed opioid use</p> <p>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).</p> <p>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).</p> <p>In 2013/14, within APHN Adelaide-Central SA4, the age standardised rate of PBS prescriptions dispensed for opioid</p>	<p><i>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.</i></p> <p><i>Australian Commission on Safety and Quality in Health Care (ACSQHC), 2015, Australian Atlas of Healthcare Variation. Sydney: ACSQHC.</i></p> <p><i>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</i></p>
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		<p>medicine ranged from 34,245 (Burnside SA3) to 45,695 (Norwood SA3) per 100,000 persons (Roche et al., 2016).</p> <p>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 highest rate and Salisbury (SA3) the third highest (Roche et al., 2016).</p> <p>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).</p> <p>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).</p> <p>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).</p>	<p><i>University, Adelaide South Australia, unpublished.</i></p> <p><i>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.</i></p>
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		<p>Patterns of Anxiolytics (alprazolam, bromazepam, buspirone, diazepam, oxazepam) dispensed</p> <p>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).</p> <p>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).</p> <p>In 2013/14, the rate of PBS prescriptions dispensed for anxiolytic medicine among 18-64 year olds in APHN SA4 regions ranged from 16,855 (Adelaide-Central SA4) to 25,474 (Adelaide-North SA4) per 100,000 persons (Roche et al., 2016).</p> <p>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).</p> <p>In 2013/14, within APHN Adelaide-Central SA4, the age standardised rate of PBS prescriptions dispensed for</p>	<p><i>Australian Commission on Safety and Quality in Health Care (ACSQHC), 2015, Australian Atlas of Healthcare Variation. Sydney: ACSQHC.</i></p> <p><i>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.</i></p> <p><i>Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V., 2016, Alcohol and Other</i></p>
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		<p>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).</p> <p>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).</p> <p>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).</p> <p>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).</p> <p>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).</p> <p>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</p>	<p><i>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.</i></p> <p><i>Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V., 2016, Alcohol and Other</i></p>
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		<p>16,626 (Mitcham SA3) to 24,026 (Onkaparinga SA3) per 100,000 persons (Roche et al., 2016).</p> <p>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).</p> <p>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).</p> <p>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).</p> <p>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).</p>	<p><i>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.</i></p>
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<p>Need for services to focus on the whole person and their circumstances, particularly social factors and physical comorbidities</p>	<p>Inability of services to have a holistic view to improve health</p>	<p>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 (APHN, 2016f).</p> <p>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).</p> <p>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</p>	<p><i>APHN, 2016f, Membership Advisory Council priority setting.</i></p> <p><i>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.</i></p> <p><i>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.</i></p>
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		<p>South Australians with low psychological distress (3%) (Roche et al., 2017a).</p> <p>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 (APHN, 2016d).</p> <p>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 (APHN, 2016c).</p> <p>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 (APHN, 2016c).</p> <p>Substance use disorders are chronic relapsing conditions usually embedded in a web of other health and social</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p>
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		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).	<i>National Drug Research Institute (NDRI), 2014, Harnessing Good Intentions Report.</i>
Timely access to appropriate health services for target population groups	Timely access and equity to health services and care	<p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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 (APHN, 2018e) <p>Furthermore, the APHN membership groups identified timely access and equity to health services as an overarching</p>	<p><i>APHN, 2016a Clinical Councils, priority setting workshops;</i> <i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i> <i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016e, Mental Health and Alcohol and Other Drugs (MHAOD) reform community consultations</i></p>

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		<p>priority for the APHN including the need to (following applicable to the AOD sector too):</p> <ul style="list-style-type: none"> - 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 (APHN, 2016f). 	<p><i>APHN, 2016f, Membership Advisory Council priority setting.</i></p>
<p>Increase health literacy through early intervention and prevention programs</p>	<p>Health literacy</p>	<p>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 (APHN, 2016c).</p> <p>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 (APHN, 2018d).</p> <p>The Central Adelaide CC prioritised early intervention of childhood mental health disorders and prevention of</p>	<p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p>

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		<p>relapse/adult development of serious and more chronic mental health issues and crises (APHN, 2016a).</p> <p>The Southern Adelaide CC prioritised the need to reduce unwarranted variation in care by improving health literacy and education (APHN, 2016a).</p> <p>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 (APHN, 2016a).</p> <p>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 (APHN, 2016c).</p> <p>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 (APHN, 2016c).</p> <p>The Southern CAC prioritised that community members and service providers need to better inform themselves about services available throughout the primary health care sector</p>	<p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p>
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		<p>and how to access those services, by improving health literacy and education (APHN, 2016c).</p> <p>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 for 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 GPs to understand the issues for older people by providing support, training and education (APHN, 2016d).</p> <p>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 (APHN, 2016d).</p> <p>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 (APHN, 2016d).</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
Increase the capacity of service providers to deliver:	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	<p><i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>

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<ul style="list-style-type: none"> • culturally safe and appropriate services, • integrated services, and • services that enable navigation and pathways to appropriate care. 		<p>health symptoms that can impact on their ability to treat clients' AOD use (APHN, 2016a, 2016c, 2016d).</p> <p>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 (APHN, 2016d). The Northern CC raised concerns on the growing need for further support and training for General Practitioners on AOD use(rs) and referral pathways (APHN, 2016c).</p> <p>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 (APHN, 2016a, 2016c, 2016d).</p> <p>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:</p> <ul style="list-style-type: none"> • Funding/Workforce/Quality: Sustainability and longevity of a service ensuring a highly skilled workforce that provides good quality, accessible and affordable care ((APHN, 2016b)). 	<p><i>Health Priority Group priority setting workshops, 2016</i></p> <p><i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p>
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		Furthermore, the Consumer and Carers HPG identified themes related to an appropriately skilled and empathic primary health workforce in MH and AOD sector (APHN, 2016d).	<i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i>
Improve communication and coordination of care particularly for target population across the health system	Care Coordination, Integration and Navigation	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • Service Connection/Continuity/Integration: A system which enables service provision to be integrated between services ensuring continuity of care (APHN, 2016b). <p>The consultations also identified that MH &AOD services lacked non-flexible pathways and are confusing systems for the most vulnerable and at-risk consumers (APHN, 2016b). Furthermore, consultations conducted with General Practitioners also identified issues such as inadequate referral pathways; lack of detailed clinical handover</p>	<p><i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p> <p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops.</i></p> <p><i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p> <p><i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p>

		<p>between service providers and lack of continuity of service provision in the MH&AOD sectors (APHN, 2016b).</p> <p>The Central Community Advisory Council (CAC) prioritised the importance in the simplification of mental health services and integration with drug and alcohol services (APHN, 2016c).</p> <p>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 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).</p> <p>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).</p>	<p><i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i></p> <p><i>Berends L., 2014, <u>Obstacles to alcohol and drug care</u>, Australian Family Physician, Vol. 42, No. 5, May 2014, assessed 2016.</i></p> <p><i>Berends L., 2014, <u>Obstacles to alcohol and drug care</u>, Australian Family Physician, Vol. 42, No. 5, May 2014, assessed 2016.</i></p>
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Indigenous Health (including Mental Health and Alcohol and Other Drugs use)

Outcomes of the service needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
Accessing appropriate primary health care services for Aboriginal and Torres Strait Islander population	Timely access and equity to primary health care services and care	<p>The Aboriginal Health HPG prioritised the need to ensure that commissioned services are culturally safe for Aboriginal people (APHN, 2018d).</p> <p>The Aboriginal Health HPG also identified ear health and access to screening and treatment for children as a need (APHN, 2018d).</p> <p><i>Community consultations</i></p> <p>Members of the Aboriginal community identified lack of respect and sensitivity from service providers, poor support, communication and coordination between services and long wait times and follow through as the top 3 irritants from their experience of health service use (APHN, 2016e).</p> <p>The Aboriginal Engagement workshops identified the following top 3 factors they would like to have in service delivery to make it better:</p> <ul style="list-style-type: none"> • Being treated with dignity and respect and without prejudice • Easy access to services when they are needed • Well-coordinated holistic approach to services (APHN, 2016e). 	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2017e, Aboriginal Engagement workshops, 2017</i></p>

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		<p>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 stigma associated with the label of “mental illness/health” so the first contact with mental health services is critical along with early intervention across the life span (APHN, 2016d).</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
<p>Increase the health workforce capacity to work with Aboriginal and Torres Strait Islander population to improve access to primary health care services</p>	<p>Health Workforce</p>	<p>The Aboriginal 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. They emphasised the need to improve the uptake of the Aboriginal health check. The Aboriginal HPG also 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 (APHN, 2016d).</p> <p>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 (APHN, 2016a).</p>	<p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p> <p><i>APHN, 2016a Clinical Councils, priority setting workshops.</i></p>

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		<p>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, 2017e).</p> <p>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, 2017f).</p>	<p><i>APHN, 2017e, Aboriginal Engagement workshops, 2017</i></p> <p><i>APHN, 2017f, Capacity Building process, 2017.</i></p>
Lack of integration, pathways and care coordination along the health continuum for Aboriginal and Torres Strait Islander population	Care coordination, integration and navigation	The Aboriginal Engagement workshops identified poor support, communication and coordination between services, long wait times and poor follow through as top irritants experienced in health service use (APHN, 2017e).	<i>APHN, 2017e, Aboriginal Engagement workshops, 2017</i>
Increase utilisation of specific MBS item numbers by General Practitioners for Aboriginal and Torres Strait Islander people/patients.	Primary health care for Aboriginal and Torres Strait Islanders	Analysis of Medicare Benefits Statistics on item number 715 by PHN (AIHW, 2017f) and analysis of Medicare Benefits Statistics by PHN (DoH, 2016) and by SA3 highlighted that Aboriginal Health Assessments are lower in the APHN when compared to other PHNs (ranked 21 out of 32 PHNs nationally), and at sub-regional levels particularly in Statistical Area Level 3 (SA3) of Playford, Port Adelaide-East and West, Salisbury, Onkaparinga, and Charles Sturt (DoH, 2016).	<p><i>Australian Institute of Health and Welfare (AIHW), 2017f, analysis of Department of Human Services Medicare Benefits Statistics, 2011/12 to 2016/17.</i></p> <p><i>Department of Health (DoH), 2016, Medicare Benefits Schedule, 2013/14 – 2014/15, unpublished.</i></p>

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		During the Priority setting workshops, the Aboriginal HPG emphasised the need to improve the uptake of the Aboriginal (children and adult) health check (APHN, 2016d).	<i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i>
Improving access to and effectiveness of primary health care services for Aboriginal and Torres Strait Islander older persons	Healthy ageing	The Aboriginal Health HPG identified access to services for older people as an issue, including support for activities such as equipment provision, transport (including transport back home for people requiring palliative care.) Perceptions about aged care can also be a barrier to access as is a lack of knowledge of available services (APHN, 2016d).	<i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i>
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	<p>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, 2017e).</p> <p>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</p>	<i>Australian Institute of Health and Welfare (AIHW), 2017e, Aboriginal and Torres Strait Islander Health Performance Framework: 2017 report, Catalogue number IHW 181, Canberra.</i>

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		<p>treatment episodes (2014/15) and 3% of Alcohol and Drug Information Service (ADIS) calls (2015) (Roche et al., 2017a).</p> <p>For APHN region in 2016 by primary and secondary drugs of concern, Aboriginal people accounted for:</p> <ul style="list-style-type: none"> • 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). <p>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).</p> <p>Aboriginal Family Clinic reported high percentage of clients presenting for AOD support, using methamphetamines with a need for increase of timely services (APHN, 2017f).</p> <p>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</p>	<p><i>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.</i></p> <p><i>APHN, 2017f, Capacity Building process, 2017.</i></p> <p><i>Drug and Alcohol Services South Australia (DASSA), 2016, Identifying the Gaps:</i></p>
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		<p>Aboriginal and/or Torres Strait Islander background and this figure has been constant over the previous 2 years (DASSA, 2016).</p> <p>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).</p> <p>Gaps in AOD treatment service provision include gaps in access to a full range of services, limited access to culturally safe or secure services, services for families, and a paucity of ongoing support and relapse prevention for those completing intensive treatment (NDRI, 2014).</p> <p>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 (APHN, 2016d).</p>	<p><i>Report on South Australian Drug and Alcohol Service Planning, unpublished.</i></p> <p><i>National Drug Research Institute (NDRI), 2014, Harnessing Good Intentions Report.</i></p> <p><i>National Drug Research Institute (NDRI), 2014, Harnessing Good Intentions Report.</i></p> <p><i>APHN, 2016d, Health Priority Groups (HPG), priority setting workshops</i></p>
Mental health and suicide prevention services across the region to target Aboriginal and Torres Strait Islander people	Primary mental health and suicide prevention services	<p><i>Community mental health services for Aboriginal people</i></p> <p>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</p>	<p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017a, South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017.</i></p>

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		<p>service per 100 population for Aboriginal people (Gibson et al., 2017a).</p> <p>Aboriginal people in CALHN had a crude rate of occasions of service with community mental health services of 132.2 per 100 people, 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., 2017b).</p> <p>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., 2017b).</p> <p>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., 2017c).</p>	<p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017b, South Australian Aboriginal Health Needs and Gaps Report: Central Adelaide Local Health Network, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>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, 2017c, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p>
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		<p>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) (Gibson et al., 2017c).</p> <p>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., 2017d).</p> <p>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., 2017d).</p> <p>The most common reason for community mental health occasions of service for all LHNs and the State, regardless of Aboriginal status or sex, was 'schizophrenia, schizotypal and delusional disorders' (Gibson et al., 2017a).</p>	<p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017d. South Australian Aboriginal Health Needs and Gaps Report: Southern Adelaide Local Health Network, 2017, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017a, South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017.</i></p>
Difficulty accessing appropriate mental health services for Aboriginal and	Timely access and equity to health services and care	The Northern CAC 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,	<i>APHN, 2016c, Community Advisory Council, priority setting workshops.</i>

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<p>Torres Strait Islander people.</p>		<p>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, 2016c).</p> <p>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 (APHN, 2016b).</p> <p>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., 2017b).</p> <p>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., 2017c).</p>	<p><i>APHN, 2016b, Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation.</i></p> <p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017b, South Australian Aboriginal Health Needs and Gaps Report: Central Adelaide Local Health Network, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017c. South Australian Aboriginal Health Needs and Gaps Report: Northern Adelaide Local Health Network, 2017, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p>
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		<p>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., 2017d).</p> <p>These high rates of service utilisation clearly indicate a burden of mental health issues in the community. There is a need to reduce the burden of mental health issues, and to address issues in primary and specialist care to prevent acute episodes. There are a wide range of support services for people with mental health issues, however given the exceedingly high rate of use of community health and hospital services, there may be need to expand and/or adapt these services to reach Aboriginal clients. Barriers in accessing affordable, timely psychology and psychiatry services should be addressed (Gibson et al., 2017a).</p>	<p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017d. South Australian Aboriginal Health Needs and Gaps Report: Southern Adelaide Local Health Network, 2017, Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W., 2017a, South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017.</i></p>
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SECTION 4 – OPPORTUNITIES, PRIORITIES AND OPTIONS

This section summarises the priorities arising from the Needs Assessment and options for how they will be addressed. This could include options and priorities that:

- may be considered in the development of the Activity Work Plan, and supported by PHN flexible funding;*
- may be undertaken using programme-specific funding; and*
- may be led or undertaken by another agency.*

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

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
<i>No new priorities identified for General Population Health (including General Practice Support and After Hours). See below table for previously reported priorities (note: previous priorities which made specific reference to After Hours have been amended and now reflected in After Hours sub-section). Specific Alcohol and Other Drugs Treatment needs priorities for Aboriginal and Torres Strait Islanders people reflected in Indigenous Health section.</i>			

APHN Needs Assessment 2019-22 Priorities for General Population Health (note: priorities will have reference title: GPH, e.g. GPH1.)	
1.	<i>The CALD community are disproportionately affected by Hepatitis B.</i>
2.	<i>Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, LGBTIQ and older people.</i>
3.	<i>Identified areas of the APHN region have childhood immunisation rates below the national average.</i>
4.	<i>Selected areas of the APHN region have high rates of smoking which correlates with areas of high prevalence of COPD.</i>
5.	<i>Selected areas of the APHN region have high rates of obesity and overweight and correlate with areas of low physical activity and poor nutrition.</i>
6.	<i>Selected APHN LGAs have higher rates of a range of chronic conditions (respiratory disease, diabetes, circulatory system disease, chronic kidney disease, musculoskeletal) and multi-morbidities.</i>
7.	<i>Services for people living with persistent pain are limited with long delays to access hospital-based services.</i>
8.	<i>Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.</i>
9.	<i>Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis).</i>
10.	<i>Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.</i>
11.	<i>Early screening of selected cancers (cervix, bowel, breast) can assist in intervention measures which can help reduce mortality as part of a wider cancer control strategy.</i>
12.	<i>A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues.</i>
13.	<i>Lack of easily understood and accessible referral pathways across systems and settings.</i>
14.	<i>A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</i>
15.	<i>Lack of community awareness about existing health care services for different population groups, consumers and providers.</i>
16.	<i>Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.</i>
17.	<i>Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventative health measures.</i>
18.	<i>Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</i>
19.	<i>Minimise instances of poor quality and unwarranted variations of care and follow up.</i>
20.	<i>Prevention and early intervention strategies for childhood and youth health conditions</i>

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<i>21. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers</i>
<i>22. A coordinated approach to improve navigation and pathways for patients to manage their conditions</i>

APHN Needs Assessment 2019-22 Priorities for General Practice Support (note: priorities will have reference title: GPH-GPS, e.g. GPH-GPS1.)
<i>1. Increase awareness and uptake of digital health systems and benefits for patients</i>
<i>2. Targeted support to increase awareness and utilisation of HealthPathways SA and specific pathways for patients</i>
<i>3. Promote and targeted support to adopt best practice in utilisation of clinical softwares to improve patient care and quality improvement activities</i>

APHN Needs Assessment 2019-22 Priorities for After Hours (note: priorities will have reference title: GPH-AH, e.g. GPH-AH1.)
<i>1. Lack of community awareness about appropriate after-hours health care services leading to increased potentially preventable hospitalisations</i>
<i>2. RACFs have a low capacity to support their residents in the afterhours setting leading to increased transportation to emergency departments and medical deputising services</i>

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

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
<i>No new priorities identified for Primary Mental Health care (including Suicide Prevention). See below table for previously reported priorities. Specific Alcohol and Other Drugs Treatment needs priorities for Aboriginal and Torres Strait Islanders people reflected in Indigenous Health section.</i>			

APHN Needs Assessment 2019-22 Priorities for Primary Mental Health Care (including Suicide Prevention) Needs (note: priorities will have reference title: PMH, e.g. PMH1.)	
1.	<i>High prevalence of mental health/behavioural issues and psychological distress in selected areas across the region.</i>
2.	<i>Provision of psychological services comparatively low in areas of highest need.</i>
3.	<i>Comparatively high numbers of people attempting to access psychological services in areas with minimal psychological service provision.</i>
4.	<i>Disproportionate quantities of mental health related medicines prescribed in women, disadvantaged areas and population groups such as people aged 75 and over.</i>
5.	<i>Difficulty in identifying and accessing appropriate mental health treatment services.</i>
6.	<i>Increase integration between AOD and Primary Mental Health (PMH) service providers to improve health outcomes.</i>
7.	<i>Increase awareness of appropriate mental health services to health professionals and community and carers through the provision of information and resources.</i>

APHN Needs Assessment 2019-22 Priorities for Psychosocial Support Services (note: priorities will have reference title: PMH-PSM, e.g. PMH-PSM1.)	
1.	<i>Responsive and appropriate psychosocial support services that meets the needs of people with severe mental health conditions.</i>
2.	<i>Increase awareness and promotion of psychosocial support services for people with severe mental health conditions and their carers.</i>
3.	<i>Increase the health workforce capacity to provide appropriate care to people with severe mental health conditions.</i>

Alcohol and Other Drug Treatment Needs

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
<i>No new priorities identified. See below table for previously reported priorities. See below table for previously reported priorities. Specific Alcohol and Other Drugs Treatment needs priorities for Aboriginal and Torres Strait Islanders people reflected in Indigenous Health section.</i>			

APHN Needs Assessment 2019-22 Priorities for Alcohol and Other Drugs Treatment Needs (note: priorities will have reference title: AOD, e.g. AOD1.)	
1.	<i>Increase accessibility to appropriate alcohol and other drugs treatment options for targeted population groups and identified areas of need in APHN region.</i>
2.	<i>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</i>
3.	<i>Increase integration between AOD and Primary Mental Health (PMH) service providers to improve health outcomes.</i>

Indigenous Health (including Indigenous chronic disease)

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
<i>No new priorities identified for Indigenous Health. See below table for previously reported priorities which made specific reference to Aboriginal and Torres Strait Islanders people.</i>			

APHN Needs Assessment 2019-22 Priorities for Indigenous Health (note: priorities will have reference title and specific to Needs Area: IH, e.g. IH-GPH1., IH-PMH1., etc.)
General Population Health (GPH)
1. <i>Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non- Aboriginal and Torres Strait Islander children.</i>
2. <i>Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people.</i>
3. <i>Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.</i>
4. <i>Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people.</i>
5. <i>Awareness of timely access to appropriate services (including after-hours services) for Aboriginal and Torres Strait Islander people.</i>
Primary Mental Health (including Suicide Prevention) (PMH)
6. <i>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.</i>
Alcohol and Other Drug Treatment Needs (AOD)
7. <i>Increase access to and availability of culturally appropriate AOD treatment services particularly alcohol and illicit drugs for Aboriginal and Torres Strait Islander people.</i>

Section 5 - Checklist

This checklist confirms that the key elements of the needs assessment process have been undertaken. PHNs must be prepared, if required by the Department, to provide further details regarding any of the requirements listed below.

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 Activity Work Plan and for the department to use for program 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).	✓