



**Australian Government**

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# **Primary Health Networks Program Needs Assessment Report**

This Primary Health Network's (PHN's) Needs Assessment report was submitted to the Department of Health and Aged Care on **15 December 2022**, and approved on **22 March 2023**.

***Adelaide PHN***

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## Acknowledgement

We 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 and present.

We would also like to acknowledge and pay our respects to those Aboriginal and Torres Strait Islander people from other Nations who live, work, travel & contribute on Kaurna Country.

Marni Naa Pudni “Welcome”



## Abbreviations

AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
ADHA	Australian Digital Health Agency
ADHD	Attention Deficit Hyperactivity Disorder
ADIS	Alcohol and Drug Information Service
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AMHSW	Accredited Mental Health Social Workers
AOD	Alcohol and Other Drugs
Adelaide PHN	Adelaide Primary Health Network
ASD	Autism Spectrum Disorders
ASR	Age-Standardised Rate
BBV	Blood-Borne Viruses
BPD	Borderline Personality Disorder
CAC	Community Advisory Council
CALHN	Central Adelaide Local Health Network
CALD	Culturally and Linguistically Diverse
CC	Clinical Council
CDU	Child Development Unit
COA	Commonwealth of Australia
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease
CRM	Customer Relationship Management
CVD	Cardiovascular Disease
DFV	Domestic and Family Violence
DASSA	Drug and Alcohol Services South Australia
DHW	SA Department for Health and Wellbeing
dTpa	Diphtheria-tetanus-pertussis
DOH	Department of Health (Commonwealth)
DOHAC	Department of Health and Aged Care (Commonwealth)
ED	Emergency Department
FTE	Full Time Equivalent
GBM	Gay, Bisexual, other Men who have sex with men
GP	General Practitioner
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HNA	Health Needs Assessment

HPG	Health Priority Group
HPN	Health Priority Network
IRSD	Index of Relative Socioeconomic Disadvantage
LETSS	Lived Experience Telephone Support Service
LGA	Local Government Area
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual + The '+' reflects our engagement with others who identify as same or multigender attracted or gender diverse but who use a wide range of different identity terms.
LHN	Local Health Network
LICBT	Low Intensity Cognitive Behavioural Therapy
MBS	Medicare Benefits Schedule
MMR	Measles-mumps-rubella
NA	Needs Assessment
NALHN	Northern Adelaide Local Health Network
NCETA	National Centre for Education and Training on Addiction
NDSHS	National Drug Strategy Household Survey
NESC	Non-English Speaking Countries
NHRA	National Health Reform Agreement
NLG	Network Leadership Group
NPA	National Priority Area
OAT	Opioid Agonist Therapy
OST	Opioid Substitution Therapy
OT	Occupational Therapists
OTC	over-the-counter
PBS	Pharmaceutical Benefits Scheme
PCC	Priority Care Centre
PEP	Post-Exposure Prophylaxis
PHA	Population Health Area
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PIP	Practice Incentive Program
PMHC	Primary Mental Health Care
PPE	Personal Protective Equipment
PPH	Potentially Preventable Hospitalisation
PrEP	Pre-Exposure Prophylaxis
QI	Quality Improvement
RACF	Residential Aged Care Facility
RACGP	Royal Australian College of General Practitioners
RHD	Rheumatic Heart Disease

SA	South Australia
SA2	Statistical Area Level 2
SA3	Statistical Area Level 3
SA4	Statistical Area Level 4
SALHN	Southern Adelaide Local Health Network
SANDAS	South Australian Network of Drug and Alcohol Services
SEIFA	Socio-Economic Indexes for Areas
SES	Socio-Economic Status
SG	Steering Group
STI	Sexually Transmitted Infections
SMD	Secure Message Delivery
TWP	Towards Wellness Plan
WAPHA	Western Australia Public Health Alliance
WCH	Women's and Children's Hospital
WG	Working Group

# 1 Narrative

## 1.1 Needs Assessment process

### 1.1.1 Introduction

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

### 1.1.2 Background

Since 2015 Adelaide PHN has completed nine NA reports by triangulating health, service and community<sup>1</sup> needs, with input from Adelaide PHN councils<sup>2</sup>. Together with our Board, they bring together a diverse range of experience and knowledge informing our evidence-based planning process to determine the local needs and priorities of our catchment area.

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

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

Name of Needs Assessment Report	Number of Priorities	Submission period
Baseline Needs Assessment (BNA)	32	March 2016
Update to BNA	37	November 2016
Core Flexible NA Update	28	November 2017
Alcohol and Other Drug (AOD) NA Update	4	November 2017
Mental Health and Suicide Prevention NA Update	2	November 2017
NA Report – 2019/20 – 2021/22	47	November 2018
NA Report – Update for 2020/21	47	December 2019
NA Report – Update for 2021/22	51	November 2020
Needs Assessment 2022/23 – 2024/25	46	December 2021
Needs Assessment 2022/23 – 2024/25 - 2022 update	42	December 2022

### 1.1.3 Adelaide PHN Needs Assessment Framework

The NA is underpinned by the Adelaide PHN Needs Assessment Framework (the Framework).

The Framework was developed in 2020 and tested in 2021. The intention of the Framework was to describe the activities and provide guidance to inform the NA process with the aim of improving the

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

<sup>2</sup> Community Advisory Council, Aboriginal Community Advisory Council, Clinical Council and Network Leadership group.

iterative and relevant annual NA by documenting and guiding the processes and procedures including evidence informed methodologies and tools.

### ***Adelaide PHN Needs Assessment Steering Group***

The NA is overseen by the Adelaide PHN Needs Assessment Steering Group (the Steering Group, SG). The Steering Group's primary role is to:

- Provide strategic oversight of the development and application of the Adelaide PHN Needs Assessment in adherence with the Framework;
- Ensure communication flow between Steering Group members and Adelaide PHN staff teams is relevant to the development or application of the Adelaide PHN Needs Assessment;
- Provide advice, input or comment on key processes supporting the development or application of the Adelaide PHN Needs Assessment;
- Identify risks and mitigation strategies concerning key processes or activities which impact on the Needs Assessment or the application of the Needs Assessment in Adelaide PHN business, and communicate these to the Adelaide PHN Executive as appropriate;
- Identify and delegate responsibilities for outputs and tasks related to the Adelaide PHN Needs Assessment; and
- Undertake decision making regarding the development and application of the Adelaide PHN Needs Assessment.

The SG membership is cross-portfolio and aims to incorporate key functions across the organisation, and provides an opportunity for any interim NA working groups to report to.

### ***Adelaide PHN Needs Assessment Working Groups***

In addition to the SG, working groups (WG) were established by national priority area to support data collection, collation and analysis. WG members provided contextual insights and subject matter expertise to ensure the data collected and synthesised is reflective of experiences in the region, and to support any additional data collection systems.

## **1.1.4 2022 process overview**

The following section broadly outlines the key phases of work undertaken in 2022, in line with the Framework.

### ***Planning and Scoping***

As per the Framework, the Adelaide PHN undertook a strategic approach to the planning of the Needs Assessment.

In line with recommendations of a 2020 scoping review undertaken by the Steering Group, the National Priority Areas (NPAs) that underwent a comprehensive update in 2022 were Population Health and Aboriginal Health. A supplementary Needs Assessment process was undertaken specifically for the Care Finder program (which is within the Older Persons and Aged Care NPA), in line with the Care Finder policy guidelines. The Adelaide PHN has also begun work to review and update our previous quantitative and qualitative analysis of after-hours service use in the region, in line with the updated funding schedule.

As part of the 2022 process only minor changes (e.g. updating data for selected indicators, and inserting findings of consultation that occurred since last NA submission) were made to the Alcohol and Other Drugs, Mental Health and Suicide Prevention, Digital Health, Health Workforce, and Older People and Aged Care NPAs, which underwent major updates in either 2020 or 2021.

## ***Data collection, analysis and prioritisation***

As outlined by the Framework, each NPA generally follows a similar methodology for each of the key stages of work, and all are undertaken in line with the needs analysis plan set in the scoping phase of work.

### **Population Health NPA update**

Both quantitative and qualitative data was sort to build upon and/or fill the gaps in evidence that exist in our understanding of the health and service needs in the Adelaide PHN population. Data collection occurred throughout the year, but for inclusion in the 2022 NA update quantitative data collection ceased in November. A wide range of data sources, both primary and secondary and were considered as part of quantitative data collection and analysis. These included, but were not limited to:

- Australian Bureau of Statistics (ABS) 2021 Census of Population and Housing, and Census-derived data on demographics
- a range of Australian Institute of Health and Welfare (AIHW) datasets and publications
- Public Health Information Development Unit (PHIDU) Social Health Atlases of Australia
- Department of Health and Aged Care datasets including health workforce data, Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and the Australian Immunisation Register, and
- data from general practices and Adelaide PHN-commissioned service providers.

Qualitative data sources such as consultation and summative reviews of services were also included in our data collection. Qualitative data collection for inclusion in the 2022 NA ceased in October to allow time for analysis before inclusion in the NA report.

Quantitative data was collected, collated and analysed by NPA. The key observations from each data source were documented and organised into health and service needs, and were then synthesized and triangulated with the qualitative data. The NPA WG supported the process by guiding triangulation and identifying key themes and formulating need statements.

Priority setting activities utilised the prioritisation tool that Adelaide PHN had previously developed based on the Hanlon methodology. The final priority statements were then considered by the NPA WG and options, opportunities for action and/or partnership were identified for each priority statement in line with the requirements of the Needs Assessment deliverable.

### **Aboriginal Health NPA update**

At the recommendation of the NA SG, Adelaide PHN commissioned the Public Health Discipline Group, College of Medicine and Public Health at Flinders University to undertake an *Aboriginal and Torres Strait Islander Health Needs Assessment* for the Adelaide PHN.

The full methodology can be found in the report on our website, but an extract is provided below.

#### ***Context, Methodology, Planning & Recommendations***

Data for the Adelaide PHN Aboriginal and Torres Strait Islander Health Needs Assessment was drawn from publicly available data sources. Prevalence data was derived from Indigenous Health Performance Framework (website initiated in 2020), which based prevalence data on National Aboriginal and Torres Strait Islander Health Survey (NATSIHS, 2018-19) and National Health Survey (NHS, 2017-18).

#### ***Indigenous Data Sovereignty and Governance***

Indigenous data is data in any format or medium on Aboriginal and Torres Strait Islander peoples, families and communities. Indigenous Data Sovereignty focusses on data autonomy across all aspects of the data journey (collection to dissemination) for Aboriginal and Torres Strait Islander

communities. Indigenous Data Governance are principles, approaches and policies which allow Indigenous Data Sovereignty to be enacted.

The Adelaide PHN Aboriginal and Torres Strait Islander Health Needs Assessment focused on drawing Indigenous data predominantly from grey literature in the form of government and non-government reports, and epidemiological data repositories. It needs to be highlighted that the majority of national and bi-national data repositories in Australia were established prior to knowledge and understanding of the importance of Indigenous Data Governance for Indigenous data. As such these repositories do not conform to Indigenous Data Sovereignty principles or practices. This is a significant limitation in these repositories, as while they contain Indigenous data, they do not engage Indigenous Knowledges or recognise the sovereign rights of Aboriginal and Torres Strait Islander individuals and communities in their repositories or reporting mechanisms. We have undertaken structured data framing to assist in counteracting this limitation but acknowledge that this is a significant limitation in the Needs Assessment.

#### *Strength-based approach*

Strength-based approaches for the framing of Aboriginal and Torres Strait Islander health outcomes have been used to decolonise outcomes and shift from a deficit discourse and data narrative. Valuing and centring Indigenous knowledges throughout the Needs Assessment process – approach, data sources accessed, data collected, and contextualisation of outcomes are essential in strength-based approaches, along with actively recognising and addressing impacts of colonisation. For example, where possible outcomes were reported for Aboriginal population only against South Australia or national Aboriginal outcomes, rather than the dominant population. However, in cases where no data was available and health inequity contextualisation was required, reporting was against the dominant population but appropriately contextualised with work from First Nation (global collective) scholars and researchers.

#### Care Finder Supplementary NA

To identify local needs in relation to Care Finder support Adelaide PHN undertook the following broad activities:

- Establishment of a care finder project working group
- A review of the existing Adelaide PHN Needs Assessment 2022/23-2024/25 to identify gaps in current evidence base in relation to the local service landscape and the needs of care finder target populations
- Development of a data collection and needs analysis plan
- Development of survey tools, questions and guidance to support data collection from consultation activities
- Desktop review and literature search
- Surveys and consultation with local Assistance with Care and Housing (ACH) providers, local navigation service providers, stakeholders including aged care peak bodies, other PHNs including Country SA PHN, and aged care organisations.

The Care Finder Working Group within the Adelaide PHN supported the needs assessment by assisting with the triangulation and bringing together the findings to formulate key need statements. Care Finder Working Group meetings, with existing service providers, also assisted the development of the needs analysis and the identification of opportunities and considerations.

The triangulation and prioritisations processes were overseen by the Care Finder Working Group to ensure priorities and processes were appropriate for the Adelaide PHN region and undertaken in line with the Adelaide PHN Needs Assessment Framework.

### 1.1.5 Consultation activities

Since 2016, Adelaide PHN has sought advice and feedback via surveys, consultations and workshops from our Advisory Councils and stakeholder groups, primary health care providers, and clinicians from acute and specialist health services about health and service needs in the region.

#### Population Health NPA update

In 2022, to provide community members and health care professionals an opportunity to influence Adelaide PHN's Needs Assessment, "Community Conversations" were introduced. Community Conversations are based on the kitchen table discussion methodology which allows small groups to participate in discussions on topics of interest to them at a time of the day and a place that suits, and which is hosted by a community member. Kitchen Table Discussions are designed to be held in homes, local cafes, and outdoor venues. It is up to the host to determine where the best venue is for their participants and to take into consideration their needs when choosing. The benefit of this process is that it is community members facilitating the consultation with their own community providing a safe, friendly, and informal environment in which to have their voice heard. Adelaide PHN contracted Health Consumers Queensland to support this process and Adelaide PHN community advisory council members were trained and hosted conversations in person or online with members of their local community. It is envisaged that the community conversations methodology will become an ongoing tool used by Adelaide PHN to hear about our community's experiences of primary health care.

Adelaide PHN CAC members hosted "Population Health" community conversations with culturally and linguistically diverse people and those who have English as a second language in September and October 2022. The results of these consultations are referred to throughout this report as Kitchen Table Community Conversations (KTCC).

A Population Health Needs Assessment Consultation (PHNAC) was conducted on 5<sup>th</sup> October 2022 and attended by members of our clinical council, community advisory council and network leadership group. Hosted by the Population Health NPA WG, the purpose of this workshop was to gain input and feedback to our thinking around Population Health as a NPA specifically to identify barriers, enablers and outcomes in three focus areas: chronic and complex conditions, illness prevention and health protection, and equitable access.

#### Aboriginal Health NPA

To ensure community insight and input was present in the needs assessment for the Aboriginal Health NPA, Adelaide PHN engaged and consulted with members of our Council groups and other stakeholder groups. This consultation process provided members the opportunity to offer feedback on the draft NA report and raise new health or service needs which impact the local Aboriginal community accessing services in the Adelaide PHN region. Two members of the Aboriginal CAC completed training in the Kitchen Table methodology, with First Nations yarning circles to be hosted but unfortunately not within the timeframe to allow inclusion in this 2022 update.

#### Mental Health NPA

In 2022, Adelaide PHN undertook stakeholder consultations to inform the evaluation and recommissioning of complex youth services scheduled for commissioning and implementation from 2023/24 to 2024/25. The consultations engaged over 70 stakeholders from diverse groups, including young people who had accessed complex youth services, staff working in complex youth services, and external stakeholders. Stakeholders provided feedback in relation to existing Adelaide PHN commissioned complex youth services, with a focus on identifying key successes and challenges of these services, as well as opportunities for the future. Relevant findings have been included within the Mental Health chapter of this update.



### Additional consultation activities

Outside of these specific consultations, the Adelaide PHN Needs Assessment also considered feedback from stakeholders captured from engagement activities.

### 1.1.6 Needs Assessment Evaluation and Review

The development of the Framework in 2020 was a core strategy towards a comprehensive evaluation process for the NA. The Framework ensures the NA is conducted using a systematic and reproducible methodology to determine and prioritise needs for the purpose of taking action - the results of which are presented in the Opportunities and Priorities tables within this report.

The NA SG as part of the governance in overseeing the NA, has the role of identifying and actioning a continuous quality improvement process. As part of the 2022 NA, the SG will conduct a review of the process and outputs. The review will include a survey, group discussion and focused interviews with the project team to identify to what extent the framework was implemented as intended and if there were any unintended outcomes or changes required.

In addition, arising issues are raised via the SG meeting and attended to throughout the year and addressed as appropriate.

Recommendations from the 2021 process were applied to the 2022 process, and learnings from the 2022 review will be considered and actioned ahead of planning for the 2023 NA.

### Gaps and Limitations

#### After-hours update

As part of the 2022 update the Adelaide PHN began reviewing and updating our previous quantitative analysis of after-hours service use in the region, as well as the qualitative analysis with a number of CAC members holding community conversations on the “After Hours” topic. However due to a constraints, such as delays to accessing data, and the availability of stakeholders and the community to participate in consultations, we were still undertaking data collection at the time of submission of this report. Our work on this topic will continue into early 2023 and the results will be submitted as part of the 2023 Needs Assessment update.

#### Workforce consultations

In previous years Adelaide PHN has conducted large surveys both General Practice and Allied Health providers in the region, however these have not been conducted since 2020, primarily due to reduced workforce capacity and reorientation of resources in our organisation because of COVID-19. Adelaide PHN has been developing and undertaking alternate mechanisms engaging with our health workforce, the results of which will be included in the 2023 update.

#### Data issues

The Adelaide PHN has a continual approach to gathering and analysing data throughout the year, but in line with the NA Framework the data collection period is open for a fixed time period in order to finalise our analysis and develop this deliverable. This means that some reports or data released outside of the data collection phase have not been included in this analysis for this update, but will be used in the evidence base that informs the work of the Adelaide PHN and included in the 2023 update.

Despite the increasing availability of relevant PHN-level data through Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS) and Public Health Information Development Unit (PHIDU), it must be noted that there are still limitations and gaps to the findings presented in this report. For instance, there is some information that is only available at a national or state level and cannot be reported on at a local level. Or, where data is available at PHN-level it is not available by specific age or population cohorts. Additionally, some available data cannot be shared

outside of the Adelaide PHN and their providers due to the confidential nature and sensitivity of the data. i.e. there is a wealth of data within HeaDS UPP Tool but due to sensitive nature of the data the majority of it can't be shared publicly.

Limitations in administrative data collections restricts our ability to quantify the health and service inequity faced by specific to population groups such as people living with a disability, people from culturally and linguistically diverse (CALD) backgrounds, and Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual+ (LGBTIQA+) communities. Further ongoing, and targeted data collection will be required to provide additional insight into the needs of these communities in the Adelaide PHN region.

### 1.1.7 Additional comments or feedback

The NA is a process, an output and resource for the Adelaide PHN. We have made major strides towards improving and embedding the NA across the functions of our organisation through the development and implementation of the NA Framework. However, the following are key points to note regarding ongoing challenges we have:

- Timing of new Commonwealth funding announcements does not always allow for in depth investigations inside the submission timeframe. This can mean priorities or needs are out of sync with funding models and commissioning cycles.
- Timing of Needs Assessment submission to Commonwealth is similar and overlaps with 12-Month Reporting, putting pressure on resourcing in the Adelaide PHN.
- Needs assessments to inform commissioning of activities in the following financial year must be completed much earlier than the submission date to inform the program/project design, commissioning approach and market development. The Adelaide PHN continue to align the timing of our activities, but this remains an ongoing challenge.
- Testing of the NA framework identified best practice and good practice of conducting a NA. A best practice NA would be for a full region health need assessment rather than needs assessment to inform commissioning. The Adelaide PHN continues to work towards best practice, but acknowledge resourcing, funding and capacity impact on the ability to do so.

## 1.2 Summary of changes

The 2022 NA process has resulted in substantial changes to Population Health chapter, including the identification of eight new priorities which replaced the previous priority statements from 2021. These are presented in Table 3.

Similarly for Aboriginal Health NPA the 2022 process has resulted in substantial changes and resulted in six new priorities, replacing the previous priority statements from 2021. These are presented in Table 4. As abovementioned the Aboriginal Health chapter in this report, contains a summary of the findings from the full *Aboriginal and Torres Strait Islander Health Needs Assessment*, which is provided as a separate report on our website.

For four NPAs (Alcohol and Other Drugs, Mental Health and Suicide Prevention, Digital Health, and Health Workforce) that only received minor updates, e.g. updates to key prevalence data or inclusion of consultation findings, the content of these chapters remains mostly unchanged and the Opportunities and Priorities tables are also unchanged from the 2021 report.

The findings of the Care Finder Supplementary Needs Assessment have been included at the end of the Older People and Aged Care chapter (Table 5).

## 2 Adelaide PHN region

### 2.1 Our region and people

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

The Adelaide PHN boundary encompasses seventeen Local Government Areas, includes three Local Health Networks (LHNs) – Northern Adelaide, Central Adelaide and Southern Adelaide and shares the Women's and Children's Health Network with Country SA PHN.

#### 2.1.1 Population

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

In 2021 an estimated 1.27 million people resided in the region, which is 71% of the population of South Australia, and 5% of the total Australian population (25.42 million people) (profile.id 2022).

The median age in the Adelaide PHN is 39 years, with 83% of the total population aged over 15 years of age. According to the 2021 census, 51% of residents are female, and 86% are Australian Citizens (profile.id 2022).

In the five years since the 2016 Census, the population of the region has grown by over 80,000 residents, equivalent to an average growth rate of 1.1% per year (profile.id 2022).

The age groups with the largest increases in this period (2016-2021) were 70 to 74 year olds, increasing by 14,293 people, and 35 to 39 year olds, increasing by 13,156 people (profile.id 2022).

Average life expectancy in the greater Adelaide between 2019-2021 was 83.5 years, for males 81.5 years and females 85.7 years, consistent with 2018-2020 where the life expectancy at birth was 83.4 years (for males – 81.4 and for females – 85.6). This is consistent with the Australian average life expectancy of 73.3 years (ABS 2022c).

While the majority of the population self-assessed themselves as having good to excellent health, 16 in every 100 people (ASR per 100) in the region aged 15 years and over rated their health as fair or poor health in 2017-18. This is 8% higher compared to the national rate of 14.7 per 100 people (PHIDU 2022c).

#### 2.1.2 Demographics

##### *Children and Young People*

In 2021, as counted at the last Census, there were 257,720 people aged 17 years and under living in the Adelaide PHN region, equivalent to 20% of total region population, which is line with the proportion of young people (22% of total population) nationally.

In our region this included 68,243 (5.4% of total region population) babies and pre-schoolers (0 to 4 years), 103,431 (8.1%) primary schoolers (5 to 11 years) and 86,046 (6.8%) secondary schoolers (12 to 17 years) (ABS 2022d)

Population estimates for the region indicates that by 2030, there will be 233,410 (17.1%) people aged 0-14 years, slightly below the estimated for Australia (18.5%) (PHIDU 2022a).

The three Local Government Areas with the highest number and proportion of young people were Onkaparinga (37,254, 21.3%), Salisbury (33,586, 23.0%) and Playford (26,429, 26.6%) (profile.id 2022).

### ***Older populations***

South Australia has a higher proportion of older people compared to the Australian average and that number is expected to continue to increase. In 2021, 311,172 people aged 60 years and over lived in Adelaide PHN, including 33,809 people aged over 85 years (PHIDU 2022a). Since 2001, the population of people aged 65 years and over living in the Adelaide PHN region has increased by 53%, compared to overall population growth of 23% for the region as a whole (profile.id 2022).

In 2021, people aged 60 years and older constituted on average 25% of the region's population, and three percent were people aged 85 years and older, slightly higher than the proportions nationally (23% and 2% respectively) (profile.id 2022).

The LGAs with highest numbers of residents aged 65 years and older are Onkaparinga (34,919 people, 15% of total), Charles Sturt (23,985 people, 10% of total) and Salisbury (22,586, 10% of total) (profile.id 2022).

Onkaparinga and Charles Sturt LGAs also had the highest number of residents aged 85 year and over, 3,887 and 3,732 people respectively (11% of total), with nine percent of all people aged 85 years and older living in the LGA of Port Adelaide Enfield (2,988) (profile.id 2022)..

Population estimates for the region indicate that by 2030, 20% of the region's total population, 274,000 people, will be aged 65 years and over, with over 39,000 people aged 85 years and over (PHIDU 2022a).

### ***Aboriginal and Torres Strait Islander population***

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

There were total of 23,525, Aboriginal and Torres Strait Islander people resided in the Adelaide PHN region, comprising 1.9 per cent of the region's total population (PHIDU 2022d). In comparison there were 870,401 Aboriginal and Torres Strait Islander people in Australia which is 3.4% of total of Australia's population.

The median age of Aboriginal and Torres Strait Islander people across the Adelaide PHN SA4 region is lower than the overall population, and ranged from 22 to 26 years (Hossain et al. 2022), with 1 in 2 (55%) Aboriginal and Torres Strait Islander people in the Adelaide PHN region aged 24 years and below. By age group, 5,632 people (24%) were aged 0-9 years, 4,805 people (20%) were aged 10-19 years, 4,497 people (19%) were aged 20-29 years, 2,961 people (13%) were aged 30-39 years, 2,153 people (9%) were aged 40-49 years, 1,861 people (7%) were aged 50-59 years, and 1,618 people (7%) were aged 60 years and older (PHIDU 2022a).

The majority (65%) of Aboriginal and Torres Strait Islander population reside in four areas within the Adelaide PHN: Playford (4,286, 18%), Port Adelaide – Enfield (3,891, 17%), Salisbury (3,696, 16%) and Onkaparinga (3,495, 15%) (PHIDU 2022a).

### ***Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual + (LGBTIQA+) communities***

There are currently no specific LGBTIQA+ population counts for the Adelaide PHN region. National estimates indicate that 3% of adults in Australia identify as gay, lesbian or an 'other' sexual orientation (ABS 2017a); if this proportion was reflective of the Adelaide PHN region in 2021 there would have been approximately 26,000 people aged 18 years and over identifying as gay, lesbian or other sexual orientation.

### ***Culturally and linguistically diverse (CALD) communities***

The Adelaide PHN is a culturally diverse region and CALD communities continue to grow. In 2021, 29% of people in the Adelaide PHN were born overseas, compared to 28% of the national population (profile.id 2022). Between 2016 and 2021, there was an increase of 40,699 persons born overseas in the Adelaide PHN (profile.id 2022).

According to the 2021 Census data, 364,144 people who were living in Adelaide PHN in 2021 were born overseas, and 20% arrived in Australia within five years prior to 2021 (profile.id 2022). There were total of 255,805 residents that were born in a predominantly non-English speaking country (NESC) this is equivalent to 21% of the total Adelaide PHN population. The majority of those from NES countries live in the Central Adelaide LHN (46%) and Northern Adelaide LHN (36%), while 18% resided in the Southern Adelaide LHN. The majority were in the 30-39 years age group (22%), with 17% in the 20-29 years age group and 16% in the 40-49 year age group.

#### **Birthplace**

In 2021, the top 10 birthplaces of people from NESC in the Adelaide PHN were: India, China, Philippines, Vietnam, Malaysia, Italy, Sri Lanka, Nepal, South Korea, and Germany (PHIDU 2022c).

The largest changes in birthplace countries in the Adelaide PHN region between 2016 and 2021 were for those born in India (+16,505 persons), Nepal (+4,212 persons), the United Kingdom (-3,238), Vietnam (+2,592 persons) and the Philippines (+2,510 persons) (profile.id 2022).

Since 2016, the top 5 country of birth of residents that were born in non-English speaking countries were India (29%), China (excludes SARs and Taiwan) (13%), Nepal (6%), Vietnam (4%) and the Philippines (4%) (profile.id 2022).

The Local Government Area of Campbelltown (24.1% of the population), Port Adelaide Enfield (23.1%), Salisbury (21.9%), Burnside (19.9%), and West Torrens (18.6%) had the highest proportion of people born in NESC and resident for longer than five years (PHIDU 2022c).

#### **Languages spoken**

The top 10 languages other than English spoken at home for people living in the Adelaide PHN region were: Mandarin, Italian, Vietnamese, Greek, Punjabi, Arabic, Cantonese, Hindi, Nepali, and Gujarati (profile.id 2022).

The top five languages spoken by people born in predominately non-English speaking countries and had arrived in Australia within five years prior to 2021 were Mandarin (14%), Punjabi (12%), Nepali (6%), Hindi (6%) and Vietnamese (4%) (profile.id 2022).

#### **English proficiency**

In 2021, 35,358 (2.9%) people born in a predominately non-English speaking country and living in the Adelaide PHN region reported they had poor proficiency in English. Salisbury (6.1%), Port Adelaide Enfield (5.5%), Campbelltown (4.5%), Adelaide City (3.7%) and Charles Sturt (3.5%) were the Local Government Areas with the highest proportion of people born overseas reporting poor proficiency in English (PHIDU 2022c).

### 3 Population Health

*Please note, the health and services needs of population groups including Aboriginal and Torres Strait Islander people, older Australians, and people living with poor mental health are presented in specific chapters of this report.*

#### 3.1 Policy and Planning Context

Population Health is a national priority area for the Adelaide PHN, as it is all PHNs across the country. The Adelaide PHN has been commissioning activities as part of its commitment to population health goals and objectives, as set out in the *PHN Program Performance and Quality Framework* since 2015.

Throughout 2022, the Adelaide PHN has undertaken work to review and refresh its approach to Population Health to ensure alignment with recent Commonwealth strategies and to ensure best practice evidence and methodologies are reflected in our approach.

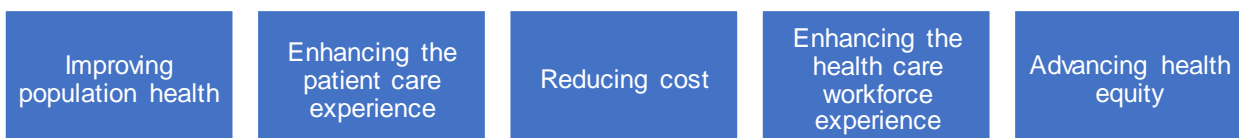
The key contextual considerations for development of the new population health framework include:

##### **Health System Dimensions**

Adelaide PHN utilizes six dimensions of quality based on the Australian Health Performance Framework to inform the identification of priorities for improvement and development and supporting individual PHNs in measuring their performance and quality against tangible outcomes for effectiveness, safety, appropriateness, continuity of care, accessibility and efficiency and sustainability.

##### **Quintuple Aim**

The Quadruple aim – enhancing patient and health care provider’s experience, improving population health, and reducing costs – is widely accepted for health care improvement. More recently, these aims expanded to the quintuple aim, adding the fifth aim of advancing health equity for providing better system of care for the most marginalised communities. Adelaide PHN is committed to focus on the quintuple aims when designing, monitoring and evaluating their models of care and services.



##### **Australia’s Primary Health Care 10 Year Plan**

The focus of Australia’s Primary Health Care 10 Year Plan 2022-2033 (DoH 2022a) (the Plan) is on Australia’s primary health care services provided through general practices, Aboriginal Community Controlled Health Services (ACCHS), community pharmacies, allied health services, mental health services, community health and community nursing services and dental and oral health services. The plan also focuses on the integration of primary health care with hospitals and other parts of the health system, aged care, disability care and social care systems.

The Plan also provides detail about the role of the PHNs in supporting primary health care including:

- Primary Care - PHN After Hours Program extension - the Government will consider future policy for after-hours services in the context of this plan, the impacts of MBS telehealth and the 2020-21 evaluation of the PHN After Hours program.
- Living with COVID-19 - Support for PHNs to Coordinate COVID Care

- Strategic, collaborative commissioning approaches between PHNs and Local Hospital Networks (LHNs) under the National Health Reform Agreement (NHRA) show significant promise in delivering more integrated, value-based care pathways at local and regional level.

### **Adelaide PHN Role**

PHNs are part of a broader health care system, and drive change through the health care system to ultimately deliver and maximise health outcomes for people and communities living in their regions.

The Adelaide PHN uses a range of levers to support positive change for people and communities, primary health care providers, and broader health systems, including commissioning, partnership, and advocacy.

## **3.2 Recommissioning of Adelaide PHN-funded activities**

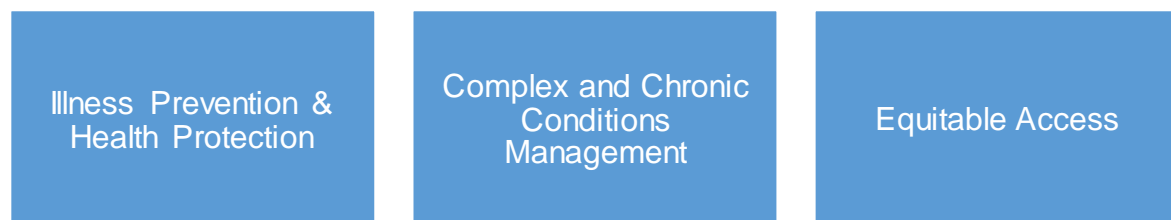
Since 2015, the Adelaide PHN has commissioned and delivered a range of activities under the banner of Population Health. Population Health was identified as a focus area for the 2022 Needs Assessment. To support the Population Health Needs Assessment and the re-design of activities, a refreshed definition of Population Health, including outcome themes and three focus areas has been developed to reflect the context of the Adelaide PHN and local needs.

### **Population Health Definition**

The Adelaide PHN population health definition is: *“An approach to protect and promote good health, prevent illness, and reduce health inequities in the Adelaide PHN region. This can be achieved by community-informed local priority setting and addressing those needs by facilitating quality population health programs on the broader determinants of health, supporting primary care providers, and coordinated quality integrated health care in partnership with our stakeholders.”*

### **Focus Areas**

As part of the population health definition development and work undertaken to update the 2022 Needs Assessment, the Adelaide PHN identified three focus areas for Population Health:



Data within the 2022 Needs Assessment has been organised under these focus areas.



### 3.3 Outcomes of the health and service needs analysis – Population Health

#### 3.3.1 Summary of identified needs for Population Health

Table 2 below summarises the health and services needs identified through the needs assessment process for the Population Health priority area. The evidence against each of these statements is provided within this chapter.

**Table 2 Summary of health and service needs identified for Population Health, 2022**

Outcomes of the health and service needs analysis – Population Health		
Identified Need	Key issues	Evidence / Chapter Section(s)
Antenatal care	The percentage of women not attending an antenatal care visit within the first 10 weeks in the Adelaide PHN are substantially higher than national rates. Rates of smoking during pregnancy are higher than the PHN and national averages in the northern and southern regions.	3.6.4 Health and service needs of specific populations groups and communities (Parents and Babies)
Culturally and Linguistically Diverse communities	Refugees and new arrivals and culturally diverse communities face language and cultural barriers to navigate and access the local health system. Health issues are compounded with lower levels of language and health literacy. CALD communities are disproportionately affected by chronic conditions and blood-borne viruses. Members of the CALD community face multiple barriers to accessing cancer screening.	3.6.3 Factors impacting access to primary health care services 3.6.4 Health and service needs of specific populations groups and communities (Culturally and linguistically diverse and emerging communities) 3.5.1 Cancer screening 3.5.2 Immunisation 3.5.3 Sexual Health and Blood Borne Viruses
Cancer Screening	Residents of the northern, western and city areas of the Adelaide PHN have lower participation rates in the three national cancer screening campaigns compared to both the Adelaide PHN and national rates, and higher rates of mortality.	3.5.1 Cancer screening 3.4.2 Chronic Conditions
Chronic conditions	Adelaide PHN residents have higher rates of hospitalisations than national rates for Diabetes, respiratory and circulatory system disease. The northern, southern and western regions of the Adelaide PHN have substantially higher rates of chronic conditions than the PHN and/or Australian averages. Language and health literacy have been identified as barriers to the management of complex and chronic conditions within the Adelaide PHN. Areas of low SEIFA scores and persons with low income have increased rates of chronic conditions.	3.4.2 Chronic Conditions 3.6.3 Factors impacting access to primary health care services 3.6.4 Health and service needs of specific populations groups and communities



Outcomes of the health and service needs analysis – Population Health		
	Long wait lists to see GPs and specialists are reported to be a barrier to complex and chronic condition management. Long wait times have been noted as a barrier to the management of complex and chronic conditions and as a reason to attend hospital ED's.	
Data	Limitations in administrative data collections restricts our ability to quantify the health issues and burden faced by LGBTIQ+ communities, CALD communities, and people living with a disability.	3.6.4 Health and service needs of specific populations groups and communities
LGBTIQ+ communities	Service providers have limited knowledge of LGBTIQ+ issues to address needs of community. Stigma and discrimination continue to be identified as barriers to accessing health services for LGBTIQ+ communities.	3.6.3 Factors impacting access to primary health care services 3.6.4 Health and service needs of specific populations groups and communities
Mental health	Residents of the Adelaide PHN have higher hospitalisation rates than national averages for mental health related conditions.	3.4.2 Chronic Conditions
People living with a disability	People with disability experience higher levels of chronic and preventable diseases, face barriers to accessing appropriate care, and a third (35%) of people living with a disability are not having their care needs met.	3.6.4 Health and service needs of specific populations groups and communities
Potentially Preventable Hospitalisations	Children aged 0 to 14 years old in the Adelaide PHN have higher rates of admission to public hospitals from potentially preventable chronic conditions than national rates. Lower SES areas in the region are associated with areas of persistently high rates of potentially preventable hospitalisations. Adelaide PHN residents have significantly higher rates of selected potentially preventable hospitalisations than national averages.	3.4.2 Chronic Conditions 3.6.4 Health and service needs of specific populations groups and communities
Risk factors	Residents living in the Northern, Western, and Southern areas of the region have substantially higher rates of health risk factors (smoking, physical inactivity and obesity) than the PHN and/or Australian averages. Residents of the Adelaide PHN have higher rates of fair or poor self-assessed health than the national rate.	3.4.1 Risk Factors
Safe services	There is a reported gap in availability of culturally appropriate workforces to safely support refugees and new arrivals and culturally diverse communities. There is a reported gap in availability of culturally appropriate workforces to safely LGBTIQ+ communities.	3.6.3 Factors impacting access to primary health care services 3.6.4 Health and service needs of specific populations groups and communities
Immunisation	Rates of childhood immunization in the Adelaide City region are below overall Adelaide PHN rates and national target in the 12-<15 Months and 60-<63 month age groups.	3.5.2 Immunisation 3.6.3 Factors impacting access to primary health care services

Outcomes of the health and service needs analysis – Population Health		
	<p>There is marked variation in COVID-19 vaccination uptake with substantially lower vaccination rates in certain CALD communities.</p> <p>Residents of the Adelaide PHN face multiple barriers to accessing vaccination.</p> <p>There is substantial regional variation in COVID-19 vaccine uptake among regions in the Adelaide PHN, with lower coverage in the western areas of the region.</p>	3.6.4 Health and service needs of specific populations groups and communities

## 3.4 Complex and Chronic Condition Management

More Australians are now living with chronic conditions than ever before. These conditions are also the most leading cause of premature mortality. Providing quality care to people living with chronic and complex conditions continues to be an emerging challenge for the Australian health care system. As such the Adelaide PHN will continue to focus on prevention and management of chronic condition management.

In line with work undertaken to explore models such as Patient-Centred Medical Home, including the 10 Building Blocks of High Performing Primary Care, the Adelaide PHN will continue to explore best practice models to support chronic and complex condition management in primary health care settings.

The proposed medium-term outcome by government within the *PHN Program Performance and Quality Framework* focuses on Potentially Preventable Hospitalisation (PPH) for chronic conditions as these conditions have need for primary care management and may be the most influenced by care coordination. The study by AIHW highlighted that those most likely to have a PPH due to chronic conditions were in people in older age groups, individuals with worse self-rated health, individuals with an increased number of different types of medication taken on a regular or ongoing basis, individuals who spoke English as their main language at home and individuals who reported that they were frequent users of GP services (AIHW 2022b).

The *Adelaide PHN Population Health Framework* takes into account that risk factors underpinning chronic disease, such as biological, socioeconomic factors, and health care access, which are complex and interwoven, are associated with poorer health outcomes.

In addition, the Adelaide PHN is committed to integrated care and will continue to work across and within community, service provider and system to support integrated health service models through joint planning and collaborative commissioning at regional and state-wide levels. These elements draw on *Australia's Primary Health Care 10 Year Plan* (DoH 2022a).

### 3.4.1 Risk Factors

*Health risk factors are attributes, characteristics or exposures that increase the likelihood of a person developing a disease or health disorder. Behavioural risk factors are those that individuals have the most ability to modify. The Australian Burden of Disease Study 2018 (AIHW 2021a), found that approximately 38% of the burden of disease in Australia in 2018 could have been prevented by reducing exposure to modifiable risk factors. Tobacco use, overweight (including obesity), all dietary risks, high blood pressure and alcohol use were the leading five risk factors contributing to total burden. PHN Program Performance and Quality Framework*

The most recent data available for the Adelaide PHN region (2017-18) indicates that the overall average rates of behavioural and lifestyle risk factors such as smoking, alcohol intake, physical inactivity, obesity, and high blood pressure, were consistent with or lower than average Australian rates (PHIDU 2021a).

However, the data highlights that substantial geographical variation exists across the Adelaide PHN. Rates in the northern, western and southern areas, specifically in the Local Government Areas of Playford, Salisbury, Port Adelaide Enfield, and Onkaparinga, are consistently higher than both Australian and Adelaide PHN rates (PHIDU 2021a).

#### **Smoking**

The modelled estimates for 2017-18 indicate 134,118 people in Adelaide PHN region or 14.5 per 100 people were current smokers, which is consistent with the Australian rate of 15.1 per 100 people. Rates varied substantially across the region, ranging from 6.2 per 100 in Burnside LGA to 21.6 per 100 in Playford LGA. Salisbury (17.2 per 100), Onkaparinga (16.3 per 100), Port Adelaide Enfield

(15.5 per 100), and West Torrens (14.7 per 100) (PHIDU 2022a) had the next highest smoking rates. Consistent with the national pattern, rates of smoking were substantially higher for males (17.6 per 100) compared to females (11.2 per 100) (PHIDU 2022c).

### ***Alcohol consumption***

The modelled estimates for 2017-18 indicate 128,931 people in Adelaide PHN region or 13.8 per 100 people consumed alcohol at a level that was considered to be a high risk to health, marginally lower than the Australian rate of 16.0 per 100 people. Rates varied substantially across the region, ranging from 10.4 per 100 in Salisbury LGA to 18.5 per 100 in Holdfast Bay LGA. Unley (17.4 per 100), Mitcham (16.9 per 100), Norwood Payneham St Peters (15.8 per 100), and Onkaparinga (15.4 per 100) had the next highest rates (PHIDU 2022c). Consistent with the national pattern, risky alcohol consumption rates were significantly higher for males (20.8 per 100) compared to females (10.1 per 100) (PHIDU 2022c).

### ***Physical inactivity***

In 2017-18, 638,171 people in Adelaide PHN region, approximately half of the region's residents, undertook low, very low or no exercises in previous week (68.0 per 100 population). This is marginally higher than the Australian Average of 66.1 per 100 population. Rates varied substantially across the region, ranging from 53.7 per 100 in Burnside LGA to 78.1 per 100 in Playford. The five PHAs with the highest rates of physical inactivity in the region were Elizabeth/ Smithfield - Elizabeth North (81.7), Davoren Park (81.0), Salisbury/ Salisbury North (80.2), Parafield/ Parafield Gardens/ Paralowie (79.7), and Elizabeth East (77.2) (PHIDU 2022c).

### ***Unhealthy weight***

Over a quarter (27%) of all adult's residents in Adelaide PHN region (342,414 people, 36.6 per 100 population) were overweight in 2017-18. This is consistent with the Australian Greater Capital City Areas Average of 35.8 per 100 population. Rates varied marginally across the region, ranging from 32.5 per 100 in Playford LGA to 39.3 per 100 in Holdfast Bay. The five PHAs with the highest rate in Adelaide region were Brighton/Glenelg (39.6), Colonel Light Gardens/ Mitcham (SA) (39.3), Panorama (39.2), Burnside - Wattle Park (39.0), and Belair/ Bellevue Heights/ Blackwood (39.0) (PHIDU 2022c).

A similar proportion of adults (23%) living in the region (294,673 people, 31.3 per 100 population) were obese in 2017-18. This is marginally higher than the Australian Greater Capital City Areas Average of 29.2 per 100 population. Rates varied substantially across the region, ranging from 21.8 per 100 in Burnside LGA to 47.5 per 100 people in Playford LGA. The five PHAs with the highest rates in Adelaide region were Davoren Park (55.5), Elizabeth/Smithfield - Elizabeth North (52.0), Elizabeth East (45.6), Christie Downs/ Hackham West - Huntfield Heights (43.2), and Playford - West (42.8) (PHIDU 2022c).

### ***High blood pressure***

One in five adult residents in Adelaide PHN region (209,499 people, 21.8 per 100 population) had high blood pressure in 2017-18. This is consistent with the Australian Greater Capital City Areas Average of 22.4 per 100 population. Rates varied marginally across the region, ranging from 18.9 per 100 in Walkerville LGA to 23.6 per 100 people in Playford LGA. The five PHAs with the highest rate in Adelaide region were Davoren Park (24.9), Salisbury/ Salisbury North (24.3), Playford-West (24.2), Northgate-Oakden-Gillies Plains (23.6), and One tree Hill (23.4) (PHIDU 2022c).

### 3.4.2 Chronic Conditions

*Chronic conditions are long lasting with persistent effects. Their social and economic consequences can impact on peoples' quality of life. Chronic conditions often have complex and multiple causes. They are not usually immediately life-threatening but tend to develop gradually, becoming more common with age. Once present, they often persist throughout a person's life, so there is generally a need for long-term management by individuals and health professionals (AIHW 2022ak).*

The Adelaide PHN population generally has higher or consistent rates of chronic disease compared to national rates, however there is substantial variation across the PHN region in terms of prevalence of chronic conditions and the impacts and outcomes, such as ill health, hospitalisations and premature death.

The following section presents data for selected chronic conditions, highlighting the prevalence rate for Adelaide PHN, the national comparison rate and the sub-regions with the highest rates for selected chronic conditions. Where available, data for hospitalisations, Emergency Department (ED) presentations, potentially preventable hospitalisations (PPH), and mortality data are presented.

#### **Long term health conditions**

In 2021, for the first time, the *Australian Census of Population and Housing* included a question to quantify the prevalence of selected long-term health conditions in the community. Census participants were asked if they had been diagnosed with a specific health condition (10 that make up approximately 60% of Australia's deaths), or any "other" condition.

Within the Adelaide PHN, of the population who completed the census, 34% reported they had at least one long-term health condition, this was marginally higher than the Australian percentage of 32% (profile.id 2021).

Based on Census data, the most common reported long-term health condition in the Adelaide PHN was a mental health condition (9.8% compared to 8.8% in Australia), followed by arthritis (9.5% compared to 8.5% nationally), asthma (8.7% compared to 8.1% nationally) and diabetes (5.5% compared to 4.7% nationally) (profile.id 2021).

Within the general practice (GP) data that was shared with the Adelaide PHN there was a total population of 1,453,178 people who had a visit between 1 July 2020 and 30 June 2021. This is the population that is referred to throughout the chronic conditions section of this report. Of the population included, and based on the disease prevalence grouping within PATCAT, the top five chronic conditions were Hypertension (13.1%), Hyperlipidaemia (11.12%), Anxiety (8.6%), Depression (8.5%) and Asthma (8.4%) (APHN 2022a).

#### **Mental health conditions**

##### **Prevalence**

The burden of mental health conditions within the Adelaide PHN is consistent with national estimates. In 2017-18, one in every five people (243,632 people, 20.4 per 100) in Adelaide PHN region had a mental and behavioural problem (PHIDU 2022c). Rates varied substantially across the region, ranging from 14.0 per 100 in Burnside LGA to 28.0 per 100 people in Playford LGA. The five PHAs with the highest rate in Adelaide region were Elizabeth/Smithfield - Elizabeth North (35.5), Christie Downs/ Hackham West - Huntfield Heights (34.3), Elizabeth East (31.8), Davoren Park (28.7), and Morphet Vale - East/Morphett Vale - West (26.7) (PHIDU 2022c).

Within the 2020-21 GP data, the percentage of the population with mental health conditions (as included in the PATCAT disease prevalence grouping) were: anxiety (8.6%) and depression (8.5%) the most prevalent mental health conditions, followed by bipolar (0.61%), autism (0.6%), Attention Deficit Hyperactivity Disorder (0.59%), Schizophrenia (0.46%) and postnatal depression (0.21%) (APHN 2022a).

## Emergency department presentations and hospitalisations

In 2018-19 there were 17,556 emergency department presentations due to mental and behavioural disorders, equivalent to a rate of 1,410.9 per 100,000. This is 18% higher than the national average (a rate of 1,194.5 per 100,000). Compared to the national rate, rates are significantly higher in the LGAs of Marion (72% higher), Playford (68% higher) and Onkaparinga (64%) (PHIDU 2022c).

Hospital admission for mental and behavioural disorders in Adelaide PHN were higher (by 9%) compared to the national rate in 2018-19, with 13,261 admissions to public hospitals in Adelaide PHN, equivalent to a rate of 1,047.6 per 100,000 population. Almost one quarter (24%) of mental health-related admissions in this period were due to mood affective disorders (PHIDU 2022c).

Compared to the national rate, rates of hospitalisation are significantly higher in the LGAs of Adelaide (55% higher), Playford (36% higher) and Marion (33%) (PHIDU 2022c).

## Mortality

Between 2016 to 2020, 707 people who resided in the Adelaide PHN region died from suicide and self-inflicted injuries. The regions with the highest rates of deaths from suicide and self-inflicted injuries were not necessarily those with the highest prevalence of mental health conditions. Holdfast Bay, Adelaide, Playford, Salisbury and Norwood Payneham St Peters were the LGAs with the highest mortality rates from suicide and self-inflicted injury, and were between 45-57% above the national rate (PHIDU 2022c). Premature mortality from suicide and self-inflicted injuries in this time period equated to 22,827 potential years of life lost (PHIDU 2022c).

## Diabetes Mellitus

As with mental health conditions, the overall average burden of diabetes in the region is consistent with national averages, however, there is significant variation in disease burden across the region in terms of prevalence, hospitalisations and premature mortality.

## Prevalence

In 2017-18, 63,741 people (5.1 per 100 population) aged 18 years and over in Adelaide PHN region had diabetes, consistent with the Australian Greater Capital City Areas average of 4.4 per 100 population. Rates varied across the region, ranged from 3.2 per 100 in the LGAs of Burnside and Holdfast Bay to 8.1 per 100 people in Playford LGA. The five PHAs with the highest rates in Adelaide region were Elizabeth/ Smithfield - Elizabeth North (8.8), Davoren Park (8.5), Enfield - Blair Athol (8.1), Elizabeth East (7.8), and Salisbury/ Salisbury North (7.8) (PHIDU 2022c).

Within the 2020-21 GP data, the percentage of the population with Type II, Type I or undefined diabetes was 5.9% (APHN 2022a).

## Hospital admissions

There were 2,753 potentially preventable hospitalisations due to diabetes complications in 2018-19, equivalent to a rate of 211.2 per 100,000 population, consistent with the national average (a rate of 208.9 per 100,000). Significant and substantial variation in diabetes hospitalisation rates was evident at the LGA-level across the region, ranging from 55% below to 73% above the national rate. Rates in the LGAs of Playford (73% higher), Salisbury (33% higher), Onkaparinga (21%) and Port Adelaide Enfield (21%) were significantly above national rates (PHIDU 2022c).

## Mortality

Between 2016-2020, 355 people who resided in the Adelaide PHN region died from diabetes. The regional variation in mortality rates was consistent with the regions highest rates of hospitalisations: Playford, Salisbury and Port Adelaide Enfield were the LGAs with the highest rates, between 69-87% above the national rate (PHIDU 2022c). Premature mortality from diabetes in this time period equated to 4,146 potential years of life lost (PHIDU 2022c).

Diabetes was the 7th ranked leading cause death in 2016-2020 in the Adelaide PHN region, contributing to 3% of all-cause mortality and 1,374 deaths (AIHW 2022c).

### **Cardiovascular conditions**

The burden of cardiovascular conditions - heart, stroke and vascular conditions - within the Adelaide PHN is consistent with national averages. However, there is significant and substantial variation across the Adelaide PHN with respect to prevalence, ED presentations, hospital admissions, and mortality.

#### **Prevalence**

In 2017-18, 59,620 people (4.7 per 100 population) in Adelaide PHN region had a cardiovascular disease, the same as the Australian Greater Capital City Areas average rate. Prevalence rates varied marginally across the region, ranging from 3.4 per 100 in the LGA of Walkerville to 5.7 per 100 people in Playford LGA. The five PHAs with the highest rates in Adelaide region were Davoren Park (6.6), Elizabeth East (5.8), Salisbury/ Salisbury North (5.7), Enfield - Blair Athol (5.7), and Henley Beach (5.7) (PHIDU 2022c).

Within the 2020-21 GP data submitted data to the Adelaide PHN, the percentage of the population that had a cardiovascular related condition were: 13.1% hypertension, 11.1% hyperlipidaemia, 2.7% coronary heart disease, 1.7% atrial fibrillation, 1.15% stroke and 0.6% heart failure. (APHN 2022a). Based on MBS item count data within the GP data submitted in 2020-21 to the Adelaide PHN, only 0.8% of the total population had a recorded heart health check (APHN 2022a).

#### **Emergency department presentations and hospitalisations**

In 2018-19 there were 14,268 emergency department presentations due to circulatory system disease, equivalent to a rate of 1,073.4 per 100,000. This is 20% lower than the national average rate of 1,344.5 per 100,000. Compared to the national rate, rates are higher in the LGAs of Playford (16% higher), and Onkaparinga (7% higher) (PHIDU 2022c).

Similarly, hospital admissions for cardiovascular conditions in Adelaide PHN were lower (by 8%) compared to the national rate in 2018-19, with 28,096 admissions in Adelaide PHN region, equivalent to a rate of 2,095.6 per 100,000 population. One quarter (25%) of circulatory system-related hospital admissions in 2018-19 were due to ischaemic heart disease, 13% due to stroke and 11% due to heart failure (PHIDU 2022c).

Compared to the national rate, the LGA of Prospect was the only LGA with a rate of hospitalisation higher than the national average (14% higher) (PHIDU 2022c).

#### **Potential preventable hospitalisations: chronic angina**

In 2018-19, there were 1,467 potentially preventable hospital admissions in Adelaide PHN due to chronic angina. Equivalent to 109.9 per 100,000 population, the rate for Adelaide PHN is slightly higher than the Australian Greater Capital City Areas average rate of 102.4 per 100,000 population. Significant and substantial variation in admission rates was evident at the PHA level, ranging from 49% below in Fulham/ West Beach to 210% above the national average in Payneham-Felixstow (PHIDU 2022c).

#### **Potential preventable hospitalisations: chronic congestive cardiac failure**

In 2018-19, there were 3,113 potentially preventable hospital admissions in Adelaide PHN due to chronic congestive cardiac failure. Equivalent to 224.9 per 100,000 population, the rate for Adelaide PHN is 12% lower than the Australian Greater Capital City Areas average rate of 190.8 per 100,000 population. Significant and substantial variation in admission rates was evident at the PHA level, ranging from 60% below to 68% about the national rates. The PHAs with the highest rates in the



Adelaide PHN region were Richmond (429.5), Aldinga (383.2), Enfield - Blair Athol (344.8), Dry Creek - South/Port Adelaide/The Parks (302.5) and Beverley/ Hindmarsh-Brompton (301.9) (PHIDU 2022c).

### Mortality

Between 2016 to 2020, 2,380 people in Adelaide PHN region died prematurely from circulatory system diseases, an annual average rate of 39.9 per 100,000 population, marginally higher than the Australian Greater Capital City Areas average of 37.7 per 100,000 population. Ischaemic heart disease was the cause in the majority (51%) of these deaths. The regional variation in premature mortality rates was substantial, ranging from 44% below the national rate in Burnside LGA, to 89% above the national rate in Playford LGA (PHIDU 2022c). Premature mortality from circulatory system diseases in this time period equated to 29,549 potential years of life lost, 49% of which was due to ischaemic heart disease (PHIDU 2022c).

Coronary heart disease and cerebrovascular disease were respectively the 2<sup>nd</sup> and 3<sup>rd</sup> ranked leading cause death in 2016-2020 in the Adelaide PHN region, contributing to 17% of all-cause mortality and 7,923 deaths (AIHW 2022c).

### Respiratory conditions

Chronic respiratory system diseases are those that affect the respiratory tract and include asthma, lung diseases, and breathing disorders. While rates of ED presentation were lower in the Adelaide PHN, hospital admissions, premature mortality and years of life lost are greater in the Adelaide PHN than the Australian Greater City Areas average.

### Prevalence

Within the 2020-21 GP data submitted to the Adelaide PHN, (in the PATCAT disease prevalence grouping) the percentage of the population that had a respiratory related condition were 11.1% (8.4% asthma and 2.7% COPD) (APHN 2022a).

#### Asthma

In 2017-18, 145,184 people (12.2 per 100 population) in Adelaide PHN region had asthma, marginally higher than the Australian Greater Capital City Areas average rate of 10.3 per 100. Prevalence rates varied substantially across the region, ranging from 8.1 per 100 in the LGA of Burnside to 15.7 per 100 people in Playford LGA (PHIDU 2022c).

#### Chronic obstructive pulmonary disease

In 2017-18, 28,854 people (2.3 per 100 population) in Adelaide PHN region had chronic obstructive pulmonary disease, consistent with the Australian Greater Capital City Areas average rate. Prevalence rates varied marginally across the region, ranging from 1.2 per 100 in the LGA of Burnside to 3.0 per 100 people in Playford LGA (PHIDU 2022c).

### Emergency department presentations and hospitalisations

In 2018-19 there were 29,973 emergency department presentations due to respiratory system disease, equivalent to a rate of 2,416.5 per 100,000. This is 10% higher than the Australian Greater Capital City Areas average rate of 2,166.3 per 100,000 population. Substantial variation in rates was evident at the LGA-level, being 55% lower in Burnside compared to the national rate, and 32% higher in Onkaparinga and 25% higher in Playford (PHIDU 2022c).

Similarly, hospital admissions for respiratory system conditions in Adelaide PHN were 10% higher compared to the Australian Greater Capital City Areas average rate in 2018-19, with 25,154 admissions in Adelaide PHN region, equivalent to a rate of 1,960.9 per 100,000 population. Fifteen percent of respiratory system-related hospital admissions in 2018-19 were due to chronic obstructive pulmonary disease, and 8% due to asthma (PHIDU 2022c).



The rate of hospitalisation in the LGA of Playford was 46% higher than the national average rate (PHIDU 2022c).

#### *Potential preventable hospitalisations: chronic asthma*

In 2018-19, there were 1,426 potentially preventable hospital admissions in the Adelaide PHN region for chronic asthma. Equivalent to 115.4 per 100,000 population, the rate for Adelaide PHN was consistent with the Australian Greater Capital City Areas average rate. Significant and substantial variation in admission rates was evident at the LGA level, ranging from 44% below in Burnside to 61% above the national average in Playford (PHIDU 2022c).

#### *Potential preventable hospitalisations: chronic obstructive pulmonary disease*

In 2018-19, there were 3,669 potentially preventable hospital admissions for chronic obstructive pulmonary disease in Adelaide PHN. Equivalent to 270.8 per 100,000 population, the rate for Adelaide PHN is 11% higher than the Australian Greater Capital City Areas average rate of 240.8 per 100,000 population. Significant and substantial variation in admission rates was evident at the LGA level, ranging from 63% below to 103% above the national rates. The LGAs with the highest rates per 100,000 population in the Adelaide PHN region were Playford (574.3), Salisbury (369.4), Onkaparinga (361.7) and Port Adelaide Enfield (341.1) (PHIDU 2022c).

### **Mortality**

Between 2016 to 2020, 941 people in Adelaide PHN region died prematurely from respiratory system diseases, an annual average rate of 15.7 per 100,000 population, marginally higher than the Australian Greater Capital City Areas average of 13.5 per 100,000 population. Chronic obstructive pulmonary disease was the cause in the majority (53%) of these deaths. Premature mortality from circulatory system diseases in this time period equated to 9,734 potential years of life lost, 45% of which was due to chronic obstructive pulmonary disease (PHIDU 2022c). The regional variation in premature mortality rates was significant and substantial, ranging from 39% below the national rate in Burnside LGA, to 155% above the national rate in Playford LGA (PHIDU 2022c). Significantly higher premature mortality rates were evident in the LGAs of Port Adelaide Enfield (90% higher), Prospect (81%), and Salisbury (68%) (PHIDU 2022c).

Chronic obstructive pulmonary disease was the 5<sup>th</sup> ranked leading cause death in 2016-2020 in the Adelaide PHN region, contributing to 4% of all-cause mortality and 1,969 deaths (AIHW 2022c).

### **Musculoskeletal system and connective tissue conditions**

Musculoskeletal conditions are those that affect the bones, muscles and connective tissues and common conditions include long-term (chronic) conditions such as osteoarthritis, rheumatoid arthritis, juvenile arthritis, back problems, gout, and osteoporosis or osteopenia (low bone density) (AIHW 2022d). It is estimated that chronic musculoskeletal conditions affect approximately 3 in 10 Australians (AIHW 2022d).

Within the Adelaide PHN, rates of ED presentation for musculoskeletal and connective tissue conditions are higher than the national average, however rates of hospitalisation are lower. There are regional variations with the Adelaide PHN for arthritis and osteoporosis prevalence.

### **Prevalence**

Within the GP practice data submitted to the Adelaide PHN, the percentage of patients with musculoskeletal conditions in 2020-21 was 14.9% (osteoarthritis 6.4%; osteoporosis 3.8%; other musculoskeletal 2.3% and inflammatory arthritis 1.6%) (APHN 2022a).

#### *Arthritis*

Modelled estimates indicated that 192,747 people (15.3 per 100) in Adelaide PHN region had arthritis in 2017-18. This is marginally higher than the Australian Greater Capital City Areas average of 14.2 per 100 population (PHIDU 2022c). Prevalence rates varied across the region, ranging from 26%

lower than the national rate in the LGA of Walkerville (11.1 per 100) to 26% higher in Playford LGA (18.9 per 100) (PHIDU 2022c).

### *Osteoporosis*

In 2017-18, 50,510 people (4.0 per 100 population) in Adelaide PHN region had osteoporosis, consistent with the Australian Greater Capital City Areas average rate. Prevalence rates varied marginally across the region, ranging from 3.2 per 100 in the LGA of Walkerville to 4.3 per 100 people in the LGAs of Burnside, Port Adelaide Enfield and Prospect (PHIDU 2022c).

### *Emergency department presentations and hospitalisations*

In 2018-19 there were 18,293 emergency department presentations due to musculoskeletal system and connective tissue diseases, equivalent to a rate of 1,447.9 per 100,000. This is marginally higher than the Australian Greater Capital City Areas average rate of 1,391.8 per 100,000 population. Substantial and significant variation in rates was evident at the LGA-level, being 66% lower in Burnside compared to the national rate, and 41% higher in Onkaparinga (PHIDU 2022c).

The hospital admission rate for musculoskeletal system and connective tissue diseases in Adelaide PHN was consistent with the Australian Greater Capital City Areas average rate in 2018-19, with 42,281 admissions in Adelaide PHN region, equivalent to a rate of 3,229.0 per 100,000 population (PHIDU 2022c). Rates of hospitalisations varied across the PHN region, from 19% lower than the national average in Port Adelaide Enfield to 46% higher than the national average rate in Holdfast Bay (PHIDU 2022c).

### *Chronic kidney disease*

Chronic kidney disease (CKD) refers to abnormalities of kidney structure or function, that are present for three months or more. It may be caused by several conditions – such as diabetes, high blood pressure or congenital conditions. CKD is largely preventable as a number of its key risk factors are modifiable. Nationally, the number of people with CKD in Australia is increasing, and prevalence rates are likely vastly underestimated (AIHW 2022e). There is limited, recent PHN-level data available for chronic kidney disease (CKD), however available data is presented below.

### *Prevalence*

In 2011-12 modelled estimates for Adelaide PHN indicated a chronic kidney disease prevalence rate of 7.7 per 100 people, lower than the Australia rate of 10.0 per 100 (AIHW 2017a). Estimates suggest that the prevalence of chronic kidney disease increases with age, affecting 4.1% of people aged 18-54 years, 9.6% of people aged 55-74 years and 34.6% of people aged 75 years and over (AIHW 2021b)

Within the GP data submitted to the Adelaide PHN (2020-21), the percentage of the population with chronic kidney disease was 1.1% (APHN 2022a).

### *Hospital admissions*

The hospital admission rate for chronic kidney disease in Adelaide PHN was 15% lower than the Australian Greater Capital City Areas average rate in 2018-19, with 2,201 admissions equivalent to a rate of 156.9 per 100,000 population (PHIDU 2022c). Rates of hospitalisations varied across the PHN region, but at the LGA-level were all lower compared to the national rate. Rates were lowest in Unley (75.9 per 100,000 population) and highest in Salisbury (205.8 per 100,000 (PHIDU 2022c). Rates of hospitalisation (total admissions; all hospitals) for renal dialysis, in 2019-20 within the Adelaide PHN were 2% greater than national rates. Rates varied between LGA regions of the PHN and ranged from 11% below the national rate in Adelaide, to 18% above the national rate in Holdfast Bay. The LGA's with the highest ASR per 100,000 were Holdfast Bay (41,815), Prospect (38,853), Playford (33,146), Marion (38,190) and Unley (36,933) (PHIDU 2022c).

In 2017-18 in the Adelaide PHN region, there were 16,629 hospitalisations with chronic kidney disease as the principal and/or an additional diagnosis, equivalent to a rate of 1,041.1 per 100,000 population, lower than the rate for Australia (AIHW 2021b).

### **Mortality**

In the five years between 2013-2017, on average each year in the Adelaide PHN region there were 986 deaths from chronic kidney disease as the underlying and/or an associated cause, equivalent to 54.2 deaths per 100,000 population, which was consistent with the rate for Australia (AIHW 2021b).

Kidney disease was the 17<sup>th</sup> ranked leading cause death in 2016-2020 in the Adelaide PHN region, contributing to 1.3% of all-cause mortality and 609 deaths (AIHW 2022c).

### **Comorbidities**

Comorbidities are a growing challenge for health professionals and patients in managing their long-term chronic conditions in Australia. Chronic conditions often have complex and multiple causes, and although not usually immediately life-threatening, they tend to develop gradually, and become more common with age (AIHW 2022ak). People with chronic conditions can also be more vulnerable to the effects of certain communicable diseases, including Influenza and COVID-19 (AIHW 2022ak).

The 2021 Census identified that approximately 10% of people in the Adelaide PHN are living with two or more long-term health conditions, 83,431 (6.6%) people with two conditions, and 45,036 (3.5%) people with three or more conditions. The five LGAs with the highest prevalence (crude rates per 100,000 population) of people with two long-term health conditions were Onkaparinga (7,907), Playford (7,680), Holdfast Bay (7,173), Tea Tree Gully (6,807), and Salisbury (6,669) (ABS 2022d).

The LGAs with the highest crude rates per 100,000 population with three or more conditions were Playford (4,855), Onkaparinga (4,262), Salisbury (3,971) and Port Adelaide Enfield (3,616) and Marion (3,539) (ABS 2022d).

Half (51%) of all people living in the region with multiple long-term health conditions were aged between 60-79 years old, 10,484 people aged 60-69 years and 12,550 people aged 70-79 years. Furthermore, the likelihood of having multiple long-term health conditions increases with increasing age, with 64% of 50-79 year old's living with two or more conditions compared to 13% of people aged 20-49 year olds (ABS 2022d).

Of the 521,130 people with chronic conditions (at least one of the following: diabetes, respiratory, cardiovascular, renal impairment or mental health) who attended a GP that submitted data to the Adelaide PHN in 2020-21, 60.2% had one comorbidity category, 25.6% had two categories, 10.3% had three categories, 3.2% had four categories and 0.7% had 4+ categories (APHN 2022a).

### **Chronic pain**

Chronic pain has recently been defined as pain that persists or reoccurs for more than three months and has been added to the International Classification of Diseases (Treede et al. 2019). It has been estimated that 1.6 million, or 1 in 5 Australians aged 45 years and over are living with persistent, ongoing pain. In 2018, chronic pain was estimated to cost \$139 billion, primarily attributed to reduced quality of life and productivity losses (AIHW 2020a).

A recent article by De Morgan et al (2022) noted that chronic pain has been identified as a health and/or service need by approximately half of the Primary Health Networks (12 out of 25 PHNs and Western Australia Public Health Alliance (WAPHA); and a priority by 9 out of 25 PHNs and WAPHA) who participated in the telephone interviews/online surveys.

In South Australia, chronic pain data (collected via survey in 2006) estimated chronic pain affects 18% of the overall SA population, with 5% of people experiencing severe pain that interferes with daily activity (Currow et al. 2010). It was stated that 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).

Within the Adelaide PHN, a joint Adelaide PHN and Country SA PHN HealthPathways Consumer survey (N=110) targeting consumers was conducted in 2018 (APHN 2018a).

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

## Cancer

The World Health Organization (WHO) has stated that throughout the world cancer is a leading cause of death and was responsible for 10 million deaths globally in 2020 (WHO 2022a). In Australia, it was estimated that in 2021, approximately 151,000 Australians would be diagnosed with cancer (413 per day) and 49,000 would die (135 per day) (AIHW 2021c). As with the other chronic conditions highlighted in this report, while overall rates are consistent with national rates, there is substantial regional variation in prevalence, incidence, potential years life lost, and mortality.

### Prevalence

According to ABS Census data, there were 38,846 people (3,059.99 per 100,000) with cancer (including remission) in the Adelaide PHN in 2021 (ABS 2022d). This is a higher rate compared to Australia which has the crude rate of 2,879.90 per 100,000 people. The LGA areas within the highest crude rates per 100,000 within the Adelaide PHN were Holdfast Bay (4,364.00), Mitcham (3,601.17), Burnside (3,582.45), Unley (3,563.57) and Walkerville (3,514.89) (ABS 2022d).

Interestingly, these high prevalence rates correlate to areas of high screening participation. These areas may therefore be recording high prevalence rates because people are actively being screened and therefore diagnosed earlier.

### Cancer Incidence

Overall, the Adelaide PHN has a 4% lower incidence rate for all cancers when compared to Australia based on 2010-2014 data. Within the Adelaide PHN, there is geographical variation for all cancers ranging from 5% above the national rate in Playford to 13% below the national rate in Walkerville (PHIDU 2022c).

The LGA regions with the highest incidence of all cancers are Playford, with an age standardised rate (ASR) of 575.5 per 100,000, followed by Marion (544.0), Port Adelaide Enfield (540.6) and Onkaparinga (538.1) (PHIDU 2022c).

Rates of breast cancer in females within the Adelaide PHN are 3% higher than national rates. Again, there is significant variation within regions across the Adelaide PHN. In Salisbury, rates are 8% below the national rate, while Prospect is 38% above. The LGAs with the highest ASR per 100,000 are Prospect (188.4), Adelaide (160.6), Burnside (152.3) and Campbelltown and Onkaparinga (147.0) (PHIDU 2022c).

Colorectal cancer incidence within the Adelaide PHN is 2% below national rates. Variation within the Adelaide PHN ranges from Walkerville (31% lower than the national rate) to Port Adelaide Enfield (8% higher). The LGAs with the highest ASR per 100,000 are Port Adelaide Enfield (71.4), Prospect (71.3), Playford (70.4), Marion (69.6) with Tea Tree Gully and Salisbury both at 68.9. (PHIDU 2022c). Incidence rates of cervical cancer within the Adelaide PHN are consistent with National rates (AIHW 2019a).

### Potential years of life lost from cancer

Between 2016 and 2020, there were 73,758.0 (12.6 per 1,000) potential years of life lost due to cancer in the Adelaide PHN. This was 6% higher than the national rate, with significant variation between regions of the Adelaide PHN ranging from 6% below the national rate in Burnside to 100%

or double the national rate in Playford. The LGAs with the highest average annual ASR per 1,000 were Playford (23.8), Port Adelaide- Enfield (18.4), Salisbury (18.3), West Torrens (17.1) and Walkerville (16.9) (PHIDU 2022c).

### Cancer Mortality

When compared to national standardised death rate (SDR), the premature mortality due to cancer (aged 0 to 74 years) was 2% higher in the Adelaide PHN from 2016 to 2020. The variation between LGAs within the PHN were substantial with Burnside 6% below the national rate and Playford 94% above (PHIDU 2022c).

The areas within the Adelaide PHN with the highest average annual ASR of death from cancer were Playford 188.3 (94% above national rate), Port Adelaide – Enfield 147.7 (52% above national rate), Salisbury 142.1 (46% above national rate), Onkaparinga 131.8 (36% above national rate) and Charles Sturt 126.7 (36% above national rate) (PHIDU 2022c).

Of note, while Playford had the highest mortality rates within the Adelaide PHN for cancer, it also had the lowest screening rates for all three of the national screening programs – Breast, Bowel and Cervical. This may suggest a correlation between lack of screening and higher rates of mortality, further highlighting the importance of early intervention and prevention.

### 3.4.3 Barriers to chronic and long-term conditions management

Participants in the Population Health Needs Assessment Consultation (PHNAC) (APHN 2022b) were asked to identify barriers and challenges in supporting management of chronic conditions. The overarching themes identified were low health literacy, a lack of system coordination, limited access to GPs for patients, and a lack of system support for GP's. Specific examples of barriers included:

- That health issues are compounded with language/health literacy
- The lack of understanding of the health system and how it works in Australia
- The long waiting lists for specialists
- The inability to access GPs and long waits for GPs
- The lack of communication between patients and hospitals that leads to missed appointments
- The lack of coordination between services -patients with chronic conditions are being treated in silos of care
- Practitioner burnout

### 3.4.4 New and Emerging Areas of Interest

#### Oral Health

The World Health Organization (WHO) states “Oral health is a key indicator of overall health, well-being and quality of life” (WHO 2022b). Within the Adelaide PHN, rates of potentially preventable admissions for dental conditions are 57% higher than the national average rate. In 2018-19, there were 5,495 hospitalisations from potentially preventable acute dental conditions, equivalent to a rate of 445.2 per 100,000 population. This is a significantly higher rate than the Australian Greater Capital City Areas Average of 270.8 per 100,000 population. Approximately 20% of admissions for dental conditions were to public hospitals. Significant and substantial variation in admission rates were evident by PHA, ranging from 19% below to 135% about the national average rate. The PHAs with the highest rates in the Adelaide PHN region were North Adelaide (674.6), Unley-Parkside (667.3), Glenside - Beaumont/ Toorak Gardens (658.9), Rostrevor - Magill (617.1), and Golden Grove/Greenwith (609.4) (PHIDU 2022c).

Comments made during the Population Health Needs Assessment Consultation (PHNAC), reiterated the importance of oral health and its importance as an indicator of overall health. For example, it was

stated that neglecting oral health is a barrier to chronic disease management and that an enabler to improve health outcomes would be to engage with oral health practitioners (APHN 2022b).

### 3.5 Illness Prevention & Health Protection

As part of prevention, risk assessment and early detection will help slow disease progression, prevent avoidable long-term complications and hospitalisation, provide treatment and referrals at an early stage of disease for better outcomes, and reduce adverse events. This is also in line with shifts in *Australia's Primary Health Care 10 Year Plan 2022-2023* from treatment to promotion and prevention and from an illness system to wellbeing system.

The Adelaide PHN will continue to support preventive activities such as cancer screening. Screening programs provide an opportunity for the early detection and management of a range of cancers in primary care settings. Most notably, breast, bowel and cervical, all of which have well established screening regimes and nationally supported programs. The Adelaide PHN is committed to working alongside primary health care providers to improve cancer screening participation rates and reduce the risk of cancers within targeted population groups.

Health protection involves the prevention and control of threats to health from communicable diseases and the environment (NSW 2022). Health protection for Adelaide PHN is achieved through a range of activities involving multiple people and agencies for immunisation. Immunisation is a simple, safe and effective way of protecting people against harmful diseases and not only protects individuals, but also others in the community, by reducing the spread of preventable diseases<sup>3</sup>.

#### 3.5.1 Cancer screening

##### *Participation in national screening programs*

Screening programs provide an opportunity for the early detection and management of a range of cancers in primary care settings. Most notably, breast, bowel and cervical are part of the national performance indicators for the PHN and all of which have well established screening regimes and nationally supported programs. The Adelaide PHN have run a range of screening programs and will continue to consider how and where the Adelaide community could increase screening rates, especially among targeted populations.

For bowel cancer screening, in the Adelaide PHN region, participation rates are higher for females (51%) than males (46%), and increased with increasing age, however less than half the eligible population is participating in the program. For breast cancer screening: participation rates are highest for women in their 60s, specifically 65-69yos, and lowest for 50-54 year olds. For cervical screening, participation was lowest in the oldest and youngest ages, with one third of eligible 70-74 olds participating and just below 60% of 25-34 year olds participating (AIHW 2022f). Additional details regarding regional variation is provided below.

##### *Bowel cancer screening*

In 2018-19, in comparison to other PHNs, the Adelaide PHN had the 6<sup>th</sup> highest rate – 48.4% of 50–74-year-old participating in the national bowel cancer screening programs (AIHW 2022f). The national rate being 43.5%. The 2018-19 participation rate for Adelaide PHN was consistent with the 2017-18 rate of 47.1% (AIHW 2022f).

Within the GP data submitted to the Adelaide PHN, among those who had a last visit recorded between 1 July 2020 and 30 June 2021, 36% of the eligible population (aged 50-74 years) have had a FOBT recorded in the last 0-2 years (APHN 2022c).

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<sup>3</sup> Australian Government, Department of Health and Aged Care, Immunization



In 2019-20, participation in the bowel cancer program varied across the Adelaide PHN region, with the lowest rates of participation in the SA3's of Playford (39.7%), Port Adelaide-West (43.3%), Salisbury (43.5%), Port Adelaide – East (44.9%), and Adelaide City (44.5%) (AIHW 2022f).

### Breast cancer screening

In 2018-19, the Adelaide PHN had the 6<sup>th</sup> highest rate of participation in the national breast cancer screening program (BreastScreen), at 59.6% of 50-74 year old women, in comparison with the other PHNs. The national rate was 54.8% (AIHW 2022f). The 2018-19 participation rate for Adelaide PHN was consistent with 59.4% in 2017-18 (AIHW 2022f), however participation rates in 2019-20 had declined to 50.9% (AIHW 2022f).

Within the GP data submitted to the Adelaide PHN, among those who had a last visit recorded between 1 July 2020 and 30 June 2021, only 4% of the target population (those between 50-74 years), had a mammogram recorded (APHN 2022c)

The 2019-20 participation rates also varied by Adelaide PHN sub-region. The lowest rates of participation being in the SA3's of Playford (43.0%), Adelaide City (44.6%), Port Adelaide East (46.4%), Salisbury (46.6%), and Port Adelaide-West (48.0%) (AIHW 2022f)

### Cervical cancer screening

In 2018-19, the Adelaide PHN had the highest rate of participation in the National Cervical Screening Program, at 51.0% of 25-74 year olds, the national rate was 46.3% (AIHW 2022f)

Within the GP data submitted to the Adelaide PHN, among those who had a last visit recorded between 1 July 2020 and 30 June 2021 within the Adelaide PHN GP data, 44% of the eligible population (aged 25-74 years) had a cervical screening result recorded (APHN 2022c).

Participation in the national program increased with age, ranging from 59.4% of 25-29 year olds to 60.4% of 65-69 year olds, then declining to 33.5% when 70-74 years of age (AIHW 2022f)

The 2018-2020 participation rates also varied by Adelaide PHN sub-regions. The lowest rates of participation in the SA3s of Playford (47.2%), Adelaide City (53.1%), Port Adelaide- West (56.5%), Port Adelaide-East (57.4%), and West Torrens (58.1%) (AIHW 2022f).

Participation rates in the three national screening programs; residents of the northern, western and city areas of the Adelaide PHN having much lower participation rates compared to both the Adelaide PHN and national rates. There appears to be a correlation between areas of low cancer screening participation and socio-economic status with three of these regions, Playford, Salisbury and Port Adelaide, having the lowest Index of Relative Socio-Economic Disadvantage (IRSD) scores in the Adelaide PHN region.

### Barriers to Screening

Kitchen Table Community Conversations, highlighted barriers to access for health screening being experienced by community members (HCQ 2022). These included:

- Lack of time and GP clinic hours
- Uncertainty around the costs of tests or the provider fee gap
- Community members not understanding the reasons for screening or evidence of necessity of screening

The Population Health Needs Assessment Consultation provided similar examples of barriers to screening (APHN 2022b). Overarching themes identified included the pressure that is being placed on the existing workforce, the lack of a wholistic approach to care and lack of appropriate education about the benefits of screening and the costs and access to screening services. Examples of comments received include:

- Overworked health professionals
- Lack of understanding of screening benefit
- Fear/misinformation in the community
- Cost and access to screening services
- Oversaturation of screening available – overwhelming for patients and clinicians

### 3.5.2 Immunisation

A broad range of immunisation providers, including GP's, nurses in General Practice, Council Immunisation Program nurses and Pharmacists, have the responsibility to offer vaccination against many vaccine-preventable diseases to the community. The Immunisation program within the Adelaide PHN ensures oversight of immunisation provider efforts and provides them with the necessary support to administer timely and opportunistic vaccination against a range of vaccine preventable diseases which will help achieve a reduction in potentially preventable hospital admissions for vaccine-preventable conditions.

Certain chronic medical conditions, such as Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Asthma increase the risk of complications of certain vaccine preventable diseases, especially zoster, pneumonia and influenza (Patel et al. 2022). Many of the regions where potentially preventable hospital admissions for vaccine-preventable conditions exist, there are also high rates of potentially preventable hospital admissions for these chronic medical conditions (DHW 2020).

Data lacks for many adult vaccination rates, however reports are produced to measure zoster vaccine uptake and influenza vaccine uptake in adults. The National Centre for Immunisation Research and Surveillance (NCIRS) *Annual Immunisation Coverage Report 2020 Summary* demonstrated zoster vaccine uptake is well below optimum with 31.3% of eligible 70-year-old individuals having received the vaccine. Influenza vaccine uptake for adults increased in 2020, reaching over 60% in those aged ≥65 years (over 75% in Indigenous adults), however, national influenza vaccination rates in young children under 5 years of age were again sub-optimal reaching 45.2% vaccine coverage despite the vaccine being funded on the National Immunisation Program (NIP). Influenza vaccine is funded for individuals aged 5- to 65-years with specific medical conditions only. Since much of this age group do not meet these criteria, the vaccine is self-funded, likely contributing to low uptake of between 22.7% and 35.8% (Hull et al. 2021).

A concerted effort should be made by PHN immunisation programs to provide additional support to immunisation providers to increase coverage in these age groups to reduce potentially preventable hospital admissions for vaccine preventable diseases.

The immunisation data presented in this section is based on the National Immunisation Program schedule for all people – specifically those immunisations covered under the program for childhood, adolescent and adult vaccination (Hull et al. 2021). In addition, information is provided on Influenza and COVID-19. National rates are reported, with South Australian and SA3 reported if available.

#### ***Participation in national immunisation programs***

The national immunisation program schedule is a series of immunisations given at specific times throughout a person's life. The immunisations range from birth through adulthood. All vaccines that are included in the national immunisation program are provided free by the federal government (Hull et al. 2021). Where possible, Adelaide PHN rates are reported below and compared to national or South Australian rates.

#### **Children**

Note: Data for Aboriginal and Torres Strait Islander children is reported in the Aboriginal Health section.



### *Childhood immunisation*

Annualised immunisation coverage data from the Australian Immunisation Register at September 2022, states that within the Adelaide PHN, 94.8% of all children aged 12<15 months, 93.0% of those aged 24<27 months and 95.8% of those 60<63 months are fully immunised (DOHAC 2022d).

While rates are high, there is variation between areas of the Adelaide PHN. For example, as at 30 September 2022, annualised immunisation coverage data states that 96.2% of children aged 12<15 months in the Burnside SA3 are fully immunised, compared to 93.3% in Adelaide City (DOHAC 2022c). Amongst those aged 24<27 months, 90.2% of those in the Prospect-Walkerville SA3 were fully immunised, compared to 95.6% in Marion. In the Unley SA3 area, 97.9% of children aged 60<63 months were fully immunised, compared to 86.9% in Adelaide City (DOHAC 2022c).

### *Influenza*

Nationally, the recorded coverage of seasonal influenza children aged 6 months to <5 years was 41.0% in 2019 and 45.2% in 2020. South Australia had higher than national coverage at 49.0% in 2019 and 49.5% in 2020 (Hull et al. 2021).

### *Adolescent immunisation*

Data for adolescent immunisation coverage is available only at the national and state level (Hull et al. 2021). Coverage data is reported below.

#### *HPV coverage*

In 2020, 80.5% of Australian girls had completed a full course of HPV vaccine by 15 years of age, marginally up from 79.8% in 2019. The course completion rate in South Australia in 2020 was 78.2%, up from 77.4 in 2019 (Hull et al. 2021).

#### *Diphtheria-tetanus-acellular pertussis (dTpa) booster vaccine coverage*

Nationally, coverage of the adolescent booster dose (by 15 years of age) of dTpa coverage was 1.7 percentage higher in 2020 than 2019 (86.8% versus 85.1%). Coverage in South Australia in 2019 was 85.7%, and increased to 88.5% in 2020 (Hull et al. 2021)

#### *Meningococcal ACWY vaccine coverage*

Coverage of meningococcal ACWY vaccine nationally in adolescents by 17 years of age, in 2020 was 74.3%. In South Australia, coverage was lower than other states at 58.1% (Hull et al. 2021)

### *Influenza*

Recorded influenza vaccine coverage nationally in adolescents aged 10 to <15 years and 15 to <20 years increased by 6.5 and 7.1 percentage points between 2019 and 2020, to 25.3% and 22.7% respectively (Hull et al. 2021).

### *Adult immunisation*

#### *Zoster vaccine coverage*

Nationally, recorded zoster vaccine coverage for adults aged 70 to <71 years was 30.5% in 2019 and 30.4% in 2020. South Australian coverage was 30.9% in 2019 and 31.3% in 2020 (Hull et al. 2021).

### *Influenza*

Influenza vaccine coverage nationally in adults aged 20 to <50 years and 50 to <65 years were 23.4% and 35.8% in 2020 an increase of 8.2 and 10.8 percentage points respectively from 2019. (Hull et al. 2021).

## COVID-19 vaccination coverage

As at the end of September 2022, over 94% of Adelaide PHN residents 16 years and over had received at least 2 doses of a COVID-19 vaccine, and 76% had received 3 doses, which is in line with the national coverage rates for 2- and 3-doses (DOHAC 2021).

At SA3 level there was substantial variation in 3-dose coverage rates across the PHN, with a 17-percentage point gap in coverage between people living in the highest (84%) and lowest (66%) socioeconomically disadvantaged areas as measured by the Socio-Economic Indexes for Areas (SEIFA). Specifically, Playford (66%), Salisbury (70%), Port Adelaide-East (72%) had the lowest coverage rates, while Burnside (84%), Unley (84%) and Mitcham (83%) had the highest coverage rates (DOHAC 2021).

A similar pattern of variation was evident for coverage rates of children aged 5-11 years, with lowest rates in Playford (30%), Onkaparinga (41%), and Salisbury (38%), and highest in Adelaide (80%), Burnside (64%) and Walkerville (63%). This however could be an effect of population size as Playford, Onkaparinga and Salisbury had the largest populations of 5-11 year olds, between 11,000 to 15,000, while Adelaide and Walkerville the smallest, approximately 600 children each (DOHAC 2022b).

Analysis of data from the AIR-MADIP project (2022) highlighted substantial variation in COVID-19 vaccination coverage both geographically and in culturally and linguistically diverse communities.

## Emerging vaccine-preventable conditions

There are a number of health issues that have been highlighted in the past year that the Adelaide PHN will continue to monitor in regard to the potential implications for Adelaide PHN populations. Examples include:

### Monkey Pox

Monkey Pox had not been identified in Australia before May 2022 and was declared a communicable disease incident of national significance on 26 July 2022 (DoHAC 2022a). The Monkey Pox virus is part of the same family of viruses as variola virus which causes smallpox, and while it is a rare viral illness that for most people symptoms will clear in 2 to 4 weeks, it can become serious and those who are immunocompromised are believed to be at higher risk of disease (DoHAC 2022a).

### Japanese Encephalitis

Japanese encephalitis virus was declared a communicable disease incident of national disease significance (DOHAC 2022e). Within the Kitchen Table discussion, the importance of up-to-date information about emerging disease was highlighted. A participant spoke about a community member who caught Japanese encephalitis virus and realised after that if they had known they would have taken preventative measures earlier (HCQ 2022).

## Barriers to vaccination

As with the feedback received for screening, Kitchen Table Community Conversations, highlighted some of the barriers to vaccination experienced in the community (HCQ 2022). An example is: *“The vaccination process is confusing, especially when you come from another country. Often the programs do not align with each other, and some children miss vaccinations if they are young like it happens between New Zealand and Australia.”*

Barriers identified include:

- Cost can be a factor and especially for those without access to Medicare
- Lack of information on the purpose of vaccination is a barrier
- Partners not informing their other half as a way of controlling them

Participants in the Population Health Needs Assessment Consultation identified barriers to vaccination, and these were similar to barriers to screening (APHN 2022b). Examples included:

- Fear/misinformation about vaccination
- Lack of trust of vaccine benefits
- Uncertainty around the costs
- Difficulties in accessing a GP
- The politicised nature of the vaccine program
- Vaccine hesitancy and misinformation
- Future cost barriers (free COVID-19 vaccinations likely to be repealed)

These barriers are consistent with the themes identified in research undertaken in Victoria with Culturally and Linguistically Diverse (CALD) communities, parents of children with disabilities, and Aboriginal communities on concerns about and barriers to uptake of COVID-19 vaccination. Similarly, access barriers; perceptions of risk, safety, effectiveness and need; and challenges regarding communication or interpretation of recommendations and schedule changes were identified as the main barriers to COVID-19 vaccination (COSSI & NCIRS 2022).

### ***Hospitalisations due to vaccine preventable conditions***

In 2018-19, there were 4,193 potentially preventable hospital admissions for vaccine-preventable conditions in Adelaide PHN. Equivalent to 325.0 per 100,000 population, the rate for Adelaide PHN is 27% higher than the Australian rate of 256.5 per 100,000 population. Significant and substantial variation in admission rates was evident at the PHA level, ranging from 26% below to 476% above the national rate. The PHAs with the highest rates per 100,000 population in the Adelaide PHN region were Elizabeth/Smithfield - Elizabeth North (1,476.9.0), Dry Creek - South/ Port Adelaide/ The Parks (540.0), Salisbury/ Salisbury North (473.5), Parafield/Parafield Gardens/Paralowie (452.3) and Beverley/Hindmarsh- Brompton (444.6) (PHIDU 2022a).

### **3.5.3 Sexual Health and Blood Borne Viruses**

In South Australia, it has been noted that sex workers, men who have sex with men, transgender people, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people and young people are at greater risk of sexually transmitted infections (SA Health 2019a). In 2019, there were 9,516 new notifications of Sexually Transmitted Infections (STI) and Blood Borne Viruses (BBV) in SA an 11% increase in the number of new notifications compared to notifications received in 2018 (Shukla et al 2021). Chlamydia trachomatis (chlamydia) is the most commonly notified STI in SA, with 6,430 notifications in 2019 (Shukla et al 2021). In 2019, the notification rate of gonorrhoea increased from 74 per 100,000 population in 2018 to 119 per 100,000 population in 2019, while the notification rate of infectious syphilis in 2019 was 9.14 per 100,000 population, a decrease from 11.7 per 100,000 population in 2018 (Shukla et al 2021). There were 50 new diagnoses of human immunodeficiency virus (HIV) infection in 2019, or 2.84 per 100,000 population, similar to that in each of the previous four years (Shukla et al 2021).

Analysis of Adelaide PHN GP data, indicates there were a total of 4,420 patients (0.3% of population) with a last visit recorded during 2020-21 with a coded diagnosis for Chlamydia (3,358), Gonorrhoea (554) or Syphilis (364) (APHN 2022c).

#### **Chlamydia**

Of the 6,430 chlamydia notifications in 2019, most were in people aged 15 to 29 years (4,803/6,430; 75%), with GPs located in metropolitan Adelaide the most frequent notifiers (30%; 1,934), followed by the specialist sexual health service Adelaide Sexual Health Centre (ASHC) (15%; 957) and country GPs (6%; 379) (Shukla et al 2021). The top three countries of birth of cases were 56% born in

Oceania and Antarctica, 2% born in sub-Saharan Africa, and 2% born in south-east Asia (Shukla et al 2021).

## Gonorrhoea

In 2019 there were 2,094 gonorrhoea notifications and the highest age specific notification rates of gonorrhoea were in the 25-29 years old age group for males (487 per 100 000 population) and 20-24 years old age group in females (291 per 100 000 population), again metropolitan GPs were the most common notification source (772/2 094; 37%), followed by the specialist sexual health service ASHC (572/2094; 27%) (Shukla et al 2021). The majority of notifications were born in Oceania and Antarctica (80%) followed by 3.4% born in south-east Asia and 2.3% in sub-Saharan Africa (Shukla et al 2021).

## Syphilis

### *Infectious syphilis*

The median age of all cases of infectious syphilis in 2019 was 34 years (range 19 to 72 years), an increase compared to 2018 with a median of 32 years. Specialist sexual health services were most likely to notify cases (ASHC 37%, O'Brien Street Practice 6%, SHINE SA 1%) in 2019, along with metropolitan GPs (26%) (Shukla et al 2021). The majority of cases notified in 2019 were born in the Oceania and Antarctica major region (128/161; 80%); 126 cases from this region were born in Australia. A low number of cases were born in other geographical regions (Shukla et al 2021).

### *Syphilis (unspecified)*

There were 148 notifications of non-infectious syphilis (greater than two years' duration or unspecified) in SA in 2019. The majority of cases notified in 2019 were born in the Oceania and Antarctica major region (98/148; 66%), with 96 born in Australia, followed by South-East Asia (6%) (Shukla et al 2021).

## Human immunodeficiency virus (HIV)

In 2019, the median age of HIV cases was 33 years (range 9 to 81 years), lower than 2018, with a median age of 37 years (range 19 to 74 years). Adelaide sexual health clinic (13/50; 26%) notified the highest proportion of HIV cases in 2019 followed by metropolitan GPs (12/50; 24%) (Shukla et al 2021). The most common region of birth for cases notified in 2019 was the Oceania and Antarctica major region (19/50; 38%), with all 19 cases born in Australia. Sub-Saharan Africa (11/50; 22%), and North Africa and the Middle East (10/50; 20%) were the next most common regions of birth (Shukla et al 2021).

## Hepatitis B

In 2020 in Adelaide PHN region, an estimated 0.74% of the population, 9,396 people were living with chronic hepatitis B, below the national average rate of 0.86%. Of those, approximately 67% had been diagnosed, 18% people received care (either treatment or monitoring) and 9.9% received antiviral treatment, the latter two below the targets in the *National Hepatitis B Strategy 2018-2022* (MacLachlan et al. 2020). Within the PHN treatment uptake was highest in the Charles Sturt (16%), Port Adelaide – West (13%), Salisbury (13%), Burnside (13%), and Marion (12%) SA3s. Despite this, in a number of these higher-uptake SA3s, treatment initiations declined during 2020, in contrast to previous increasing trends.

In 2020, the majority of people living with chronic hepatitis B were born overseas (70%), 27% were Australian-born (non-Aboriginal and/or Torres Strait Islander) and 3% were Aboriginal and/or Torres Strait Islander (MacLachlan et al. 2020).

### *Hepatitis B – newly acquired*

Data from 2019 indicated there were five notifications of newly acquired Hepatitis B in SA, with a notification rate of 0.28 per 100,000 compared to 0.23 per 100,000 in 2018. (Shukla et al 2021).

All the five cases in 2019 were males and the median age of cases in 2019 was 43 years (range 26 to 63 years). Two cases in 2019 were born in Australia, in the Oceania and Antarctica major region, one in North-West Europe, and one in the South-East Asia region (Shukla et al 2021).

#### *Hepatitis B – unspecified*

In 2019, there were 281 notifications of hepatitis B (HBV) infections of unspecified duration in SA, compared to 278 in 2018 and 47% were reported in females, 53% reported in males (Shukla et al 2021). The most frequently reported major region for the country of birth of cases notified in 2019 were North East Asia (85/281; 30%) followed by South East Asia (81/281; 29%), with 34 (12%) cases born in the major region Oceania and Antarctica and 20 cases were born in Australia. (Shukla et al 2021).

#### Hepatitis C

In 2016 in Adelaide PHN region, an estimated 0.50% of the population, 6,197 people were living with chronic hepatitis C, below the national average rate of 0.76%. Treatment uptake in Adelaide PHN was 60.0% by the end of 2020, the third highest of all PHNs in Australia. Uptake was above or similar to the national average of 47.0% in all of Adelaide's SA3s, with the exception of Prospect – Walkerville (38%) and Mitcham (39%). Uptake reached or approached the National Strategy target of 65% uptake in Tea Tree Gully (>85%), Marion (>85%), Norwood – Payneham – St Peters (75.0%), Charles Sturt (75%), Onkaparinga (65%), and Campbelltown (64%) (MacLachlan et al. 2020) .

#### *Hepatitis C – newly acquired*

There were 28 notifications of newly acquired hepatitis C (HCV) infections in SA, with a corresponding notification rate of 1.6 per 100,000 population. In 2019, there was one case diagnosed in a 6-month-old child, attributed to perinatal transmission as the child's parents were HCV positive and the child was born in a refugee camp overseas (where the mother did not receive prenatal care) (Shukla et al 2021). As with previous years, the majority of cases (25/28; 89%) were born in the major region of Oceania and Antarctica, all of whom were born in Australia (Shukla et al 2021).

#### *Hepatitis C (unspecified)*

In SA in 2019, there were 313 notifications of hepatitis C (HCV) infections of unspecified duration and the majority of cases (211/313; 67%) were born in the major region of Oceania and Antarctica, including 208 that were Australian born (Shukla et al 2021).

### 3.6 Equitable Access to primary health care

The Adelaide PHN is focused on supporting people living in Adelaide PHN region to access affordable, appropriate and high-quality health care irrespective of background or personal circumstance.

Australia's health system is hard to navigate, particularly for parents with young children, people with complex chronic conditions, people from culturally and linguistically diverse backgrounds (CALD), people identifying as LGBTIQ+, people in socioeconomically disadvantaged circumstances. Poor access has potential to increase reliance on the use of secondary and tertiary care.

Based on the available evidence base of quantitative and qualitative data, we can identify that some populations or communities are consistently demonstrating the poorest health outcomes, experiences, or reduced access to services. Within the Adelaide PHN region, inequitable access to primary health care services is particularly evident for:

- Culturally and Linguistically Diverse (CALD) communities
- Parents and babies
- Children and young people
- LGBTIQ+ communities
- People living with a disability

- Low Socio-Economic-Status communities

### 3.6.1 Primary health care services

Primary health care is the basis of health care within Australia, as it provides the first point of contact with the health system. It includes a broad range of activities and services that are delivered outside the hospital setting, from health promotion and prevention to treatment and management of acute and chronic conditions. It can be provided in the home or in community-based settings such as in general practices, other private practices, community health, local government, and non-government service settings (PWC 2018).

Medicare-subsidised services provided in non-hospital settings enable eligible Australians to use a wide range of general practice, diagnostic, allied health, specialist, and nursing and Aboriginal health worker services at no or partial cost. Since 2019-20, there have been marginal increases in overall rates of Medicare-subsidised services (per 100 people) at the broad service level for GP attendances (a 5% increase), specialist attendances (2%) and allied health attendances (4%), while use of GP After-hours services have declined substantially by 36% (AIHW 2022g).

Data from 2021-22 illustrates that the overall use of non-hospital Medicare-subsidised services, such as GP, allied health and specialist attendances, diagnostic imaging, and GP after hours services, did not vary substantially from the pattern of service access nationally and compared to other metropolitan regions. However, within the Adelaide PHN region attendances and use of services varied depending on a person's age and where a person lived. These differences are highlighted in more detail below (AIHW 2022g).

#### **Snapshot of primary care services**

Adelaide PHN uses multiple data sources to understand the supply and distribution of primary health care services in our region, including our internally managed CRM, *HealthPathways SA* and external sources such as the *National Health Service Directory*. More detail about services in our region is provided in the Health Workforce chapter.

#### **General practice (GP) services**

According to Adelaide PHN CRM in 2021/2022 there were 330 General Practices in the region (APHN 2022d).

#### **GP attendances**

While primary health care occurs in a number of settings, the ongoing relationship between the General Practitioner (GP) and patient ensures that the patient encounter is core to primary health care with the GP providing a continuum of patient care throughout their life course (PWC 2018).

In 2021-22, 9,047,940 services were provided to 1,125,612 people living in the Adelaide PHN region (88% of total population), which is consistent with the national and metropolitan rate (90%). In line with the pattern nationally, older people used GP services more than younger people. In 2021-22, the data suggests that 100% of people aged 65–79 and aged 80 and over living in the region, received an GP service compared to only 81% of 0-14 year old's and 75% of 15-24 year old's (AIHW 2022g).

By SA3, there were moderate variations in rates of service per 100 people across the region, approximately 33% between the lowest and highest rates, and the pattern was associated with socioeconomic status (SES), with regions of lower SES having higher rates of services. The SA3s with the highest rates were Salisbury, Playford, Tea Tree Gully and Onkaparinga (AIHW 2022g).

In the 12 months preceding 2019-20 within the Adelaide PHN region:

- more than 4 in 5 people (84%) had consulted a GP at least once
- four in 5 people (78%) had a preferred GP



- one in 11 (8%) saw a GP for urgent medical care, and
- one in 10 people (11%) saw a GP 12 or more times (ABS 2020b).

### Enhanced Primary Care services

Enhanced primary care services include GP Health Assessments, GP Chronic Disease Management Plans, GP Multidisciplinary Case Conference, Medication Management Reviews, and GP Mental Health.

In 2021-22, a total of 733,462 enhanced primary care services (EPCS) were provided to 294,618 people living in the region which is a decrease in both services and people from 2020-21, equivalent to 8% of total GP attendances. In 2021-22, 502,755 GP Chronic Disease Management Plans were provided to 193,790 people (69% of total EPCS), 173,090 GP Mental Health services to 108,154 people (24% of total) and 49,052 GP Health Assessments to 48,310 people (7% of total). The proportion of people receiving GP services for Chronic Disease Management Plans and GP Health Assessments increased with increasing age, whereas the majority of GP Mental Health services were provided to people aged between 25-44 years (AIHW 2022g).

### Consumer experiences of GP services

Results of the ABS *Patient Experience Survey* indicated that in 2019-20, 27% of people living in the Adelaide PHN region could not access their preferred GP in the preceding 12 months, and 18% who saw a GP waited longer than they felt was acceptable to get an appointment. Approximately 1 in 5 people (21%) people in the region needed to see a GP but didn't, and 4% of people delayed seeing a GP due to cost (ABS 2020b).

### Allied health services

Allied health services include those delivered by audiologists, chiropractors, diabetes educators, dietitians, exercise physiologists, occupational therapists, optometrists, orthoptists, osteopaths, physiotherapists, podiatrists, psychologists, social workers and speech pathologists (AIHW 2021d).

In 2021-22, 1,402,524 services were provided to 504,653 people (39%) living in the Adelaide PHN region, which is consistent with the national and metropolitan rate (37%). In line with the pattern nationally, older people use allied health services more than younger people. In 2021-22, 69% of people aged 65–79 and 78% of people aged 80 and over living in the region, received an allied health service compared to only 18% of 0-14 year olds and 27% of 15-24 year olds (AIHW 2022g).

By SA3, there were moderate variations in rates of service per 100 people across the region, approximately 20% between the lowest and highest rates, and the pattern was associated with socioeconomic status (SES), with regions of lower SES having lower rates of services. SA3s with the lowest rates were Playford, Salisbury, Port Adelaide – East, and Port Adelaide – West (AIHW 2022g).

### Mental health services

Australians access services to support their mental health needs through a number of pathways, including hospital and community-based services, emergency departments, GPs, medical specialists and/or allied health professionals. Due to the diversity of mental health support services available; there is no single, overarching data collection which can be used to report on the mental health care being received by Australians.

In 2021-22, in total 638,070 Medicare-subsidised mental health related services were provided to 199,549 people in the Adelaide PHN region (AIHW 2022g), an increase in services but a decrease in people receiving since 2019-20 (AIHW 2021e). Psychologists provided approximately half (53%) of the Medicare-subsidised mental health-related services received in 2021-22, with GPs providing a 27%, and psychiatrists providing 19% of these services (AIHW 2022g). Across all service types, the majority of services were provided to people in the 15-24 and 25-44 age groups, who had the highest rate of services per 100 population (AIHW 2022g).

By SA3, there were clear variations in rates of service per 100 people across the region by service type in line with socioeconomic status (SES); regions of higher SES had higher rates of both clinical psychologist (2.6 times from highest to lowest rate) and psychiatry services (3.6 times higher). The regions with the lowest rates were Playford, Salisbury, Port Adelaide – East, and Port Adelaide – West. There was less variation in rates of GP mental health services, and in contrast the rates were higher (1.4 times) in SA3s of lower SES (AIHW 2022g).

### 3.6.2 After-Hours services

The Australian Government provides a range of Medicare-subsidised after-hours services to support Australians with access to health care in various settings including consulting rooms, consumers' homes, or residential aged care facilities. After-hours care is categorised as urgent and non-urgent, depending on when and where care is provided.

In Australia a comprehensive primary health care service is the capacity for people to access services after-hours. In this context, 'after-hours' health care refers to services provided on Sundays, before 8 am and/or after 12 pm on a Saturday, or at any time other than 8 am to 6 pm on weekdays (AIHW 2022h). After-hours primary health care can help reduce delays by patients to seek care and has the capacity to improve continuity and coordination of care (AIHW 2022h). According to the ABS Patient Experience Survey, approximately one in every 10 adults (8.2%) living in the Adelaide PHN region in 2019-20 had seen a GP in the after-hours period, a rate which has been fairly consistent since 2013-14 (AIHW 2021f).

As part of the 2022 Needs Assessment update the Adelaide PHN began reviewing and updating both our previous quantitative analysis of after-hours service use in the region, as well as the qualitative analysis with CAC members holding Community Conversations on the after-hours topic. However due to a number of constraints, such as delays to accessing data and the availability and capacity of stakeholders, service providers and the community to participate in consultations, we were still undertaking data collection at the time of submission of this report. Our work on this topic will continue into early 2023 and will be used to inform any upcoming redesign and/or commissioning activities, with the results of our analysis to be submitted as part of the Needs Assessment update in 2023.

In response to findings on this topic from previous needs assessments, Adelaide PHN has commissioned a number of services to support people to access care in the after-hours period. Since July 2017 Adelaide PHN has provided the *Adelaide After Hours* website which is an online directory of general practices, hospitals, dentists, and pharmacies available to all Adelaide residents, linked to information provided in the National Health Service Directory. The website supports people to find the closest appropriate medical support according to where they are at a point in time, or it can be used to plan ahead to find services open at later times and locations. This website also provides a range of helplines and useful health information. Adelaide PHN also commissions two walk-in after-hours mental health services, one in the north and one in the south of our region, and LETSS which is an after-hours telephone service designed to provide non-clinical mental health information and support people with mental health challenges, as well as their carers, family and friends to navigate the mental health system in the Adelaide metropolitan region area.

#### **After-hours service awareness**

As mentioned, Adelaide PHN is currently undertaking consultations to update our understanding of stakeholder, provider and community needs and awareness, in relation to after-hours service use, needs and opportunities. The following is a summary of the findings from previous consultations.

In 2019, improving awareness of after-hours services among the community and providers was an issue in the Adelaide PHN region. The CC identified the need for greater promotion of after-hours services in primary health care to ensure community uptake, particularly in culturally and linguistically diverse communities, and suggested that GPs are referring patients to ED rather than after-hours



services, so greater awareness is needed among GPs in order to avoid this (APHN 2019a). The CAC raised the need for GP's to improve the promotion of after-hours services to their patients (APHN 2019a).

CAC and CC 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 LGBTIQA+ community, and for other population groups including people experiencing homelessness, those with low incomes, and the elderly (APHN 2019a).

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

Previous feedback gained from the workforce (GPs, Business and Practice Managers, SA Ambulance Service staff, and LHN Nurses) participating in the Priority Care Centre (PCCs) program identified several accessibility barriers that limit the service ability in the after-hours. These included access to support services such as radiology and pathology due to restricted operating hours; GP recruitment issues in the after-hours period; and inconsistent operating hours of PCCs (some provide after-hours services but not all) that mismatch high demand times in emergency departments (sociable after-hours) (Adelaide Primary Health Network (APHN) 2019).

### Use of HealthDirect helpline

healthdirect is a government-funded virtual health service that provides access to health advice and information via a website, app and telephone helpline to help people make informed health decisions. Callers to the helpline are triaged by registered nurses who ask a series of clinical questions. Based on the urgency of their situation, callers are advised how to manage their health issue themselves or what medical help to seek. In the after-hours period, callers to healthdirect may be offered a telephone or video call back from a doctor via the after-hours GP helpline, an extension of the healthdirect helpline (HealthDirect Australia 2021b).

In 2020 there were 64,793 calls to the HealthDirect helpline (Nurse Triage) while in 2021, there were 81,242 calls. In 2021, residents living in the LGAs of Onkaparinga, Salisbury, Port Adelaide Enfield, Playford and Charles Sturt made the most call episodes to the HealthDirect helpline (Nurse Triage), with the highest call rate per 1,000 population in Adelaide City (HealthDirect Australia 2021a).

Calls to the HealthDirect helpline (nurse triage) have increased by 17% in the five years between 2016 and 2021. From 2020 to 2021, there was a 25% increase in calls to the helpline, from 65,000 to 81,000, possibly due to the impacts of COVID-19. In 2021, three in every 10 calls (29%, 23,497 calls) were for children aged 0 to 4 years old, which is consistent with analysis of previous years data. In 2020 and 2021 approximately 4-5% of all calls made by Adelaide PHN residents to the Nurse (Triage) Helpline were triaged to the After-Hours GP Helpline (HealthDirect Australia 2021a).

Analysis of the HealthDirect Australia data shows that for 2021 there were 3,525 calls transferred to the After-Hours GP Helpline consistent with the 2020 figure of 3,365 calls. In 2021, residents living in the LGAs of Onkaparinga, Playford, Salisbury, Port Adelaide Enfield and Marion had the most calls triaged to the After-Hours GP Helpline (HealthDirect Australia 2021a).

In 2021, 31% of the calls triaged to the After-Hours GP Helpline concerned children, with 1,098 calls for people aged 0 to 4 years old (HealthDirect Australia 2021a).

### Medicare-subsidised after-hours services

The Australian Government provides a range of Medicare-subsidised after-hours services to support Australians with access to health care in various settings including consulting rooms, consumers'

homes, or residential aged care facilities. After-hours care is categorised as urgent and non-urgent, depending on when and where care is provided.

In 2021-22, 455,642 after-hours GP services were provided to 234,393 people, equivalent to 18% of the region's population, which is consistent with the national rate (17%). The majority of after-hours services in the Adelaide region in 2021-22 were non-urgent (89%) (AIHW 2022g).

The rate of use of GP services use in the after-hours period is higher in Adelaide PHN compared to the National rate but lower than the rate for all metropolitan PHNs (grouped) (AIHW 2022g). Rates of GP after-hours activity in the Adelaide PHN had decreased by 36% between 2019-20 to 2021-22, in comparison to the five years from 2013-14 to 2017-18 where rates had increased (AIHW 2019b).

Use of after-hours GP services was highest amongst older adults aged 80 years and over for non-urgent, urgent, and total service types, with a rate of services per 100 people over three times the average rate for Adelaide PHN residents (AIHW 2022g). Almost one-third (29%) of people aged 80 years and over received an after-hours GP service, compared to 19% of 0-14 year olds (AIHW 2022g).

There were clear variations in rates of service per 100 people across the region associated with socioeconomic status (SES); regions of lower SES had substantially higher rates of total (2.9 times from highest to lowest rate), urgent (4.2 times higher) and non-urgent (2.9 times higher) after-hours services. The SA3 regions with the highest rates of total and non-urgent services were Playford, Port Adelaide – East, and Port Adelaide – West, and Salisbury. For urgent after-hours services, Playford, Adelaide City, Salisbury and Charles Sturt had the highest rates per 100 people (AIHW 2022g).

### ***Use of acute services in the after-hours period.***

Adelaide PHN is currently undertaking analysis of emergency department and hospital inpatient datasets to update previous analyses on acute service activity in the after-hours period; the results of which will inform, where relevant, any upcoming redesign and/or commissioning activities, and be published in the 2023 Needs Assessment update.

Previous analysis on these datasets (2013/14 and 2014/15 financial years) indicated that approximately two-fifths of all unplanned Emergency Department (ED) presentations occurred in the after-hours period, and two-fifths of these presentations were triaged as semi-urgent or non-urgent (SA Health 2015). 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.

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

### **Lower urgency ED presentations**

Emergency department presentations that are lower urgency are sometimes used as a proxy measure of access to primary health care. Higher presentation rates may suggest a lack of access to GPs or other primary health services, which may have been better placed to manage a person's health condition (AIHW 2020b).

Rates of lower urgency ED presentations have shown a gradual decline from 94.2 per 1,000 population in 2015-16 to 81.4 per 1,000 population in 2019-20 (AIHW 2021g). Just under half (48%) of all lower urgency ED presentations in the Adelaide PHN region occurred during the after-hours period when general practices and other alternate health services are usually closed. In 2019-20, the after-hours lower urgency ED presentation rate was 39.1 per 1,000 people, consistent with the metropolitan PHN group average, but lower than the national rate of 52.0 per 1,000 people (AIHW 2021g).

Within the Adelaide PHN region, children (0-14 years) and young people (15-24 years) had the highest rates for lower urgency ED presentations across the three categories (total, in-hours and after-hours). Despite representing 17% of total population people aged 0-14 represent 30% of all lower urgency presentations in 2019-20 (AIHW 2021g).

There were clear variations in rates of lower urgency ED presentations across the region associated with socioeconomic status (SES); regions of lower SES had substantially higher rates of all-hours (3.1 times between highest to lowest rate), in-hours (3.5 times higher) and after-hours (2.6 times higher) presentations per 1,000 people. The SA3 regions with the highest rates of all-hours and in-hours lower urgency presentations were Onkaparinga, Playford, Port Adelaide – West, Charles Sturt and Salisbury. In the after-hours period, rates of lower urgency ED presentations per 1,000 people were highest in Onkaparinga, Playford, Charles Sturt, Port Adelaide – West, and Port Adelaide – East (AIHW 2021g).

### **COVID-19 Impacts on After Hours**

Although the impact of COVID-19 on after-hours services is not available at a PHN level yet, it is starting to be reported on at a national level. The proportion of people who reported that they delayed or did not use a GP service or an after-hours GP service when needed due to COVID-19 was 9.8% and 7.3%, respectively (AIHW 2022). Females were more likely to delay or not use GP services when needed due to COVID-19 than males (13% and 7%, respectively). This was the same for after-hours GP services (8.5% and 5.4%, respectively) (AIHW 2022a).

## **3.6.3 Factors impacting access to primary health care services**

### **Health literacy**

In Australia, low levels of health literacy in consumers is affecting health-related behaviours, utilization of health services and navigation of the health system (Choudhry et al. 2019). People with low health literacy are more likely to have worse health outcomes overall and adverse health behaviours, such as lower engagement with health services, including preventive services such as cancer screening; higher hospital re-admission rates; non-adherence and improper usage of medication; and lower ability to self-manage care (AIHW 2020c). Improving health literacy will increase the involvement people can have in their own healthcare: from choosing a health care provider to empowering individuals to be able to make informed choices and decisions every day about how to manage their lives and their health. This is particularly important for people with chronic conditions, for whom the need to management is ongoing and often complex (PC 2021).

The most recent reported health literacy data available comes from the 2018 National Health Survey. In 2018, 1,319 persons aged 18 years or over in South Australia completed the Health Literacy Survey, conducted by the Australian Bureau of Statistics. Of those, 97% agreed or strongly agreed they have sufficient information to manage their health and 90% agreed or strongly agreed they were able to appraise health information. (Australian Bureau of Statistics (ABS) and ABS 2019) Despite these numbers, health literacy amongst community and population groups continue to be raised as an issue through consultations (HCQ 2022; APHN 2022b).

The AIHW has stated *“the COVID-19 pandemic highlighted the importance of health literacy in the wider community, as whole populations are asked to understand and rapidly digest complex health concepts relating to infection, immunity and use of the health care system to produce a coordinated response to try and slow the spread of disease.”* (AIHW 2020c). This reiterates the importance of developing and delivering health messages that consider the health literacy levels of the population and vulnerable sub-populations that are understandable and effective.

Nationally, 67% of people born overseas in a mainly non-English speaking country have less than adequate levels of literacy and health literacy, meaning that they may not be able to effectively exercise their choice or voice when making healthcare decisions (ABS 2013).

Kitchen Table consultation results indicate that health literacy is an issue for the CALD population as per comments such as: *“Health literacy is what makes the difference. Women are often ignored because medical professionals think that we are hysterical or dramatic, with knowledge you can challenge their expertise as being the expert of your own health”* (HCQ 2022).

Key points identified by participants included:

- There are challenges for migrants and refugees in understanding health information and how to apply it to make informed decisions
- Migrants rely on people from their own communities for information and knowledge
- Health information is not standardised
- When health information is translated, it is only available in a few languages (HCQ 2022)

Similarly, participants in the Population Health Needs Assessment Consultation (APHN 2022b) noted examples of health literacy barriers for patients with chronic and complex conditions to be:

- The lack of understanding in the CALD community about chronic illness and the health system in general
- Health issues are being compounded with language health literacy issues

### **Barriers to Equitable Access**

Access, integration, coordination, and navigation barriers have been consistently raised as an issue in consultation with members of Adelaide PHN Clinical Councils, Community Advisory Councils, and Network Leadership Group (APHN 2016a, 2016b, 2021a, 2022b) and during Adelaide PHN facilitated GP's Roundtable Workshops with GPs in the region (APHN 2019b).

In 2022, Population Health Needs Assessment Consultation and Kitchen Table Community Conversations, noted these and additional barriers (HCQ 2022). A summary of the primary barriers identified through the 2022 consultations have been grouped under the health system dimensions: effectiveness, safety, appropriateness, continuity of care, accessibility and efficiency and sustainability.

#### **Effectiveness**

- The link between oral health and health outcomes is being neglected, particularly in relation to chronic disease prevention and management
- Health is not a priority when there are other social issues present (homelessness, financial hardship)
- There are time constraints on GP appointments

#### **Safety**

- Practitioners are burnt out and over worked
- There is a lack of appropriate medical information available in hospitals for CALD populations, and the need for interpreter services.
- GPs and healthcare support staff are not adequately trained in LGBTQI+ and cultural education

#### **Appropriateness**

- There is still stigma associated with LGBTQIA+ patients
- There are limited services for CALD and LGBTQIA+ populations
- There is a shortage of GPs who will see LGBTQIA+ patients
- There is a lack of interpreters available for CALD populations

- Women of ethnic background do not feel comfortable speaking to male doctors
- Gender appropriate services are required

### Continuity of Care

- The health system is operating in silos that is affecting communication between providers, that results in duplication of information across primary and acute settings
- Patients with chronic conditions are treated in silos due to the lack of continuity of care.
- There is a lack of coordination between GPs and allied health care providers
- There is a lack of communication between patients and hospitals resulting in missed specialist appointments

### Accessibility

- There are long wait lists to see GPs and specialists
- There are long wait times to see specialists, especially for specific or complex issues and for surgery.
- There is a shortage of bicultural GPs and health professionals
- The increased use of technology is a barrier for older patients and those with complex health conditions.
- Barriers to CALD communities include not being familiar with Australian health system, language barriers, health literacy, not knowing how to ask for information
- Technology is a barrier to access service in some populations (Older, low SES)
- The cost of care and preventative medicine is a barrier to access, particularly for CALD populations and those in lower SES groups
- The cost of care, screening and immunisation is a prohibitive factor for some CALD populations
- There are still long wait times to even access a GP, then once an appointment is available, appointment times are too short
- There are financial barriers to healthcare among CALD populations including for those without access to Medicare

### Efficiency and Sustainability

- GP scope of practice is limited
- Long waitlists for community-based services were stated as a reason for attending hospital emergency departments
- There is a preference and therefore high demand for GPs who are multilingual or have an understanding of the patient's culture and language

## 3.6.4 Health and service needs of specific populations groups and communities

*Please note, the health and services needs of priority population groups including Aboriginal and Torres Strait Islander people, older Australians, and people living with mental ill health are presented in other chapters of this report.*

### **Culturally and linguistically diverse and emerging communities**

Measuring how the health care system responds to the needs of culturally and linguistically diverse (CALD) Australians is challenging, as information to identify CALD people in health data is limited, is not collected consistently, and is not routinely reported on (AIHW 2022aj). Additionally, the term

“CALD” can have multiple definitions, and includes aspects such as a person’s country of birth, their ancestry, where their parents were born, what language/s they speak and their religious affiliation. Within CALD groups, there can also be difference e.g. those born in the same country may not identify with the same culture or speak the same language (AIHW 2022aj).

The growing population of CALD communities require changes in the provision of health service to meet their specific health needs. In Australia, there is a higher utilisation of tertiary care by migrants compared to the local population (Renzaho 2009). The COVID-19 pandemic has also highlighted the difficulties that people from CALD backgrounds have in accessing health care and the impact this has on health outcomes (DoH 2022a).

People from CALD backgrounds have multiple interacting social factors and diseases, low access to health services, and face challenges in the multilevel health and social systems. (Khatri and Assefa 2022).

Past consultations with Adelaide PHN councils and stakeholder groups identified CALD and new and emerging communities as a priority population group for the Adelaide PHN (APHN 2016a, 2016c, 2016d, 2016b). Mental health, and alcohol and other drug needs of these communities, and access to mental health, alcohol and other drug and primary health care services in the region were specific areas of concern (APHN 2016c).

Research by Principe (2015) identified that people from CALD backgrounds are among the population groups missing out on accessing suitable services or gaining equitable health care outcomes. This is supported in other literature, for example a study undertaken in 2014 with refugee women living in South Australia found the main barrier to accessing primary health care and understanding GPs and pharmacists was not being able to speak or comprehend English (Clark et al. 2014). Additionally, a study of women with culturally diverse backgrounds (Lam et al. 2018) found that just 19% identified as “breast aware”, and only 27% aged over 40 had participated in annual clinical breast exams. Australian research has also identified that CALD communities particularly from Asia and the Pacific are disproportionately affected by Hepatitis B (MacLachlan et al. 2020).

### Refugees and new arrivals

Consultations with local stakeholders representing the multicultural sector, primary health care and research identified that refugee and new arrival populations have limited understanding of the Australian health system and lack access to appropriate and timely primary health care services. Low health literacy also limits their ability to make informed decisions about their health and health care (APHN 2017a).

#### New arrivals

Informal discussions with state representatives from refugee health services highlighted and reaffirmed some of the primary care access challenges and issues that are experienced by people migrating to South Australia (Refugee Health 2022).

There were total of 58,816 recent arrivals (2016-2021) in the Adelaide PHN region. Of them, 49,672 (84%) did not speak English at home, and 7,873 (13%) had reported to have poor proficiency in English (ABS 2022d, 2022d).

The Local Government Areas with the highest proportion of people born in NESO for less than five years (recent arrivals) were Adelaide City (19.2% of the population), West Torrens (7.4%), Norwood Payneham and St Peters (3.0%), Port Adelaide Enfield (6.4%), and Prospect (6.4%) (PHIDU 2022c).

Local stakeholders have suggested that primary health care providers, including GPs don’t have the support, training, and capacity to deliver culturally safe and culturally appropriate services to refugee and new arrival populations (APHN 2017a, 2022b). The lack of formalised partnerships and referral pathways between the migrant health sector and primary health care services impact access and effectiveness of services. System integration of primary health care services for refugees and new



arrivals would improve access and delivery of culturally appropriate and sensitive primary care services to these populations (APHN 2017a).

### *Refugees*

Helping refugees and new arrivals to better understand and make decisions about their health and health care is a focus of the Adelaide Refugee and New Arrivals Program (ARANAP). The program commissioned by Adelaide PHN, is designed to support refugees and people who have been in Australia for less than five years – helping them access culturally appropriate primary health care services, improving their knowledge of health issues and supporting connection of services to ensure their health care needs are met. Some of the key outcomes for 2021/2022 include support to attend eye and hearing assessments as well as dental check-ups.

In 2021, 311 people came to the Adelaide PHN on a Humanitarian visa and 4,616 people came on the family visa. Salisbury received the highest number of people on Humanitarian and Family visas. The number of people coming on different visas has been impacted by the COVID-19 border restrictions (DOHA 2022). It was noted in informal discussions that arrival numbers in SA for the past 3 years are lower than average because the Humanitarian Settlement Program was paused due to COVID-19 in March 2020. In addition, figures reported by the DOH don't include people who have recently arrived from Ukraine or the Emergency Afghani arrivals in 2021 (Refugee Health 2022).

In 2022, issues concerning CALD populations, including refugees and new arrivals, continue to be raised by during Kitchen Table Community Consultations and Population Health Needs Assessment Consultation participants (APHN 2022b; HCQ 2022):

- Stakeholders highlighted the lack of interpreters for CALD clients and language barriers, the lack of culturally appropriate services
- The barriers for the community to receive good health information include not being familiar with the health system in Australia, language barriers, health literacy, and not knowing how to ask for information
- The lack of visibility that clinics are culturally safe for minority groups
- The lack of understanding by CALD communities about chronic illness and management
- The cost of screening and immunisation
- Lack of interpreters for CALD people

Commissioned service providers within the Adelaide PHN region also highlighted difficulties when seeking an appropriate translator for their clients, especially translators from smaller sized CALD groups, given the many different cultures and languages spoken in the region (APHN 2021b).

Community consultation reaffirmed this with key findings that included statements such as “language is a barrier to most information being available in English” and “new arrivals learn about health care through the services supporting them and friends” (HCQ 2022). Similarly, stakeholder consultation continues to highlight health literacy as a barrier to supporting the management of complex and chronic conditions (APHN 2022b).

### *Parents and Babies*

The Government is committed to improving health outcomes for parents and children in the first 2,000 days of life, which have major impacts on the rest of people's lives. Infants and young children aged under five years, experienced total burden of disease mainly from a range of infant and congenital conditions, including pre-term and low birthweight complications, birth trauma and asphyxia, cardiovascular defects and sudden infant death syndrome (SIDS). Other high-burden diseases for this group were asthma, lower respiratory infections and dermatitis and eczema (SA Health 2021).

## Smoking in pregnancy

The chemicals in tobacco smoke can affect an unborn baby's development, cause complications during pregnancy and may have lifelong effects on the child (DOHAC 2022a). While overall rates in the Adelaide PHN are lower than national rates, there is substantial variation across the region. In the two years from 2017-2019, the percentage of females smoking during pregnancy was lower in the Adelaide PHN (8.9%) than nationally (9.5%). Rates of smoking during pregnancy were lowest in Campbelltown (2.1%) and highest in the Local Government Areas of Playford (18.3%), Salisbury (12.3%), Onkaparinga (10.6%), Port Adelaide Enfield (9.2%) and Charles Sturt (8.0%) (PHIDU 2022c).

## Infant mortality and low birthweight

Compared to national rates, infant mortality and low birthweight babies were lower in the Adelaide PHN, although again there is regional variation. In 2016-2020, the average annual Infant Mortality Rate (IMR) per 1,000 in the APHN region was 2.6 (185 cases), which is lower than the Australian rate of 3.2. (PHIDU 2022c). Variation in the region ranged from 1.6 per 1,000 in Mitcham to 4.1 per 1,000 in Playford (PHIDU 2022c). Between 2017-2019, there were 6.7% low birthweight babies born in the Adelaide PHN, consistent with the Australian rate of 6.7%. Within the region, percentages ranged from 5.0% in Burnside to 7.6% in Salisbury (PHIDU 2022c).

## Antenatal care

In the two years from 2017-2019, the percentage of women who did not attend antenatal care visits within the first 10 weeks in the Adelaide PHN was higher (79.1%) than the Australian rate of 47.4%. Rates of women who did not attend antenatal care visits in the first 10 weeks for all women giving birth were lowest in Unley (66.9%) and highest in Onkaparinga (90.9%), Playford (85.6%), Salisbury (81.5%) Port Adelaide Enfield (80.5%) and Marion (80.2%) (PHIDU 2022c).

## Children and young people

Adelaide PHN needs assessment consultations identified that access to appropriate and timely services for children and young people, particularly in relation to early interventions, prevention and support services, were a key need for this population group. A lack of identified care coordination, and a lack of funding and capably skilled workforce were identified as impacting level of care coordination and collaboration (APHN 2016a, 2016c, 2018b).

Aligned with *Australia's Primary Health Care 10 Year Plan 2022-2023* (DoH 2022a), Adelaide PHN will endeavour to improve access to primary health care services delivered by allied health professionals for children and young adults accessing complex health services.

In 2021, as counted at the last Census, there were 257,720 people aged 17 years and under living in the Adelaide PHN region. This included 68,243 babies and pre-schoolers (0 to 4 years) (5.4% of total region population), 103,431 (8.1%) primary schoolers (5 to 11 years) and 86,046 (6.8%) secondary schoolers (12 to 17 years).(ABS 2022d)

## Risk Factors

In 2017-18, 39,186 children (17.3 per 100 population) aged 2-17 years were overweight, and 19,074 (8.4 per 100) children were obese, both higher than the Australian Greater Capital City Areas Average rates of 16.6 per 100 and 7.2 per 100 respectively (PHIDU 2022c).

By SA3, Tea Tree Gully (18.2 per 100), Salisbury and Charles Sturt (both 18.0 per 100) had the highest rates of overweight children, while West Torrens, Tea Tree Gully, Salisbury and Holdfast Bay had higher rates (9.0 per 100) of obesity compared to the Australian Greater Capital City Areas average rate (PHIDU 2022c).



## Developmental vulnerability

In 2021, 2,411 (5.3%) of children living in the region were vulnerable on two or more domains. The SA3 areas in the Adelaide PHN region with the highest proportions of developmentally vulnerable children were Playford (299, 20.7%), Salisbury (284, 15.5%), Onkaparinga (244, 12.2%), Port Adelaide – East (111, 13.2%), and Charles Sturt (111, 9.3%) (AEDC 2022).

## Long-term health conditions

According to Census data, there were 220,780 persons in the Adelaide PHN aged 0-14 years in 2021 (PHIDU 2022c). Of those, 18,340 (8.3%) reported having one or more long term health conditions, which is consistent with Australian data (8.1%) (PHIDU 2022c).

Within the Adelaide PHN, 13,452 persons aged 0-14 years reported they had asthma (ASR 6.3 per 100 people), 4,238 (ASR 2.0 per 100 people) reported a mental health condition and 10,028 (ASR 4.6 per 100 people) reported they had any other long-term condition. This is consistent with Australian ASR of 6.3 per 100 people for asthma, 2.1 per 100 people for mental health and slightly higher for those who reported any other condition (4.1 per 100 people) (PHIDU 2022c).

In 2018/19, there were 803 admissions to public hospitals in the Adelaide PHN due to total chronic conditions in children aged 0-14 years. This is equivalent to an ASR per 100,000 of 369.4 which is higher than the Australia's ASR of 329.6. There were 440 public hospital admissions for persons aged 15 to 24 years within the Adelaide PHN due to total chronic conditions. This equates to the ASR per 100,000 of 272.4 which is lower than the Australian rate of 302.2 (PHIDU 2022e).

Within the Adelaide PHN, there were 3,884 (1,788.1 per 100,000 population) admissions to public hospitals for persons aged 0 to 14 years old due to all potentially preventable chronic conditions in 2018-19. This is a higher rate than the Australia's ASR of 1,611.5 per 100,000. Regionally, the ASR ranged from 1,004.7 in Unley to 2,789.0 in Playford (PHIDU 2022e).

## Respiratory system conditions

### *Emergency department presentations and hospitalisations*

In 2018-19, there were 9,197 emergency department presentations for diseases of the respiratory system in persons aged 0-4 years, 3% below the national rate, and 1,841 presentations for persons aged 15-24 years, 33% below the national rate (PHIDU 2022e).

In the Adelaide PHN in 2018-19, there were 5,267 admissions to public hospitals for respiratory system diseases in persons 0-14 years, which was 13% above the national rate. In persons aged 15 - 24 years, there were 846 admissions, 24% below the national rate (PHIDU 2022e). Within the PHN region admissions varied by sub-region: for 0-14 year olds the admission rate in Burnside was 26% below the national rate while Playford was 44% above. There was substantial variation for the 15-24 year age group, Burnside was 77% below the national rate, while Playford was 26% above (PHIDU 2022e).

## Asthma

As with chronic conditions reported earlier in this chapter, there is substantial variation in asthma rates across the region in the younger age groups. For 0-14 year old's, the ASR ranged from 3.7 per 100 people in Walkerville to 8.3 per 100 people in Playford (PHIDU 2021a).

### *Potential preventable hospitalisations: chronic asthma*

In 2018-19, there were 1,124 admissions to public hospitals with a principal diagnosis of chronic asthma in children aged 0 to 14 years in the Adelaide PHN, an ASR per 100,000 of 517.2. This was higher than the Australia's rate of 345.0. There were 115 public hospital admissions for people aged 15 to 24 years due to chronic asthma. This equates to an ASR per 100,000 of 71.4 which is lower than the Australian rate of 93.5 (PHIDU 2022e).

*Emergency department presentations and hospitalisations: chronic asthma*

In 2018-19, there were 594 admissions to public hospitals in children aged 0 to 14 years due to potentially preventable chronic asthma, an ASR per 100,000 of 273.1 which is higher than the Australia's rate of 230.7. There were 115 public hospital admissions for persons aged 15 to 24 years because of potentially preventable asthma. This equates to the ASR per 100,000 of 71.4 which is lower than the Australian rate of 93.5. (PHIDU 2021) The lowest ASR per 100,000 in the PHN for children aged 0 -14 years was Unley (142.9), the highest was Playford (393.4) (PHIDU 2022e).

**Mental health conditions**

In 2021, 4,238 people aged 0-14 years reported they had a mental health condition in the Adelaide PHN. This is 8% below the national rate. There was regional variation with the rate in Prospect 57% below the national average, while rates in Playford were 40% above national rates (PHIDU 2022e).

*Emergency department presentations and hospitalisations: mental health conditions*

In 2018-19, there were 1,002 emergency department presentations for mental and behavioural disorders in persons aged 0-14 years, 63% above the national rate, and 4,332 presentations in persons aged 15-24 years, 33% above the national rate (PHIDU 2022e). Regional variation is demonstrated again – in the 0-14 years age group: Unley was 54% below the national rate, while Adelaide was 143% above, similarity in the 15-24 year age group, Burnside was 44% below the national rate while Playford was 107% above (PHIDU 2022e).

**Disability**

In 2018, 16,819 (8%) people aged 0-14 years living in the Adelaide PHN had a disability, including approximately 10,600 people (5% of the population) with a profound or severe core activity limitation meaning they always or sometimes need assistance or supervision with self-care, mobility, and/or communication (ABS 2020a).

Across the region there was moderate variation in rates of total disability, ranging from 5% to 13% by local government area of residence, whereas rates of profound or severe core activity limitation by local government area, showed more marginal variation ranging from 4% to 7%. The local government areas with the highest rates for both total disability and profound and severe limitation were Playford (13% and 7% respectively), Onkaparinga (9% and 6%) and Salisbury (9% and 5%) (ABS 2020a).

**Autism**

According to the ABS Survey of Disability, Ageing and Carers (SDAC), an estimated 205,200 Australians had autism in 2018 and the number of people with autism in Australia, this has increased considerably in recent years, from an estimated 164,000 people (25.1% increase) since 2015 (ABS 2019a). Of those who were estimated to have autism in 2018, 180,200 were identified as also having disability (88%) 2015 (ABS 2019a).

The proportion of the population with Autism Spectrum Disorder (ASD) in South Australia (all ages) is estimated to be 0.7% (ABS 2015a), equivalent to approximately 12,500 people in 2021. Approximately 70% of those diagnosed with ASD are under 20 years, which based on South Australian population in 2021, equates to approximately 9,000 young people having ASD (ABS 2015a).

Analysis of Adelaide PHN General Practice data as of September, 2022 (audit month, filtered by 0-18 years) indicates there have been 10,711 patients aged 0 to 18 years who have visited a general practice and have a coded diagnosis of ASD. This is equivalent to 1.7% of all patients aged 0 to 18 years (APHN 2022e).

*Early intervention services for children*

In 2021-22, 555 children received a Medicare-subsided *Early Intervention Services for Children* which is an assessment, diagnosis and preparation of a treatment and management plan for a child aged under 13 years with autism, another PDD or another eligible disability (AIHW 2022g).

## **Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual + (LGBTIQA+) Communities**

The Adelaide PHN's Community Advisory Council identified that Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual + (LGBTIQA+) communities should be a priority population group for the (APHN 2019c). To better understand the health and service needs of this population and build upon the evidence presented in previous Needs Assessment submissions, in 2020 the Adelaide PHN undertook an environmental scan of recent relevant literature, conducted consultations with the Adelaide PHN councils and stakeholder groups and interviews with several LGBTIQA+ service providers in the region. This section summarises the general primary health care and service needs and issues that were identified from this process; health and service needs relating to mental health and alcohol and other drugs treatment for LGBTIQA+ communities are reported in those respective chapters.

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

While many LGBTIQA+ people live happy and healthy lives, as a group they may be more likely than the general population to experience poor social, physical and mental health (DoH 2019a), have higher rates of substance use (FFF 2018; AIHW 2019c), and poorer outcomes compared to general population (Karen et al. 2017). LGBTIQA+ people also have a higher incidence of life-limiting illness and tend to present to health care services later and with more advanced disease than the general population (Bristowe 2018; DoH 2019a). A recent Australian study of the health and wellbeing of LGBTIQA+ young people (Hill et al. 2021) highlights the burden of mental health faced by young LGBTIQA+ people aged 14 to 21 years in South Australia:

- 81% reported high or very high levels of psychological distress, almost 3 times the rate of a comparable cohort in the general population.
- 49% reported having ever being diagnosed with generalised anxiety disorder and over two-fifths (45.0%) with depression.
- 59% experienced suicidal ideation and 10% attempted suicide in the past 12 months.
- 25% had attempted suicide in their lifetimes; and
- 63% reported having ever self-harmed and 38% reported self-harming in the past 12 months.

There is a large and consistent evidence base showing that a range of social, psychological and economic factors are recognised as increasing the risk of adverse impacts on physical and mental health and contribute to the higher health burden and poorer outcomes in LGBTIQA+ communities. These factors, including social exclusion, violence, homelessness, stigma, discrimination and marginalisation also create substantial barriers to accessing health and social care services (McNair 2003; FFF 2018; Mooney-Somers 2018; Leonard et al. 2015; Strauss et al. 2017). In line with the above, fear of and experiences of stigma and discrimination as a barrier to accessing primary health

services was a reoccurring issue identified in consultations with Adelaide PHN councils and stakeholders (APHN 2020a).

Consultations also raised a number of workforce-specific barriers to the accessibility, appropriateness and effectiveness of primary health care in our region. They included service providers: lacking cultural competency when engaging with LGBTIQA+ people e.g. misgendering, asking inappropriate questions and using inappropriate language; having limited knowledge of the specific health needs of LGBTIQA+ people; providing services that did not adequately meet communities' needs; and having limited capability to connect, integrate or refer consumers to appropriate services (APHN 2020a).

These issues are reflective of national and international research (DoH 2019a; Mullens et al. 2017; SARAA 2019; Strauss et al. 2017; Waling et al. 2019);.

In 2022, (Saxby et al. 2022) reported that among Australian gay, bisexual, and other men who have sex with men (GBM) structural stigma was associated with a reduced likelihood of being on combination therapy for HIV and fewer HIV-related clinical visits. A lack of safe and inclusive LGBTIQA+ specific sexual health, mental health and alcohol and other drug treatment services in the region was also a reoccurring need identified during Adelaide PHN consultations (APHN 2020a). In consultations undertaken this year (APHN 2022b), key issues reiterated and identified include:

- There is still stigma associated with LGBTIQA+ patients
- The lack of GPs who will accept or feel comfortable treating LGBTIQA+ patients
- The wait times for GPs who do accept LGBTIQA+ patients
- The need to offer LGBTIQA+ (sensitivity) training
- The potential loss of income to GPs if they prioritize attending non-compulsory training (such as LGBTIQA+ sensitivity)

### ***People with a disability or limitation***

People living with a disability are one of the population groups in our society who experience health inequities. People living with a disability experience higher levels of chronic and preventable diseases, face barriers to accessing appropriate care and die younger than other Australians (DoH 2022a).

Disability and health have a complex relationship – long-term health conditions might cause disability, and disability can contribute to health problems. The nature and extent of a person's disability can also influence their health experiences. For example, it may limit their access to, and participation in, social and physical activities. In general, people with disability report poorer general health and higher levels of psychological distress than people without disability. They also have higher rates of some modifiable health risk factors and behaviours, such as poor diet and tobacco smoking, than people without disability (AIHW 2022i).

The *National Roadmap for Improving the Health of People with Intellectual Disability* (DoHAC 2021) highlights that people with intellectual disability experience:

- More than twice the rate of avoidable deaths
- Twice the rate of emergency and hospital admissions
- Substantially higher rates of physical and mental health conditions; and
- Significantly lower rate of preventative healthcare.

In 2018, 226,230 (19%) people living in the Adelaide PHN had a disability, including approximately 67,000 people (6% of the population) with a profound or severe core activity limitation meaning they require always or sometimes need assistance or supervision with self-care, mobility, and/or communication (ABS 2020a).

Consistent with national prevalence, disability prevalence in the Adelaide PHN region increased with increasing age, with 8% of 0-14 years olds with a disability compared to 49% of people age 65 years and over (ABS 2020a).

Across the region there was substantial variation in rates of total disability, ranging from 14% to 26% by local government area of residence, whereas rates of profound or severe core activity limitation by local government area, showed more moderate variation ranging from 3% to 8%. The local government areas with the highest rates for both total disability and profound and severe limitation were Playford (26% and 8% respectively), Onkaparinga (20% and 6%) and Salisbury (20% and 6%) (ABS 2020a).

In the 2021 Census of Population and Housing, 84,424 people (or 7% of the population) in Adelaide Primary Health Network reported needing help in their day-to-day lives due to disability (profile.id 2022). Between 2016 and 2021, there was an increase in the number of people in the Adelaide PHN region reporting a need for assistance, with the largest increase by age group being 10 to 19 year olds (+2,215 persons), people 85 and over (+1,848 persons), 70 to 74 year olds (+1,757 persons) and 75 to 79 years (+1,507 persons) (profile.id 2022).

Other than overall estimates of disability by age and area of residence, data is not available to describe the type, nature and impact of disability for residents of the Adelaide PHN region, however key State- and National-level estimates have been summarised below.

#### *Assistance needed and received*

For all people with a reported disability in South Australia in 2018, the main activities for which assistance was needed were healthcare (30%), property maintenance (28%), household chores (23%), cognitive or emotional tasks (23%) and mobility. Of the people who needed assistance, 65% felt their needs were fully met, while 35% were either not met or only partly met (ABS 2020a).

#### *Disability group*

National prevalence estimates major cities in 2018 showed that many people living with a disability reported multiple impairments; 49% intellectual, 41% psychosocial, 31% sensory and speech, 31% physical restriction, 4% an acquired brain or head injury and 24% other (AIHW 2022i).

#### *Main conditions of people with disability*

Nationally, almost 8 in 10 (77%) people with disability reported a physical condition as their main disorder. Musculoskeletal disorders were the most commonly reported (30%) physical disorders, and include conditions such as arthritis and related disorders (13%), and back problems (13%) (ABS 2020a).

Mental or behavioural disorders were reported as their main condition by 23% of people with a disability. The most common mental or behavioural disorders were psychoses and mood disorders (8%), intellectual and development disorders (7%) and neurotic, stress related and somatoform disorders (6%) (ABS 2020a).

#### *Older people living with a disability*

The likelihood of experiencing disability increases with age. This means the longer people live, the more likely they are to experience some form of disability (ABS 2020a).

Modelled estimates for the Adelaide PHN region in 2018, suggest that more than 99,000 people, equivalent to almost half (49%) of all people aged 65 years and over were living with a disability. Estimates highlighted the regional variation by LGA, with 38% of people in Unley living with a disability, compared to 62% of older people in Playford LGA (6,717 people). Onkaparinga LGA had the high number of people (14,638, 50%) followed by Salisbury (10,682, 55%) (ABS 2020a).

Over 29,200 older people living in the region had a profound or severe limitation, equivalent to 14% of all people aged 65 years and over. Playford LGA had the highest proportion of people with a profound



or severe limitation (20%, 2,181 people), while Onkaparinga (4,084, 14%) and Charles Sturt (3,285, 16%) had the highest numbers. Similarly, Onkaparinga and Charles Sturt LGAs had the highest number of people with mild or moderate limitation, 9,128 and 5,975 people respectively. Playford LGA also had the highest proportion of with 36% of people aged 65+ years living with a mild or moderate limitation (ABS 2020a).

Furthermore, 2015 estimates suggested that that over 74,000 older people living in the Adelaide PHN region needed regular assistance with self-care, mobility and/or communication, and of whom 8,500 had unmet formal care needs (PHIDU 2022b).

Within the PHNAC, one participant raised subsidising home visits for patients with a disability as a way to improve access to health services (APHN 2022b).

### People with intellectual disability

Recognising the importance of supporting vulnerable populations within the APHN region and providing health care providers with the resources and training to support appropriate patient care, it has been identified that people living within the APHN with intellectual disabilities require further supports to ensure the care provided is equitable across the region.

People with intellectual disability need timely, affordable and accessible health care that meets their needs across their lifespan, notably including the transition to adulthood. Models of care across the health system need to be built on person-centred, disability-integrated approaches, with decision making shared between health professionals, people with intellectual disability, their families and carers, and support workers. When health professionals listen to the needs of people with intellectual disability and make reasonable adjustments when delivering health care, patient experiences and health care outcomes are greatly improved.

In line with the *National Roadmap for Improving the Health of People with Intellectual Disability* (DoHAC 2021) it is important that we continue to support and work with primary health care providers to develop better models of health care to support people with intellectual disabilities and work towards achieving the key objectives of the roadmap.

### Low socio-economic status communities

Socio-economic factors remain important determinants of health, with people in socio-economically disadvantaged circumstances experiencing poorer access and health outcomes. Families and individuals with limited resources not only have more chronic disease, but they are also at greater risk of dying prematurely as a result of chronic health condition (Broerse et al. 2021).

The Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-Economic Disadvantage (IRSD) is an indicator that quantifies the relative level of socio-economic disadvantage and/or advantage based on these characteristics as measured in the *ABS Census of Population and Housing*. A lower score on the index means a higher level of disadvantage. While the socio-economic status (SES) of the Adelaide region as a whole is improving, it is important to note that there are some areas in the north of our region (within the LGA of Playford) that are classified in the top 1 percentile of most disadvantaged regions in Australia based on their IRSD score. In 2016, the Adelaide PHN region has an overall IRSD of 985.4, with scores by Local Government Area ranging from the most disadvantaged at 854.0 (City of Playford) and 918.0 (City of Salisbury) to 1072 (Town of Walkerville) and 1081 (City of Burnside) (ABS 2017a).

In South Australia, the correlation between higher levels of disadvantage leading to poorer health outcomes are demonstrated through data collected in the South Australian Population Health Survey (Wellbeing SA 2020). For example, SEIFA areas of low and lowest scores, correlate to higher proportions of children with diagnosed heart disease and/or stroke, reported asthma and reported mental health conditions. In adults, low income (\$40,000 and below) is correlated with higher reported use of mental health services, reported mental health conditions, high or very high psychological

distress, higher rates of food insecurity in the last 12 months and reported rates of chronic disease (diabetes, asthma, COPD, CVD, arthritis and cancer) (Wellbeing SA 2020).

As reported throughout this chapter there is a clear association between socioeconomic status of an area and service use. To reiterate, within the Adelaide PHN regions of lower SES have:

- Higher rates of modifiable risk factors including smoking, physical inactivity, obesity, high blood pressure
- Higher rates of smoking during pregnancy and lower rates of participation in antenatal care
- Higher prevalence of chronic conditions including mental health, diabetes, cardiovascular and respiratory conditions, and co-morbidities,
- Higher rates of hospitalisations and higher rates of mortality from diabetes, cardiovascular and respiratory conditions and cancer
- Lower rates of participation in bowel, breast and cervical cancer screening
- Lower rates of COVID-19 vaccination uptake
- Higher rates of Medicare-subsidised GP services
- Lower rates of Medicare-subsidised allied health services and Medicare-subsidised mental health-related services provided by a psychologist or psychiatrist, and
- Higher use of after-hours health services including GP services, after-hours HealthDirect helpline and emergency departments for lower urgency care.

Additional considerations for low SES communities highlighted by stakeholder consultations include: cost of immunisation, screening and healthcare is a barrier to accessing services, and the fact that preventative health is not a priority for people that are barely surviving financially (APHN 2022b).

### Hotspots of Hospitalisation

'Hotspots' are small areas with a consistent, and comparatively high rate of hospitalisation for a particular health problem compared to the larger region. Areas were identified as hotspots if they were sufficiently and persistently hot (a rate of at least 50% above the state average for a specified number of years) and therefore considered likely to stay hot. Within the Adelaide PHN, areas of low SES have had persistently high rates of hospitalisation, more than any other in the region, specifically the SA2s of Elizabeth, Smithfield - Elizabeth North, Christie Downs, Davoren Park, Salisbury North, Salisbury, Port Adelaide, and Hackham - Onkaparinga Hills (DHW 2020). For example, between 2004 to 2018:

- Elizabeth SA2 hotspot persisted for all 15 years;
- Davoren Park, Christie Downs, Hackham West - Huntfield Heights SA2s were hot for 13 years;
- Smithfield - Elizabeth North was hot for 11 years (DHW 2020).

By broad condition category:

- Elizabeth, Smithfield - Elizabeth North SA2s qualified as a hotspot for acute, chronic and vaccine-preventable conditions.
- Davoren Park, Salisbury, Salisbury North, Christie Downs and Port Adelaide qualified as a hotspot for chronic and vaccine-preventable conditions.
- The greatest need in terms of PPA conditions occurs in the SA2s of Elizabeth, Smithfield - Elizabeth North, Christie Downs, Davoren Park, Salisbury North, Salisbury, Port Adelaide, and Hackham - Onkaparinga Hills (DHW 2020).

### People at risk of/or experiencing homelessness

Persons experiencing homelessness or who are at risk of homelessness are particularly vulnerable and often have complex health, social and financial needs. Homelessness has been shown to be associated with health inequalities such as shorter life expectancy, higher morbidity, and increased use of acute care services, with the social determinants of homelessness often exacerbating poor health (Stafford and Wood 2017).

Based on the *2016 Census of Population and Housing: Estimating Homelessness* report, there were 5,831 homeless persons in South Australia. Based on Statistical Area 3 level data, Adelaide had the highest number of homeless persons (562, 10%), followed by Salisbury (539, 9%) and Onkaparinga (444, 7%)(ABS 2019b).

The Zero Project, which tracks active homelessness in the inner city of Adelaide, reported that on June 30<sup>th</sup>, 2022 there were 279 people who were classed as 'actively homeless', meaning they were sleeping rough, temporarily sheltered or had an unknown address. This is up from 249 on May 31, 2022 (SAAEH 2022).

In March 2022, 204 males and 224 females aged 55 years and older were homeless in South Australia. In March 2022 alone, 8,233 nights of short term/emergency accommodation were provided to 458 SHS clients and 81 SHS clients received financial assistance for short term/emergency accommodation (AIHW 2022j).

In the study undertaken by Hill et al. (2021) which examined the wellbeing of LGBTIQ+ young people in South Australia, it was reported that:

- 23.0% of participants experienced one or more forms of homelessness in their lifetime, including 11.0% in the last 12 months.
- 17.2% of participants had run away from home or the place they lived at some point in their lives, and over one-tenth (11.3%) had ever left home or the place they live because they were asked or made to leave
- 26.9% of participants reported that their experience/s of homelessness were related to being LGBTIQ+.

### 3.6.5 Impact of COVID-19

Since COVID-19 identification in December 2019, it has had a devastating effect on communities around the world. Health systems have been forced to make rapid choices about how to prioritise care, manage infection control and maintain reserve capacity for future disease outbreaks. The interruption of normal patterns of health care and the suspension of services has meant that the pandemic has also had a major impact on the detection and treatment of many non-COVID-19 conditions including chronic conditions which impacted the region's population health.

In the initial response to COVID-19, the Australian Government responded by supporting the MBS telehealth arrangements, COVID pathology testing, electronic prescribing, the national network of general practice respiratory clinics and a range of other measures. Adelaide PHN will continue to support local GPs, general practice staff, pharmacy, and other primary health care providers working on the frontline across Adelaide to support the COVID-19 response to protect population health.

The AIHW has summarised a list of events that may have impacted on service use over the period March 2020 to September 2021 across Australia (AIHW 2022ai). These events and dates include:

- March 2020 – national lockdown introduced
- June 2020 – second wave of COVID-19 cases in Victoria
- August 2020 – Lockdown in Victoria
- October 2020 – Victorian lockdown eased
- December 2020 – outbreak of cases in Sydney's Northern Beaches



- January to March 2021 – brief snap lockdowns in some states and territories to contain COVID-19 spread
- July to October 2021 – a series of extensive lockdowns and/or extended lockdowns in New South Wales, Victoria, and Australian Capital Territory.

Although there isn't PHN level data on the effects of COVID-19, where possible data at the national and state level is presented at this time.

### ***Impact on mortality***

In Australia in 2020, there were 3.5 per 100,000 deaths due to COVID-19 (ABS 2022b), with the COVID-19 death rate 2.5 times as high for people born overseas as those born in Australia. A recent AIHW report highlighted the differences in death rates during the Delta and Omicron waves of COVID-19 (AIHW 2022k). It was reported that during the Delta wave, Australians born overseas had a rate of death close to 4 times higher than that of people born in Australia, with rates particularly high for those born in the Middle East, North Africa and South-Eastern Europe. During the Omicron wave, the inequality decreased and since July 2022 the death rate of those born in Australia has been higher than those born overseas (AIHW 2022k).

In addition, during all waves of COVID-19, mortality rates have been higher amongst people from areas of greatest disadvantage, with the highest proportion during the Delta wave at around 40 per cent. This proportion has fallen to around 30 per cent during the Omicron wave (AIHW 2022k).

### ***Impact on cancer screening participation***

It has been noted by the Royal Australian College of General Practice (RACGP), that COVID-19 had an impact on all three of the national cancer screening programs (RACGP 2022a). In April 2020, approximately 1,100 screening mammograms were done compared to 74,000 in April 2018. National data reports that overall, 137,000 fewer mammograms were performed in 2020 compared to 2019. For cervical cancer, national screening rates dropped by 67% in April 2020 and there was also a drop in national bowel cancer screening whereby 1.375 million test kits were returned in 2019, and only 1.288 million kits were returned in 2020 (RACGP 2022a).

### ***Impact on spread of vaccine-preventable conditions***

In South Australia, there were 11,678 notifications of laboratory confirmed influenza in 2022 (as at 12 November 2022), significantly higher than the previous two years (40 notifications for 2021 and 1,583 notifications in 2020) but lower than the pre-COVID-19 notifications of 27,093 in 2019 (SA Health 2022).

### ***Impact on health behaviours***

The AIHW has reported that for the period April to June 2020, similar proportions of people had increased as had decreased exercise and other physical activity (AIHW 2022l). In addition, of those adults who usually drank alcohol, 20% had increased their consumption compared with before COVID-19 restrictions. Different data sources showed that between 13% and 27% had decreased consumption (AIHW 2022l).

### ***Impact on chronic condition monitoring and diagnosis***

As a major provider of pathology services, Clinicalabs have noted that the impact of Australia's COVID-19 lockdowns had an impact on critical health diagnoses (ACL 2022). It was noted that in addition to cancer diagnoses, COVID-19 impacted cancer, diabetes and cholesterol testing, diagnosis and management (ACL 2022). Clinicalabs estimated that there was a downturn in the volume of test for diabetes and cholesterol, partly due to people being locked down or reluctant to visit their doctors. In addition, there may have been some patients that requisitions for routine tests, including diabetes and cholesterol, but were reluctant to attend collection centres during outbreaks (ACL 2022).

Clinical labs estimated the number of unperformed tests returning an abnormal result and translated it to the number of people who would therefore be undiagnosed. In South Australia, this translated to 661 for HBA1c, 2,138 glucose and 297 for cholesterol (ACL 2022).

In South Australia, it was reported that there was a 9.5% percentage downturn in malignancy diagnosis. This could have then potential delayed diagnosis and therefore the treatment of these cancers, resulting in their progression to a later stage, associated with increased morbidity and mortality rates (ACL 2022).

### ***Impact on the primary care workforce and primary care services***

In their 2022 *General Practice: Health of the Nation* report, the RACGP reiterated that GP's are under extreme pressure in their roles, and that pressure has been exacerbated by COVID-19 (RACGP 2022b). Long term challenges for the health system and the health care workforce include deferral of care, workforce burnout and long COVID (Hensher et al. 2021).

The 2022 Adelaide PHN community consultation with stakeholders, also reaffirmed the impact of COVID-19 on workforce. Practitioner burnout, the shortage of GPs, and the inability for patients to get into see GP's, particularly by the elderly were highlighted as issues exacerbated by COVID-19. Additionally, delays in referrals to specialists, the inability for some patients to access/utilize telehealth and the increased access challenges experienced by CALD and LGBTIQA+ communities (APHN 2022b).

The AIHW has noted that COVID-19 has changed the way primary care services are delivered (AIHW 2022a). During the height of the pandemic, there was a need to adapt and increase the use of alternatives to face to face care. In their web article titled "General practice, allied health and other primary care services", the AIHW states that after the introduction of telehealth Medicare-subsidised items in March 2020 in response to the pandemic, more than one-third (36%) of GP services were delivered via telephone or video-conference in April 2020, up from 8.0% in March 2020 (AIHW 2022a). In addition, as at 22 March 2022, 63% of COVID-19 vaccine doses in Australia were administered in primary care settings (AIHW 2022a).

### ***Impact on family, domestic and sexual violence***

Family, domestic and sexual violence is a major health and welfare issue in Australia and can have lifelong impacts on victims and perpetrators. It can affect people of all ages and backgrounds, but predominantly affects women and children (AIHW 2021q).

While lockdowns and restrictions were necessary to contain the pandemic, leaders in the domestic family violence (DFV) sector expressed concerns early during 2020 that these lockdowns would lead to the escalation of domestic and family violence (Carrington et al. 2021).

A national survey of service providers from the DFV sector, including 1507 qualitative responses, confirmed the concerns raised early in the COVID-19 pandemic about the profound effects on increasing women's risk and vulnerability to domestic violence, while at the same time, making it more difficult for women to leave violent relationships, to report violence and access support (Carrington et al. 2021).

Nationally, a survey of more than 10,000 women aged 18 and over found that around 1 in 10 (9.6%) women had experienced physical violence from their partner since the beginning of the COVID-19 pandemic (AIHW 2021q). It has also been stated that one in 4 women (26%) who had experienced physical or sexual violence in the 12 months since the start of the pandemic said they had been unable to seek assistance on at least one occasion due to safety concerns (AIHW 2021q).

In South Australia, the SA Police Force reports (to September 2022) that the number of family and domestic abuse (related to the person) offences known or becoming known to police in the pre-COVID rolling year were 8,060, while in the current rolling year the number is 10,160, an increase of 26% (SAPOL 2022).

### ***Impact on Gay and Bisexual Men's HIV-Related Behaviour***

In 2020, there were 708 participants in the Adelaide Gay Community Periodic Survey (Broady et al. 2020). Of those, 51.4% reported that COVID-19 had reduced the number of male sex partners they had had in the six months prior to the survey (Broady et al. 2020). Behavioural surveillance data of gay and bisexual men (GBM) in Australia was collected across five states from July 2017–June 2021. When adapted to assess the impact of participants' HIV behaviour during COVID-19, it was noted that the number of male partners, recent HIV testing and pre-exposure prophylaxis (PrEP) use all fell, and HIV risk among the smaller group of participants who reported casual sex increased (Holt et al. 2022). In addition, COVID-related changes were generally more pronounced among GBM aged under 25 years, participants from suburbs with fewer gay residents, and bisexual men (Holt et al. 2022).

### ***Impact on employment, school and childcare***

The ABS has undertaken a number of surveys in order to provide insights into the household impact of COVID-19. Data is being collected on COVID-19 and cold/flu symptoms, COVID-19 testing, and the impacts of COVID-19 and cold/flu on employment, school, or childcare attendance. The survey asked households with children aged under 18 whether a child experienced any impacts on school or childcare attendance due to a cold or flu in the past four weeks. In September 2022, one in five households with children (21%) reported that school or childcare attendance was impacted by a cold or flu (similar to 22% in August 2022). The survey asked employed Australians how their main job would be impacted if they contracted COVID-19. The most common responses in September 2022 included:

- not being allowed to work until well enough (60%), down from August 2022 (67%)
- being required to work from home if well enough (18%), similar to 15% in August 2022
- working from home if well enough (26%), consistent with August 2022 (23%)
- would be required to return to the workplace if asymptomatic (8%) up from 4% in August 2022 (AIHW 2022I).

### ***Impact on long-term health conditions - Long COVID***

Long COVID or Post COVID-19 Syndrome, is defined by SA Health as “the ongoing physical, mental, emotional and cognitive symptoms that a person may continue to experience for more than 12 weeks after testing positive”. For patients with symptoms lasting between 4 weeks to 12 weeks since COVID-19 diagnosis, this is termed “Ongoing symptomatic COVID-19” (CALHN 2022b). In South Australia, long COVID clinics have been established at the Royal Adelaide Hospital, The Queen Elizabeth Hospital and Flinders Medical Centre. The Women's and Children's Hospital will also provide a specialist service for children with Long COVID symptoms through its outpatients clinics. South Australians require a GP assessment and referral to access the long COVID clinics (CALHN 2022b).

### 3.7 Opportunities and priorities – Population Health

Table 3 summarises the priorities arising from the analysis of population health needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. Eight new priorities were identified for Population Health, replacing the previous priorities from 2021.

**Table 3 Population Health Priority Statements for the Adelaide PHN, 2022**

Priority	Priority area	Priority sub-category	Expected Outcome
Families, children and young people can access timely early intervention, prevention and support services	<i>Population Health</i>	<i>Other – Children and families</i>	Improved health outcomes for people in the Adelaide PHN
People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	<i>Population Health</i>	<i>Chronic conditions</i>	Fewer preventable hospitalisations in the Adelaide PHN for people with chronic and complex conditions
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access timely, culturally safe and appropriate primary health care services	<i>Population Health</i>	<i>Appropriate care (including cultural safety)</i>	People in the Adelaide PHN region can receive timely, coordinated, culturally appropriate services from local health providers
Integration, coordination and partnerships between primary and acute care supports continuity of care and improved health outcomes	<i>Population Health</i>	<i>Continuity of care</i>	Improved health outcomes for people in the Adelaide PHN region
LGBTIQA+ communities can access timely, culturally safe and appropriate primary health care services	<i>Population Health</i>	<i>Appropriate care (including cultural safety)</i>	People in the Adelaide PHN region can receive coordinated, culturally appropriate services from local health providers
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	<i>Population Health</i>	<i>Access</i>	People in the Adelaide PHN region can access general practices and other services as appropriate
People in the Adelaide PHN region have awareness of, and timely access to preventative and early intervention services	<i>Population Health</i>	<i>Early intervention and prevention</i>	Improved health outcomes for people in the Adelaide PHN region
People living with a disability can access safe, inclusive and appropriate health care services	<i>Population Health</i>	<i>Appropriate care (including cultural safety)</i>	People in the Adelaide PHN region can access general practices and other services as appropriate

## 4 Aboriginal and Torres Strait Islander Health

Below is a summary of findings from the *Aboriginal and Torres Strait Islander Health Needs Assessment for the Adelaide Primary Health Network* (Hossain et al. 2022), produced by The Public Health Discipline Group, College of Medicine and Public Health, Flinders University on behalf of Adelaide PHN.

The full report is available on our website: [Needs Assessment - Adelaide PHN](#)

### 4.1 Summary

#### 4.1.1 Population

In South Australia, 2.4% of the population (43,000 people) identified as Aboriginal and/or Torres Strait Islander in the 2021 Census. Of these figures, 95.4% identified as Aboriginal and 2.3% as Torres Strait Islander (ABS 2022a).

The proportion of those identifying as Aboriginal and/or Torres Strait Islander in South Australia has grown from 2.0% in 2016, and 1.9% in 2011 (ABS 2022a). This increase in identification is thought to be multifactorial; through families impacted by colonial policies discovering and reconnecting, through to families and individuals feeling safer to identify.

In the 2021 Census, Adelaide North (SA4) reported the largest number (11,400) and largest proportion (2.5%) of Aboriginal and Torres Strait Islander people. While Adelaide South (SA4) reported 5,386 Aboriginal and Torres Strait Islander people and the second greatest number, it was the third biggest proportion (1.4%) of total population in the PHN region. Adelaide West (SA4) had the second highest proportion (1.9%) of the regional population. Adelaide Central and Hills (SA4) region has the lowest count and proportion (0.8%) of Aboriginal and Torres Strait Islander people. (ABS 2022a).

The area with the greatest proportion of Aboriginal and Torres Strait Islander people, Adelaide North, has the youngest age structure with median age being 22 (54.4% of the total population is 24 or younger) (ABS 2022a). This is followed by Adelaide South with the median age being 22, and 54.1% of the population being 24 or younger (ABS 2022a). The median age of Aboriginal and Torres Strait Islander people in Adelaide West was 25 with 48.3% being 24 or younger. In Adelaide Central and Hills the median age was 26 (ABS 2022a).

#### 4.1.2 Multiple Dimensions of Life

Health and wellbeing is a balance and harmony between 'mind, body, spirit and nature' for Aboriginal and Torres Strait Islander individuals (Milroy 2008). These dimensions, the balance and harmony they require are described eloquently through the work of Professor Helen Milroy, a Palyku child and adolescent psychiatrist (Milroy 2006). Each single dimension is multilayered, intricate, and interconnected. The cultural determinants of health and wellbeing for Aboriginal and Torres Strait Islander people interact across these dimensions acting as protective factors for balance and harmony, whereas ongoing colonisation, racism and whiteness threatens the integrity of these dimensions. In this next section data has been drawn to highlight these dimensions in the Adelaide PHN area.

#### *Physical Dimension*

Connection to country and kin is essential in providing Aboriginal and Torres Strait Islander individuals with strength, ground and protection for their identity. Over 60% of Aboriginal and Torres Strait Islander people identify with a clan or language group, with around 76% of respondents recognising their homelands, which is greater than the national average of 74% (Milroy 2006). In addition, approximately 55% of South Australian respondents are able to visit their homelands or

traditional lands, which is greater than the national average for Aboriginal and Torres Strait Islander peoples. However, we find that less Aboriginal and Torres Strait Islander people in South Australia live on their homelands or traditional lands, which is reflective of ongoing colonisation impacts in South Australia on Aboriginal and Torres Strait Islander peoples.

### ***Psychological Dimension***

This dimension relates to the interconnectedness of kinship relationships, connection, obligations, responsibilities and reciprocity all in the context on one's culture and identity (Milroy 2006). Central to this is connection to knowledge holders and teachers – Elders, senior community representatives and kin. This is critically important for children over their life course for identity development, approximately 44% of Aboriginal children reported spending time with an Aboriginal Elder or senior community representative in the past week, 96% of Aboriginal children had participated in informal learning and teaching activities with their main carer (AIHW 2020d).

Strong family connection and cohesion was evident with over 90% of Aboriginal and Torres Strait Islander people in SA reporting contact with family and friends weekly, 90% having a say on family business and 82% of the Aboriginal and Torres Strait Islander people reported feeling they were able to confide in someone outside of the household. However, only 57% of Aboriginal and Torres Strait Islander people in SA reported being able to attend a cultural event in the last 12 months, which was below the national average (AIHW 2020d).

Feeling safe, culturally and emotionally secure and not being a victim of physical or threatened violence in the last 12 months was reported in 65% of Aboriginal and Torres Strait Islander respondents in South Australia and was below the national average, over 75% of respondents were not exposed to actions of this nature in the last 12 months (AIHW 2020d).

### ***Social Dimension***

Family encompasses vast kinship networks, which are essential for identity development and passing of knowledge (Milroy 2006). Beyond the individual the social dimension is essential for community cohesion and business. Reporting for Aboriginal and Torres Strait Islander families and household composition currently fails to encompass these important networks and is a short coming. Feedback from the Aboriginal and Torres Strait Islander Community Advisory Council for Adelaide PHN (the Council) in this area identified that there was no recognition of true family structure, in recognising the role of extended family and the pivotal role that grandparents play in caring for children.

In Adelaide there was variability in households where at least 1 person identified as Aboriginal and/or Torres Strait Islander. One family households, consisting of one parent were the most common household type (Adelaide North: 31.9%, Adelaide South 27.4%, Adelaide West 26.8%, Adelaide Central and Hills 24.7%), followed by one family households with a couple and children (Adelaide North: 27.4%, Adelaide South 27.7%, Adelaide West 22.0%, Adelaide Central and Hills 24.7%). Other households were also common, where other included three or more family household, lone person, group, visitor only, or household with only persons under 15 years (ABS 2022a).

### ***Cultural Dimension***

Culture includes connection and identity, in the 2021 census ancestry data was collected, the most common self-report Ancestry by Aboriginal and Torres Strait Islander. This information contains pertinent information on how Aboriginal and Torres Strait Islander respondents classify their Ancestry and consider their identity. The predominant Ancestry response was Aboriginal across all regions. Torres Strait Islander Ancestry included: South Australia 3.1%, Adelaide West 4.2%, Adelaide South – not reported (small numbers), Adelaide North 3.4%, Adelaide Central and Hills 5.4% (ABS 2022a). Culture is grounded in country, where connection, identity and healing come from (Milroy 2006). The ability to engage and practice culture is central to health and wellbeing of the whole community. Language use in households is an example of connecting and practicing culture in this



dimension, it was reported to be steadily decreasing over 1991-2016. While English is the most reported language used in Aboriginal and Torres Strait Islander households in Adelaide and reflective of colonisation in Australia, 10.1% of households report Indigenous language use at home with 5.2% of households reporting Pitjantjatjara use (ABS 2022a).

### ***Spiritual Dimension***

Aboriginal people are spiritual beings, part of the oldest continuing civilisations, where knowing, doing and being plays a central role in spirituality (AIHW 2021h; PC 2022). Central to this dimension is Indigenous knowledges (knowing, being and doing), and encompasses dreaming teachings and ceremony, belonging, connectivity, beliefs and holistic healing as connected to country. Ongoing colonisation has acted to create spiritual genocide, which has impacted all Aboriginal and Torres Strait Islander families in the Adelaide PHN region. What has ensued in this process, through the resilience of Aboriginal and Torres Strait Islander peoples is a multi-dimensionality to spirituality and identity for some individuals, in part through interaction with other cultures and knowledge systems, through religion or health and healing. It is noted that there was limited reporting for this dimension across data sources. Feedback from community consultations with the Council reported a lack on emphasis of recovery and good news stories in this area.

*“Holistic services guided by the social determinants of health ... desire to seek alternate ways of treating people / alternative medications / practices”.*

### **4.1.3 Health needs analysis**

#### ***Mental health***

The most reported long-term condition by the Aboriginal and Torres Strait Islander people living in South Australia was mental health conditions (ABS 2022a).

- mental health condition (17%) was more commonly reported by women (women vs men: 17.3% vs 11.6%),
- Asthma (17%) was more commonly reported by women (women vs men: 17% vs 11%).

In South Australia 36% of Aboriginal and Torres Strait Islander people felt high levels of psychological distress regardless of remoteness. Psychological distress experienced by Aboriginal and Torres Strait Islander people living in non-remote South Australia was higher than the national average of all Aboriginal and Torres Strait Islander Australians (36.4% vs 32.0). Psychological distress reported by South Australian Aboriginal and Torres Strait Islander people increased from 30.2% in 2004-05 to 37.1% in 2018-19 (AIHW 2022m).

Aboriginal and Torres Strait Islander people living in South Australia were less likely to access community mental health care services as compared to those nationally (2017-18: 1041.2 per 1000 vs 1150.6 per 1000) but more likely to be hospitalised for mental health related conditions (2016-17: 46.1 per 1000 vs 32.2 per 1000) (AIHW 2020e).

Aboriginal and Torres Strait Islander Australians had a higher risk of suicide. In 2015-19, 5.5% of all deaths in Aboriginal and Torres Strait Islander communities were reported as suicide while a further 3.7% were reportedly due to mental health related conditions. Compared to 1.9% for non-indigenous people. More than half of suicide related deaths in South Australian Aboriginal and Torres Strait Islander communities occur in the age group of 35 to 44 years (AIHW 2022n).

Feedback from the Council around mental health outcomes in the Adelaide PHN region provided insights for ways forward in the future (Hossain et al. 2022):

- co-design of community mental health programs targeting holistic health and healing, increases in Aboriginal Liaison Officers or Health Workers with targeted training, access to 24-hour care and walk in services

- peer support programs and structures
- “Shame is the biggest thing holding people back.”
- a need for services specifically Aboriginal men
- programs and works for LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual) in the Aboriginal and Torres Strait Islander community
- patient centred approaches to care across networks
- training and awareness for families
- “There are increases in suicides affecting the community. Need education for family around how to identify early signs or what to look out for, along with education around coping mechanisms.”

### ***Indigenous Health Check***

Only 21% of Aboriginal and Torres Strait Islander people in Adelaide have received at least one Indigenous health check in the last financial year, with Onkaparinga area remaining proportionality lower than other regions at 11% compared to Adelaide city 24.9% and Playford 32.2% (AIHW 2022o).

The Indigenous Health Check for ages 0 to 4 was designed for Aboriginal and Torres Strait Islander children to provide an appropriate and needs-suited preventive healthcare check in various social and cultural determinants health improvement. Data from Indigenous Health Check rate shows that less than 1 in 4 Aboriginal and Torres Strait Islander children in Adelaide PHN underwent a health check either in-person or by telephone in 2020-21 (AIHW 2022o).

Feedback from the Council indicated a need for more education and understanding that 715 can be accessed through mainstream health services. But also identified that the overall cultural safety of Indigenous Health Checks and services providing it was of significant concern for Aboriginal and Torres Strait Islander individuals and families, along with education and awareness of the checks. (Hossain et al. 2022):

### ***Dental***

Aboriginal and Torres Strait Islander children in SA aged 4 and under are at twice the risk of being hospitalised for dental issues compared to those nationally (13.8% vs 6.2%), and these children continue to be at a higher risk of hospitalisation due to dental problems until 15 years of age (9.2% vs 6.1%) (AIHW 2022p).

Community consultations with the Council identified that dental care was a huge concern in the Adelaide PHN. Specifically out-of-pocket expenditure for dental access was noted as a barrier as there was no financial assistance for gap payments and wait lists to access dental care are exorbitant. The Council also commented on the importance of access to good oral care and hygiene, especially for early intervention and prevention as it can impact on so many areas of life i.e., surgical interventions (Hossain et al. 2022):

### ***Cancer***

In South Australia, Aboriginal and Torres Strait Islander women in every age group have a lower BreastScreen participation rate compared to other Aboriginal and Torres Strait Islander women across Australia (AIHW 2022q).

Access to BreastScreen services for Aboriginal and Torres Strait Islander women is a national policy feature of BreastScreen Australia. Co-designed programs with Elders and Senior community representatives have been recommended to increase these BreastScreen participation rates (AIHW 2022q).



## ***Diabetes***

South Australian was the third highest (20.2%) for the prevalence of Diabetes for Aboriginal and Torres Strait Islander people, after Western Australia (24.0%) and Northern Territory (21.8%) (AIHW 2022r).

## ***Rheumatic fever and rheumatic heart disease***

Aboriginal and Torres Strait Islander Australians had a disproportionately higher representation (87%) in the total numbers of individuals with rheumatic heart disease (RHD) in QLD, WA, SA and NT, with 17 out of 20 cases of RHD being an Aboriginal and Torres Strait Islander person (AIHW 2022s).

In non-remote South Australia, between 2015 and 2017, there were a total of 28 hospitalisations due to acute rheumatic fever or chronic rheumatic heart disease. Recent progression studies on RHD, have found death or non-fatal complications occur in around one-fifth of uncomplicated cases for patients <35 years (AIHW 2022s).

Internationally RHD is a recognised indicator for socioeconomic deprivation, impacted frequent streptococcal bacterial infections (throat or skin) and inadequate access to healthcare, even in high income countries this condition impacts the most marginalised. This is a treatable condition through administration of antibiotics and monitoring to stop progressions, community co-designed initiatives are needed to strengthen, and tailor make community specific approaches to combat RHD (Hossain et al. 2022).

## ***Transgenerational trauma and grief***

Discussion with the Council identified that service delivery and access for transgenerational trauma and grief was an ongoing issue, while mainstream services are available for access they do not identify with the specific nature and cause of trauma and grief from a cultural perspective. Specific training on narrative/yarning approaches to care, along with cultural hubs for support were suggested to improve access and support (Hossain et al. 2022).

## ***Pregnancy and antenatal care***

2.6% of SA Aboriginal and Torres Strait Islander women did not receive any antenatal care compared to 0.8% Aboriginal and Torres Strait Islander women nationally and 0.2% non-Indigenous women in SA (AIHW 2021i).

These outcomes are consistent with other reports where Aboriginal women have a lower rate of accessing antenatal care and reported feeling disenfranchised, abandoned, and judged while pregnant and accessing care (Hossain et al. 2022).

These outcomes have been further supported through the Council, with transgenerational trauma and grief still impacting significantly on pregnant Aboriginal and Torres Strait Islander women in the Adelaide PHN, and fear of the 'System' (Child Protection Service) (Hossain et al. 2022).

Approaches to improving antenatal care attendance in South Australia have included culturally specific care through Aboriginal Family Birthing Programs. (Brown et al. 2016). Additionally increased employment of Aboriginal Maternal Infant Care (AMIC) workers in health services. Community co-designed programs which centralise the role of AMIC workers to target areas of importance for antenatal care (i.e. smoking during, nutrition access to antenatal care) are needed to improve birth outcomes for Aboriginal and Torres Strait Islander communities (AIHW 2022t).

More than half (51.2%) of all Aboriginal and Torres Strait Islander women in South Australia smoked in the first 20 weeks of their pregnancy, and 41.5% of these women continued smoking after 20 weeks of pregnancy. (AIHW 2022u) In SA Aboriginal and Torres Strait Islander women had a higher rate of smoking during pregnancy when compared to those nationally (51.8% vs 44.3%) (AIHW 2022u).

A range of state specific community co-designed programs have been developed such as SISTAQUIT, which could be tailored to a SA context. This would require community leadership, co-design and support (Hossain et al. 2022).

#### 4.1.4 Service analysis

##### *Workforce, cultural safety and trauma-informed service provision*

Increasing the number of Aboriginal and Torres Strait Islander people working in health is key to providing culturally safe and responsive health services. There is developing work in this area. For example, Central Adelaide Local Health Network (CALHN) has a strategic plan toward employment and retention of Aboriginal workforce to improve the Aboriginal health, across the tertiary education sector there are dedicated pathways and support programs for Aboriginal and Torres Strait Islander students. The plan is with the intention to build a culturally-strong and sustainable workforce, and to demonstrate the commitment to work together, in sharing Aboriginal culture, knowledge and values (CALHN 2022a).

While increasing Aboriginal workforce is essential, non-Indigenous workers and services need to provide culturally safe and responsive services. Community consultations with the Council identified the cultural safety of both health providers and health professionals as a key area for improvement:

- “Cultural awareness training – mandatory for all General Practitioners on a yearly basis, including measures” (Hossain et al. 2022):

Presently the Royal Australian College of General Practitioners provides cultural awareness and cultural safety training, for their Continuing Professional Development (CPD), but this training is not mandatory or contextualised for the local Aboriginal and Torres Strait Islander setting in which a health professional may be working. This format is also described as the ‘sheep dip’ approach to Cultural Safety and there is little evidence in demonstrating that this training shifts the way in which health professionals practice their care to improve health and wellbeing outcomes for Aboriginal and Torres Strait Islander communities (Ryder et al. 2019).

Trauma informed service and care is a priority for Aboriginal and Torres Strait Islander community in the Adelaide PHN and this needs to be provided using a decolonisation processes (Hossain et al. 2022).

*“Trauma is not being addressed and it is manifesting in poor health outcomes for our people.”*

## 4.2 Opportunities and priorities – Aboriginal Health

Table 4 summarises the priorities arising from the analysis of Aboriginal health needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. Six new priorities were identified for Aboriginal Health, replacing the previous priorities from 2021.

**Table 4 Aboriginal Health Priority Statements for the Adelaide PHN, 2022**

Priority	Priority area	Priority sub-category	Expected Outcome
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate workforce and primary health care services	<i>Aboriginal and Torres Strait Islander Health</i>	<i>Safety and quality of care</i>	Aboriginal and Torres Strait Islander people are able to access primary health care services as required
Aboriginal and Torres Strait Islander people can access trans-generational trauma and grief counselling services and narrative therapies for suicide prevention and mental health	<i>Aboriginal and Torres Strait Islander Health</i>	<i>Appropriate Care</i>	Aboriginal and Torres Strait Islander people are able to access counselling support in a culturally safe environment as required
Aboriginal and Torres Strait Islander people can access timely, culturally safe and appropriate primary mental health care services	<i>Aboriginal and Torres Strait Islander Health</i>	<i>Mental Health</i>	Aboriginal and Torres Strait Islander people are able to access primary health care services as required
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate services for chronic conditions management and early interventions	<i>Aboriginal and Torres Strait Islander Health</i>	<i>Chronic conditions</i>	Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care
Aboriginal and Torres Strait Islander people can access culturally safe information and access to Breast, Cervix and Bowel cancer screening services	<i>Aboriginal and Torres Strait Islander Health</i>	<i>Early intervention and prevention</i>	PHNs address needs of Aboriginal and Torres Strait Islander people in their region
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate AOD treatment services	<i>Aboriginal and Torres Strait Islander Health</i>	<i>Other – Alcohol and other drugs</i>	Aboriginal and Torres Strait Islander people are able to access primary health care services as required

## 5 Older People and Aged Care

*Older Australians are a diverse group, with different ages, socioeconomic backgrounds, life experiences and lifestyles. These factors all influence the ageing process and affect health and wellbeing (AIHW 2021d).*

*Older people refers to those over 65 years of age, and aged care is the support provided to older people in their own home or in an aged care (nursing) home.*

*People's experience of getting older will be varied and diverse. While many older Australians may feel they are in one of the best periods of their life, for others, particularly those with health or financial challenges, getting older is much less satisfying (Council on the Ageing (COTA) 2021)*

### 5.1 Demographic Profile

In Australia, if present trends continue, 25% of Australians will be over the age of 65 by 2050. South Australia has one of the largest populations of older people in Australia and that number is expected to continue to increase. In 2016, 205,775 people aged 65 years and over lived in Adelaide PHN. Population estimates for the region indicate that by 2025 almost 249,000 people aged 65 years and over will be living in the region, increasing to 274,000 by 2030, 20% of the region's total population (PHIDU 2021a). By 2030, estimates indicated that approximately 39,300 people aged 85 years and over will be living in the region (PHIDU 2021a).

The *Social Health Atlas of Older People in Australia* produced by the Public Health Information Development Unit (PHIDU 2020a) provides the following demographic snapshot of older people living in the Adelaide PHN:

#### Cultural Diversity

In 2016, there were 759 Aboriginal and Torres Strait Islander people aged 65 years and over living in the region, and 2,948 aged 50 years and over.

Almost 44,000 people, or one in every five people (21%) aged 65 years and older living in the Adelaide PHN region was born in a predominately non-English speaking country, and of these people 11,330 report that they have poor proficiency in spoken English. As identified in the 2016 Census, the top five countries of origin for people aged 65 years and over born in predominately non-English speaking countries were Italy, Greece, Germany Netherlands, and Vietnam.

#### Income and living arrangements

Almost two-thirds (63%) or 144,000 older people living in the Adelaide PHN region receive the aged pension, 47% of older people in the region are considered to have low income, and 18,600 older people (8%) are Seniors Health Card holders.

In 2016, 26% of people aged 65 and over lived alone, increasing to 35% of people 85 year and over.

#### Disability and caring

Modelled estimates from 2015 suggest that over 74,000 older people living in the Adelaide PHN region needed regular assistance with self-care, mobility and/or communication, and of whom 8,500 had unmet formal care needs. Approximately 38,400 older people living in the region had a profound or severe disability, the majority (73%) of who live in the community and not in supportive accommodation. One out of 10 older people in the region provide unpaid assistance to a person with a disability.

## 5.2 Health Profile

### 5.2.1 Health Status

To help ground some of the anecdotal trends about perceptions of ageing, the Local Government Association (SA) commissioned a large random survey of people born between 1946 and 1964 and living in South Australia. Most of these respondents rate their current health as 'good' or 'very good', but almost 50% reported living with a health condition or disability that impacted on their wellbeing (UPRS for the Local Government Association of SA (LGA) 2015).

At a national level, the proportion of adults who reported excellent, very good or good health declined with increasing age, 78% of people aged 65-74 years to 66% of people aged 85 years and over (ABS 2020b). A South Australian survey of older people found that 92% of survey respondents selected health and wellbeing as an important aspect of growing older. The results also indicated a decline in self-rated health with age, with approximately 40% of those aged 70-79 years, and more than 50% of those aged over 80 years rated their health as fair or poor. The health issues that most affected daily activities were vision (22%) and mobility (19%) (OFTA 2014).

In 2017, approximately half of all South Australian males (54%) and females (53%) aged 75 years and over were living with two or more of the following health risk factors: high blood pressure, high cholesterol, physical inactivity, 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 risks factors (HPCSA 2018).

### 5.2.2 Chronic Conditions

Chronic conditions are the leading cause of illness, disability, and death in Australia. Tackling chronic conditions and their causes is the biggest challenge facing Australia's health system. Along with our ageing population, increasing consumer expectations and the high cost of pharmaceuticals and treatments, ever-increasing rates of chronic conditions are putting unprecedented strains upon individuals, communities, and the health system. Over the past 40 years, the burden of disease in Australia has shifted away from infectious diseases and injury, well suited to an episodic care model, towards chronic conditions requiring attention to prevention activities and coordinated management. Chronic conditions are occurring earlier in life and Australians may live for longer with complex care needs. This means individuals require more services from a range of providers across the health system over extended periods of time (AHMAC 2017).

#### **Multimorbidities**

The *National Strategic Framework for Chronic Conditions 2017 -2025* (AHMAC 2017) reports:

- In 2014–2015, more than 50 per cent of Australians reported having at least one chronic condition, and one in four (23 per cent) reported having two or more chronic conditions.
- The likelihood of having one or more chronic conditions increases with age and in Australia's ageing population there is a corresponding increase in multimorbidities
- Almost one in three Australians (29 per cent) aged 65 and over reported having three or more chronic diseases, compared with just 2.4 per cent of those aged under 45.

Similar rates were reported for South Australia; 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).

### 5.2.3 Dementia

Dementia is a syndrome usually of a chronic or progressive nature in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Dementia results from a variety of diseases and injuries that primarily or secondarily affect the brain, such as Alzheimer's disease or stroke WHO 2021).

Dementia poses a substantial health, aged care and social challenge, and with Australia's ageing and growing population, it is predicted to become an even bigger challenge in the future (AIHW 2021j). Dementia is irreversible and as the condition progresses, health and functional ability decline, leading to increasing care need. While there is no known cure for dementia, there are strategies to manage symptoms, which can help people with dementia maintain independence and quality of life for as long as possible (AIHW 2021j).

In Australia in 2021:

- Dementia was the second leading cause of death, and the leading cause of death for women.
- An estimated 472,000 Australians were living with dementia, and the number is expected to more than double by 2058.
- An estimated 28,300 people live with younger onset dementia, expected to rise 41,250 people by 2058. This can include people in their 30s, 40s and 50s.
- Almost 1.6 million people in Australia are estimated to be involved in the care of someone living with dementia
- Approximately 70% of people with dementia live in the community (AIHW 2021j).

In the Adelaide PHN region it is estimated that over 26,600 people are living with dementia in 2021, and this will increase to 54,400 by 2058 (Dementia Australia 2021).

Most people with dementia are living with multiple long-term health conditions. In 2018, 95% of people with dementia had at least one additional long-term health condition and more than one in six (18%) had nine or more long-term health conditions (AIHW 2021j).

Many people living with advanced dementia move into residential aged care to receive the support and care they need, including end of life care. It is estimated that more than half of the people living in permanent residential aged care in 2019 had a diagnosis of one of the forms of dementia. The real percentage is likely higher, given the prevalence of undetected dementia (Dementia Australia 2021).

### 5.2.4 Frailty

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health (e.g. infection, new medication, fall, constipation or urine retention) (BGS 2014). Older people who are frail are less resilient to acute illness and trauma, and are at an increased risk of adverse outcomes, procedural complications, falls, institutionalisation, disability and death (Clegg et al. 2013). Old age alone does not define frailty, and frailty is not an inevitable consequence of ageing (RACGP 2019).

A study of South Australians aged 65 years and over, found that frail older adults were more likely to present to hospital Emergency Departments (EDs) than their pre-frail or robust counterparts, yet visited general practitioners (GPs) at the same rate as older adults with pre-frailty. With the exception of GPs, frail older adults were higher users of other health care services (Dent, Dal Grande, et al. 2017).

Due to the need to treat multiple comorbidities frail older people have an inherent risk of polypharmacy. Without appropriate medication reconciliation or alternative prescriptive intervention frail older people can suffer various negative effects on their health due to the adverse actions from the multiple medications used to manage their conditions (Nwadiugwu 2020).



The management of frailty requires a person-centred, multidisciplinary (including general practice, pharmacy, physiotherapy and dietician) team care approach, that considers and addresses a person's physical and medical risk factors (Dent, Lien, et al. 2017). Early detection and management of frailty in community-dwelling older people may prevent or delay transfer to residential aged care, therefore it is important to establish mechanisms for identifying frailty among older adults, particularly those living in the community (Waller et al. 2021).

### 5.2.5 Loneliness and social isolation

Loneliness and social isolation are risk factors for all-cause morbidity and mortality with outcomes comparable to other risk factors such as smoking, lack of exercise, obesity and high blood pressure. Loneliness has been associated with decreased resistance to infection, cognitive decline and mental health conditions such as depression and dementia. Older people are particularly vulnerable to experiencing loneliness and social isolation. Approximately 50% of individuals aged over 60 are at risk of social isolation and one-third will experience some degree of loneliness later in life. Loneliness and social isolation have been associated with a reduction in health status and therefore a decreased quality of life. Not all older people experience loneliness in the same way or to the same degree and hence there is a pressing need to tailor interventions to meet individual's requirements (Fakoya et al. 2020).

### 5.2.6 Mental health

Good mental health is a key factor associated with healthy ageing, and this is determined by a combination of psychological, biological and/or social and cultural factors (Slade et al. 2009). While the prevalence of mental health disorders tends to decrease with age, there are certain sub-groups of the older population that are at higher risk. These groups include people in hospital, supported accommodation, people with dementia, and older carers (RANZCP 2016; Rickwood 2005). People living in residential aged care are another subgroup at higher risk of poor mental health. At 30 June 2019, of those people living in permanent residential aged care, the majority (87%) were diagnosed with at least one mental health or behavioural condition and 49% had a diagnosis of depression (DoH 2021a).

#### *Prevalence*

Approximately 22,000 people aged 65 years and over in the Adelaide PHN are estimated to require treatment for mental health in 2021/22, and this figure is expected to increase to 42,000 by 2024/25. By step of care, in 2021/22 approximately 5,800 people aged 65 years and over are expected to require treatment for a severe mental disorder, 5,500 are expected to require treatment for a moderate mental health disorder, while 6,900 will require treatment for mild mental health disorder. A further 3,800 people will experience some indication of mental ill health or risk factors for mental illness 2021/22 and would benefit from early intervention and relapse prevention treatment options (DoH 2021a). A further 6,700 people aged 65 years and over will require treatment due to behavioural and psychological symptoms of dementia in 2012/22 (DoH 2021a).

### 5.2.7 Falls

Falls are a common health concern facing older people (RACGP 2019). The number of people who fall over the age of 65 years is increasing, and fall-related injury represented the single largest cause of hospitalisation from external causes in people living in metropolitan Adelaide in 2017/18 (AIHW 2021k). More than one in three people aged 65 or over fall at least once a year and many fall more often, which can impact on people's wellbeing and lifestyle (Thain et al. 2012). Falls are even more common among residents of aged care facilities, and in people with dementia the number of falls-related incidents in hospital are high. Injuries from falls are high due to the prevalence of underlying disease and reduced physiological reserve in older people (RACGP 2019).

In 2018/19, 7,858 people aged 65 years and over living in Adelaide PHN region were hospitalised at a public hospital due to a fall (PHIDU 2020a). In 2017/18 328 people living in metropolitan Adelaide died as a result of a fall (AIHW 2021k). Falls accounted for over two-thirds (70%) of hospitalisations and



approximately 50% of deaths resulting from an external injuries in people living in metropolitan Adelaide in 2017/18 (AIHW 2021k).

A significant proportion of falls (40–60%) leads to injury, and a further 10–15% leads to serious injury, which may include hip fracture. Hip fracture has a significantly associated mortality rate – 10% die within a month, 20% within six months and 33% within a year. Only a small number of older patients (~20%) regain full mobility after a fall (Thain et al. 2012).

Most individuals fall due to a combination of intrinsic, personal factors and external factors; therefore to prevent falls a person-centred, multi-component approach is often required, that considers a wide range of contributing factors (RACGP 2019).

## 5.3 Use of health services

### 5.3.1 Primary health care

Primary health care is the basis of health care within Australia, as it provides the first point of contact with the health system. It includes a broad range of activities and services that are delivered outside the hospital setting, from health promotion and prevention to treatment and management of acute and chronic conditions. It can be provided in the home or in community-based settings such as in general practices, other private practices, community health, local government, and non-government service settings. While primary health care occurs in a number of settings, the ongoing relationship between the General Practitioner (GP) and patient ensures that the patient encounter is core to Primary Health Care with the GP providing a continuum of patient care throughout their life course (PWC 2018).

#### **GP attendances**

In 2019/20 at a national level, the proportion of adults accessing General Practitioners increased with age – 94% of 65-74 year olds, 97% of 75-84 year olds, and 98% of people aged 85 years and over saw a GP in the preceding 12 months (ABS 2020b).

Nationally, overall Medicare usage rates for people aged 65 and over grew only slightly between 2005–06 and 2016–17, but have increased more sharply in recent years among people aged 85 and over. By total number, this oldest age group accounted for 6.9 million Medicare claims for unreferral GP attendances in 2016–17 (5% of all unreferral GP attendances). There were more than twice as many claims per person for those over 65 and over than for those under 65 years (AIHW 2017a).

Within the Adelaide PHN region in 2020-21, there were over 2.97 million GP attendances for people aged 65 and over, equivalent to 35% of the total 8.58 million GP attendances in the region (AIHW 2021l).

In 2020-21, 18,214 people in residential aged care received at least one GP attendance in the facility. In total, GPs provided 314,358 aged care attendances, equivalent to 17.3 GP attendances per residential aged care patient (AIHW 2021l).

#### **Enhanced Primary Care services**

The proportion of older people receiving GP services for Chronic Disease Management Plans and Health Assessments increased with age. In 2020/21, 45% percent of people aged 65-79 years living in the Adelaide PHN region received a GP Chronic Disease Management Plan service, compared to 61% of people aged 80 years and over. Less than one in 10 people aged 65-79 years received a GP Health Assessment in 2020/21, compared to three in people aged over 80 years (AIHW 2017a).

#### **After-hours services**

The Australian Government provides a range of Medicare-subsidised after-hours services to support Australians with access to health care in various settings including consulting rooms, consumers' homes, or residential aged care facilities. After-hours care is categorised as urgent and non-urgent, depending on when and where care is provided.

Use of After-hours GP services was highest amongst older adults aged 80 years and over for non-urgent, urgent, and total service types (AIHW 2017a). Almost one-third (32%) of people aged 80 years and over received an after-hours GP service, 28% non-urgent attendances and 11% urgent. The rate of non-urgent GP after-hour services provided to people aged 80 years and over was three times the rate for Adelaide PHN residents, and for urgent services the rate for people aged 80 years and over was five times the region rate (AIHW 2017a).

### **Allied health attendances**

Allied health services include those delivered by audiologists, chiropractors, diabetes educators, dietitians, exercise physiologists, occupational therapists, optometrists, orthoptists, osteopaths, physiotherapists, podiatrists, psychologists, social workers and speech pathologists (AIHW 2021d).

In line with the pattern nationally, older people aged 65 and over living in the Adelaide PHN region use allied health services more than younger people. In 2020-21, 71% of people aged 65–79 and 79% of people aged 80 and over living in the region, received an allied health service compared to only 31% of 25-44 year olds and 29% of 15-24 year olds received an allied health service (AIHW 2021e).

### **Mental health services**

Older Australians access services to support their mental health needs through a number of pathways, including hospital and community-based services, emergency departments, GPs, medical specialists and/or allied health professionals. Due to the diversity of mental health support services available; there is no single, overarching data collection which can be used to report on the mental health care being received by older Australians. A study by COTA demonstrated that 6% of their participants had accessed mental health services (Council on the Ageing (COTA) 2018).

In 2020/21 over 58,000 Medicare-subsidised mental health related services were provided to people aged 65 years and over in the Adelaide PHN region. This represents nine percent of the total 675,743 mental health-related services subsidised by Medicare in that year. Psychologists provided a quarter of these services, with GPs and psychiatrists providing a similar proportion of the mental health-related services received by people aged 65 and over (AIHW 2021e).

### **Mental health-related medication**

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

Playford SA3 had the 2nd highest rate of PBS prescriptions dispensed for anxiolytic (anti-anxiety) medicines in Australia for people aged 65 years and over with 74,380 per 100,000 people, twice the Australian rate (ACSQHC 2015). Rates for anxiolytic dispensing were also high in Port Adelaide - West (59,011), Salisbury (58,342), Tea Tree Gully (54,215), and Marion (52,324) (ACSQHC 2015).

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

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

While there is a correlation between areas of lower socioeconomic status particularly in the north of the Adelaide PHN region, and higher rates of mental health-related PBS prescriptions dispensing to people aged 65 years, the patterns may also reflect the distribution of older residents and the density of aged

care facilities across the Adelaide PHN region. The Adelaide PHN also notes that based on the available data, it is not possible to determine the extent to which antidepressant and antipsychotic medicines were prescribed for conditions other than mental health.

### 5.3.2 Use of acute health care services

#### *Emergency Department Presentations*

In 2018/19, the overall total rate for emergency department presentations for people aged 65 years and older living in the Adelaide PHN was nine percent lower than the national rate. Rates varied across the region, with rates significantly higher than the national rate for people living in the Local Government Areas of Playford (33% higher), Onkaparinga (19%) and Salisbury (9%) and Port Adelaide Enfield (6%) (PHIDU 2021a).

By triage category, presentations for resuscitation were 69% higher and emergency presentations seven percent higher than the national rates. Semi-urgent and non-urgent presentations were significantly below the national rate, 27% and 64% respectively (PHIDU 2021a).

The top three causes of emergency department presentations for people aged 65 years and over in 2018/19 were injury, poisoning and consequences of other external causes, diseases of the respiratory system, and diseases of the circulatory system (PHIDU 2021a).

#### *Hospitalisations*

In South Australia people aged 65 years and over take up a disproportionately large amount of overnight stays in hospital, with people aged between 65-75 years of age twice as likely as the rest of the population to be admitted to hospital. Despite being only 5% of the population, people aged 80 and over take up more than 25% of overnights stays, with those aged over 85 years are more than five times as likely to be admitted to hospital (OFTA 2014).

#### *Potentially Preventable Hospitalisations (PPHs)*

In 2015-16 people aged 65+ years and living in the Adelaide PHN region made up 48% of potentially preventable hospitalisations in South Australian hospitals; people aged 85 years and over made up 14% (SA Health 2017). This remained consistent at 48% through 2016-17 and 2017-18. 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 (SA Health 2018a).

In 2018/19 the 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, pneumonia and influenza and chronic diabetes complications (PHIDU 2021a).

## 5.4 Factors impacting service use and provision

A national survey of Australian's aged 50 years and over identified a number of issues and barriers for older Australian's when accessing health care (Council on the Ageing (COTA) 2018):

- One in ten respondents (12%) were unable to access a health or medical service despite wanting to. Dental services, GP/nurse, optical and physiotherapy were other services which older Australians were unable to access.
- 59% of respondents reported some difficulties in accessing a health or medical services. The main reasons were the cost of the services; long waiting list; travel distance; cost of medicines; lack of suitable services available; lack of transport; cost of transport; and concern/embarrassment about asking for help
- People living with a disability, without private health insurance and on an annual household income of less than \$30,000 were more likely to report a reasonable level of difficulty in accessing medical services.

Van Gaans and Dent (2018) highlighted that multiple factors contribute to the ability of older people to access health services. These included geographical location, accessibility to transport, long waiting times for appointments, affordability, level of multi-morbidity and cultural background. Both van Gaans and Dent (2018) and Principe (2015) identified that older culturally and linguistically diverse (CALD) populations face substantial barriers and inadequate health care services.

## 5.5 Palliative Care

Palliative care is described by the World Health Organisation as an approach that improves the quality of life of patients and their families who are facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual (WHO 2020a). The benefits of palliative care are well documented and aim to wrap care around the person, informed by their wishes, choices, and health care preferences in the place of their choice (WHO 2020a).

The demand for palliative care services is increasing due to the ageing of the population and the increases in the prevalence of cancer and other chronic diseases that accompany ageing (WHO 2014).

Several studies have attempted to quantify the need for palliative care in Australia; estimates range from 50%– 90% of total deaths. Sleeman et al.(2019) conducted a study into 'serious health related suffering' in the top 20 conditions associated with palliative care. Using this as a proxy for palliative care need, the authors suggested that in 2016 around 51% of deaths required palliative care. Adopting this value in today's context suggests there are 82,000 deaths in Australia which would benefit directly from palliative care each year. Using the same value in the South Australian context over 7,000 people would directly benefit from palliative care each year. Similarly, estimations based just on mortality data (14,426 SA deaths in 2017) indicate that about 41% to 72% of people in South Australia who die from a life-limiting condition each year, currently between 5,800 and 10,400 would benefit from some form of palliative care services (SA Health 2019b). With expectations that 8.2 million individuals aged 65 and over will be added to the South Australian population by 2060 and an estimated 400,000 deaths of which 214,000 will require palliative care.

### *Access to palliative care services*

Palliative care can be provided in a range of settings, including at home, at a hospital, in a hospice, in an aged care facility, and in an institutional setting (such as a correctional facility or accommodation for people living with a disability) (AHA 2019a). Palliative care involves a range of clinical and other supports delivered by different providers, including volunteers, depending on the patient's needs. These may include general practice and primary care, specialist medical, nursing and allied health practitioners, community, disability, aged and social services, grief and bereavement services, and specialist palliative care services (comprising multidisciplinary teams with specialised skills, competencies, experience and training in palliative care) for patients with complex needs (AHA 2019a).

An exploratory analysis by Australian Healthcare Associates identified a number of barriers to accessing quality palliative care. Consumer barriers included lack of understanding, awareness and comfort discussing palliative care, fear and mistrust, delayed diagnosis, and financial constraints (AHA 2019a). Barriers for providers include lack of awareness, skills and competencies, lack of available services and support, referral issues and insufficient funding (AHA 2019a). Language and communication barriers, and cultural understanding and preferences were barriers for both consumers and providers (AHA 2019a). These identified barriers are relevant to the Australian population as a whole, however are likely to be magnified for the under-served populations such as Aboriginal Torres Strait Islander people and people from CALD backgrounds.

### *Aboriginal and Torres Strait Islander peoples*

Aboriginal and Torres Strait Islander peoples make up 3.3% of Australia's population. Aboriginal and Torres Strait Islander peoples are more likely to have serious chronic health conditions including kidney

disease and coronary heart disease than non-Aboriginal and Torres Strait Islander people. Many of these conditions are life-limiting illnesses. Lung, liver, and cervical cancers are more common than among non-Aboriginal and Torres Strait Islander people, and Aboriginal and Torres Strait Islanders are more likely to be diagnosed with cancer at an advanced stage (AHA 2019b).

The high rate of life-limiting conditions including advanced kidney and heart disease among Aboriginal, and Torres Strait Islander Peoples increases the need for access to palliative care. Yet many are unaware of palliative care. Others are reluctant to talk about death and dying, and many face racism and discrimination that prevents access to care. Together with a fear or mistrust of 'Western' medicine, language barriers, and poorly serviced rural locations this has a major impact on their experience at the end of life (AHA 2019b).

### Cultural and Linguistically Diverse Communities

The Australian population includes many people that were born overseas or have a parent born overseas or speak a variety of languages. Members of the CALD community are very diverse and generalisations are not appropriate, however some members of the CALD community have a higher incidence of life-limiting conditions that are less common within the general population. Migrants from non-English speaking countries and people born here but with a non-English first language are more likely to experience language and cultural barriers which prevent timely access to palliative care (AHA 2019a).

### People in aged care

Older Australians entering Residential Aged Care Facilities (RACFs) are increasingly experiencing unpredictable prognostic trajectories characterized by periods of disability, frailty, and illness. The older the person was when they died, the more likely they were to have been using aged care at the time of their death (AIHW 2020f).

Very few residents enter residential aged care with a well-documented advance care plan, and older persons entering aged care present with co-morbid conditions including dementia affecting their capacity to complete an advance care directive (APHN 2020b). Many residents will be unable to communicate their wishes for palliative care at the time care is provided. Consequently, to have a real choice in the care they receive RACF's must acknowledge the importance of advance care planning for all residents to ensure their decisions from admission to end of life are clearly documented to reflect individual preferences, values, beliefs, wishes and concerns (APHN 2020b).

Evidence from RACFs in the Adelaide PHN region highlighted that wide variation exists across sites and organisations in terms of systems and processes, and workforce knowledge and skills to support and implement advanced care planning and ultimately safe, person-centred palliative care (APHN 2020b).

A number of recommendations from the *Royal Commission into Aged Care Quality and Safety* (COA 2021) argue that high quality palliative care becomes core business for aged care services. These include a right to fair, equitable and non-discriminatory access to palliative and end-of-life care, improved access to specialist palliative care services and requirements for regular staff training. Urgent consideration should also be given to how palliative care is reflected in the Aged Care Quality Standards.

## 5.6 Aged Care Services

About 95 per cent of South Australians aged over 65 live independently at home, while one in four people aged 85 and over live-in aged care (SA Health 2020).

### Overview

Aged care is not a single service. It is provided over a range of programs and services. The care ranges from low-level support to more intensive services. Aged care includes:

- assistance with everyday living activities
- respite



- equipment and home modifications
- health care, including nursing and allied health care
- accommodation (COA 2021)

Aged care is provided in people's homes, in the community and in residential aged care settings. The aged care system offers care under three main types of service, the Commonwealth Home Support Programme, Home Care Packages, and residential care. Most of the aged care budget is spent on residential aged care, more than two-thirds of people using aged care services do so from home (COA 2021).

### **Region snapshot**

As reported by the AIHW (2021m) in Adelaide PHN region as at 30 June 2020:

- There were 154 residential aged care facilities, 107 home care services, and 249 home support services.
- Over 52,000 older people in the Adelaide PHN region used home support services, over 7,400 used home care services and over 12,700 accessed residential aged care.
- The occupancy rate for residential care in the Adelaide PHN region at 30 June 2020 was 93%.

### **Identified issues**

#### **Access to aged care**

The aged care system is difficult to access and navigate. People trying to get aged care have reported the experience as time-consuming, overwhelming, frightening and intimidating. A lack of easily accessible information about services available and the quality of services makes it difficult for people to make informed decisions about aged care services (COA 2021).

Most older people want to remain living in their own homes, rather than moving to residential aged care. However, in the current aged care system, older people often wait too long to get access to care at home. As confirmed in the *Royal Commission into Aged Care Quality and Safety* there is an overwhelming preference of older people to remain in their community for as long as they are able, and yet there is a chronic lack of resourcing for home care packages and community-based services and long waiting times to access home care services (Australian Aged Care Collaboration 2021). For example, in 2018–19, the waiting times between being assessed as eligible for a Home Care Package to being assigned a package ranged from seven months for a Level 1 package to 34 months for a Level 4 package (COA 2021).

As with health care, it can be difficult for some groups of older Australians to access aged care services. For example, they may face language barriers, and available services may not be culturally appropriate, or they may fail to meet people's needs. Cultural practices and family culture can also influence what a person needs from aged care services and how they access them. For example, where informal, family-centred care is available, people may not seek formal aged care (AIHW 2021c). Many people who come from diverse backgrounds and have had varied life experiences have problems accessing aged care services that meet their particular needs. This includes people from culturally and linguistically diverse backgrounds, veterans, people who are homeless or at risk of becoming homeless, care leavers, and people from the lesbian, gay, bisexual, transgender and/or intersex communities. The existing aged care system is not well equipped to provide care that is non-discriminatory and appropriate for people's identity and experience (COA 2021).

#### **Addressing needs of people receiving aged care**

People receiving aged care, particularly those in residential aged care, do not consistently receive the health care they need. This includes doctor visits, mental health services, oral and dental health care, and preventative and holistic care. People in aged care have increasing health care needs and their care needs are often not identified or are identified late. Older, frail people often cannot travel to access health

care services and health care providers, particularly specialists, are reluctant to provide their services in a person's place of residence (COA 2021).

People in aged care also have limited access to services from allied health professionals, including dietitians, exercise physiologists, mental health workers, occupational therapists, physiotherapists, podiatrists, psychologists, speech pathologists and specialist oral and dental health professionals. A survey found that in 2018–19, only 2% of Home Care Package funding was spent on allied health (COA 2017).

The needs of older people with mental health conditions are not being adequately addressed across the aged care system. Depression is very common. Older people should have access to the same mental health support as all members of the community, but they do not. It is often difficult for people living in residential aged care to access specialist mental health services, such as psychologists and psychiatrists. Furthermore, many staff members working in aged care are not sufficiently skilled or trained to identify and support people living with mental health conditions (COA 2021).

Around 28% of people using home care, 20% of people using permanent residential aged care and 20% of people using respite or transition care at 30 June 2020 were from a CALD background (DoH 2021b). The aged care workforce commonly includes many people from non-English-speaking backgrounds, but from different backgrounds to those common among aged care users (AIHW 2021d). The Royal Commission into Aged Care Quality and Safety states that 'cultural safety must be embedded throughout aged care'. It proposes an Aboriginal and Torres Strait Islander aged care pathway that brings culturally safe and flexible aged care that meets the needs of Aboriginal and Torres Strait Islander people wherever they live (COA 2021).

### Adoption of digital health technology and infrastructure

Telehealth improves access to high-quality general practice care in RACFs and keeps residents safe (COA 2021). Clear variations in the digital health literacy of aged care providers and workforce are evident in the Adelaide PHN region (APHN 2021c, 2021b). The *Royal Commission into Aged Care Quality and Safety* also identified nationally that there are problems and limitations with the current technology infrastructure and architecture for aged care. Variable use of digital record keeping for clinical and administrative information management, including of My Health Record; duplicative record keeping; and the lack of interoperability of information and communication systems across aged care, primary and acute systems were identified as key issues (COA 2021).

### 5.6.1 Aged Care Workforce

The aged care workforce is made up of administration, direct care and ancillary/pastoral care roles. In South Australia, there were approximately 12,400 direct care FTE made up of nurses (practitioner, registered and enrolled), personal care workers, allied health professionals and assistants working in aged care in 2020 (DoH 2021b). Nationally 35 per cent of the total direct care workforce identified as being from a CALD background in 2020, and two per cent of the total direct care workforce identified as Aboriginal and Torres Strait Islander (DoH 2021b).

The impact of the COVID-19 pandemic has been particularly felt among consumers and workforce of the aged care sector. Older Australians are more at risk of becoming seriously ill from the virus, and the deaths that have occurred were disproportionately among residents in aged care facilities (DoH 2021b). The pandemic has also raised issues about staff working at multiple sites, and levels of staff training in infection prevention and control (DoH 2021b).

The *2020 Aged Care Workforce Census* (DoH 2021b) also identified potential gaps in workforce training. While 90% of the residential aged care workforce nationally receive regular professional development on Infection Prevention and Control, only 64% receive training on Palliative Care or Falls Risk, and only 62% receive Diversity Training. The proportion of the Home Care Package Program and Home Support Program workforces receiving ongoing professional development is even lower: 24% and 20%



respectively for Palliative Care, 38% and 34% respectively for Falls Risk and 43% and 40% respectively for Diversity Awareness.

In a large number of residential aged care facilities there are not enough workers to provide high quality and safe, person-centred care. In many cases, the mix of staff who provide aged care is not appropriately matched to the care needs of older people. Many staff members work in stressful and sometimes unsafe workplaces. Some are untrained, while others have inadequate training—and most need much more training. Aged care is part of the health care and social assistance sector, which has been the fastest growing industry every year in Australia since 2015. Australian Government research from 2018 projected that there would be 129,100 new jobs for carers or aides in the five years to May 2023. The aged care sector is competing for its workforce with other parts of the health and social assistance sector, especially the disability sector (DoH 2021b).

DOH APPROVAL PENDING

## 5.7 Care Finder Supplementary Needs Assessment

### 5.7.1 Summary of identified needs

Prior to the initial commissioning of care finder services, all PHNs undertook additional activities to supplement existing Needs Assessments, to identify local needs in relation to care finder support. The needs identified through the supplementary needs assessment process are summarised in Table 5 below.

**Table 5 Summary of local needs identified in relation to Care Finder support program, 2022**

Identified need	Key issue
There is a lack of PHN area specific data on the target populations	Adelaide PHN unable to accurately quantify the distribution of sub-populations and their specific needs in relation to care finder services
Older people including care finder target populations are not evenly distributed across the Adelaide PHN region	The local government areas of Onkaparinga, Playford, Port Adelaide Enfield and Charles Sturt have the highest number people identified as being within the care finder target populations. Population numbers are expected to increase over the next decade
Service providers will need to consider the range of factors that create barriers to accessing support for older people	A range of barriers were identified that impact the ability of older people, and specifically those populations identified as care finder target populations, to access aged care and support services. This includes language, literacy, cognition, knowledge and cultural barriers, past trauma, mistrust and fear, previous bad experience with services, geographic and financial barriers
There is a gap between available services and client demand, with some target populations potentially underserved	Quantitative data predicts a substantial increase in older populations living in the region, and consultations indicate that there is an undersupply of relevant geographically spread services to meet existing and future client demand.
There is a need to include a broad focus with <i>My Aged Care</i> (MAC) to ensure all customer cases are being resolved as well the most complex and intensive	Clients will have varying levels of need in relation to support, some will be more complex and require more intensive support than others. Services must therefore be able to offer a range of supports, and be able to provide ongoing general information, education and advice on the aged care system to a broad base of consumers.
There is a need to maintain continuity of service, and ensure single point of contact so clients only have to tell their story once and not to multiple staff and/or services	Feedback from consultations indicated that some current users of support services feel like they are being passed on from one agency or provider to another, needing to tell their story across multiple services. Clients have reported that they are being forced to repeatedly retell their story, which can often be painful or traumatic experiences.

Identified need	Key issue
There is a need to raise awareness of and inform the general population of consumers about MAC and increase awareness of services available to older South Australians, particularly those in more vulnerable groups	<p>There is still a lack of knowledge in the region about MAC, and services available to older South Australians. Feedback from providers indicated it was important for consumers to know about MAC before they need it, or before it becomes a crisis, and suggested that this should be considered as the entry level support activity for Care Finder.</p> <p>The lack of knowledge about MAC and compounds the stress for clients and their family when aged care services are needed due to an unexpected change of circumstances such as the death of a spouse, a decline in health, hospitalisation or other sudden life event</p>
There is a need for stakeholders and providers to stay informed about client and sector needs to ensure delivery of appropriate services	To maintain the appropriateness of services, providers highlighted that they need to understand what current and emerging issues people in the region are facing, and what trends the sector is experiencing. This is often dependent on the maintenance of strong relationships with support partners, and a high-level of understanding of all aspects of the sector including advocacy requirements.
There is a need for flexibility in service delivery models, including opportunities for outreach, group activities, etc., to ensure services are accessible and appropriately meet the needs of all clients requiring support	<p>Flexibility to address unmet need, and enhance current service models to meet the requirements of the care finder program was highlighted in stakeholder consultations. Outreach models were suggested to support follow-up with provider and clients to ensure ongoing service provision is accepted and taking place, particularly for more complex cases and those in denial of need.</p> <p>The experience of current navigation support providers in the region suggested that group activities and/or services based on social connection were an important way to provide access to information and supports for more vulnerable groups, such as people identifying as LGBTIQ+</p>
There is a need to maintain strong relationships with support partners and to undertake ongoing community development work to ensure the delivery of culturally appropriate support and assistance to the diverse populations of our culturally and linguistically diverse (CALD) communities	<p>A number of barriers to accessing services were identified for people identifying as CALD, including language barriers, the lack of culturally appropriate services, and family culture. Stakeholder consultations indicated that the barriers that impeded their engagement with people for those from CALD backgrounds include cultural, language, literacy, or digital literacy skills, as well as a lack of knowledge about the aged care system and rights and entitlements in Australia.</p> <p>Relationships and networking between and with organisations and individuals representing organisations that provide support to CALD people was identified as being essential to develop trust, continuity and understanding of service needs. As was a range of culturally appropriate complementary programs, and a diverse multicultural and multilingual workforce (Board, staff and volunteers).</p>
Homeless clients, or clients at risk of homelessness are particularly vulnerable and often have complex needs	<p>Data from specialist homelessness services indicate that in March 2022 between 400-500 people aged 55 years and over were homeless in South Australia. Stakeholder consultations highlighted the complexity and vulnerability of many homeless clients or those clients at risk of homelessness, and the additional resources that may be required from navigation services to support these clients compared to other aged care clients.</p> <p>Specific issues identified by stakeholders included the need to provide coordination and support to access to housing, need for appropriate case management, and to increase availability and better response times of home care services.</p> <p>Stakeholders also raised the need for referral patterns to lead to housing options without having to provide or fund transitional housing options via care finder program.</p>

## 5.8 Opportunities and priorities – Older People and Aged Care

Table 6 summarises the priorities arising from the analysis of the needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. All four priorities were unchanged from the 2021 Needs Assessment.

**Table 6 Older People and Aged Care Priority Statements for the Adelaide PHN, 2022**

Priority	Priority area	Priority sub-category	Expected Outcome
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care	<i>Aged Care</i>	<i>Chronic conditions</i>	Older people in the PHN region are supported to enjoy a greater quality of life
Older people requiring community and residential aged care services are supported by a skilled, motivated, and empowered workforce	<i>Aged Care</i>	<i>Workforce</i>	Local health and other care providers are supported to deliver coordinated, effective and appropriate care to older people in the PHN region
Older people living in the community and residential aged care are supported by timely, accessible, coordinated primary care services in and out of hours	<i>Aged Care</i>	<i>Continuity of care</i>	Local health care system provides coordinated, quality care to older people
Older people have access and support from palliative care services which address their needs, wishes and health care preferences	<i>Aged Care</i>	<i>Access</i>	Older people in the PHN region are supported to access primary health care services that meet their needs

## 6 Mental Health

*'Mental health and wellbeing is more than the absence of mental health conditions... it is a state in which a person has the skills and resources to navigate adversity, meet their needs, and live a way they find meaningful.'* (SAMHC 2017)

### 6.1 Policy and Planning Context

The Adelaide PHN is charged by the Commonwealth Government with improving the efficiency and effectiveness of primary mental health care services for people, particularly vulnerable populations at-risk of poor health outcomes, who cannot access Medicare Benefit Schedule (MBS) due to access barriers. Adelaide PHN does this through planning and funding primary health care services and building partnerships with key agencies to foster an integrated system of care (APHN et al. 2020).

The way Adelaide PHN responds to mental health and suicide in the region is guided by the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) (COAG 2017) and the 2022 National Mental Health and Suicide Prevention Agreement (the National Agreement) (COA 2022).

The Fifth Plan specifies that PHNs are required to commission services across the following six priority areas:

1. Low intensity mental health services to improve targeting of psychological interventions to support people most appropriately with mild mental health conditions.
2. Early intervention for children and young people with, or at risk of, mental health conditions, including those with severe mental conditions who are being managed in primary care.
3. Psychological therapies for people in under-served and/or hard to reach populations, including rural and remote populations.
4. Primary mental health care services for people with severe mental health conditions being managed in primary care, including clinical care coordination for people with severe and complex mental conditions.
5. Encourage and promote a regional approach to suicide prevention; and
6. Enhance and better integrate Aboriginal and Torres Strait Islander mental health services at a local level (COAG 2017).

The National Agreement sets out the shared intention of the Commonwealth, state and territory governments to work in partnership to improve the mental health of all Australians, reduce the rate of suicide toward zero, and ensure the sustainability and enhance the services of the Australian mental health and suicide prevention system.

In response to the Fifth Plan, and recognition of the critical importance of integrated services, the Adelaide PHN, Local Health Networks (LHNs) and stakeholders in the Adelaide metropolitan region have partnered to develop the *Towards Wellness Plan* (TWP). The TWP focuses on improving coordination of care for consumers and carers through the collective advancement of integration along a stepped care continuum. The TWP emphasises service delivery across the lifespan, taking into account the diverse health and social needs across the life course (APHN et al. 2020). The TWP aims to address the needs of people across the mental health stepped care continuum from prevention, early intervention, to supporting chronic and complex (severe) mental health conditions.

The TWP is underpinned by six priority areas that overlap with the Fifth Plan:

1. Integrated regional planning and service delivery;
2. Suicide prevention;
3. Coordinating treatment and supports for people with chronic and complex (severe) mental health conditions, and physical health;

4. Coordinating treatment and supports for children, young people and their families, particularly those with chronic and complex (severe) mental health conditions, and improving access to child and youth services overall;
5. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention; and
6. Ensuring a consistent approach to patient experience and outcome measures when evaluating services (APHN et al. 2020).

## **6.2 Recommissioning of Adelaide PHN-funded Primary Mental Health Care services**

In 2021, Adelaide PHN undertook stakeholder consultations to inform the recommissioning of primary mental health care services scheduled for commissioning and implementation from 2022/23 to 2024/25. The consultations engaged over 100 stakeholders from diverse groups, including people with lived experience of mental conditions, GPs, mental health clinicians, and representatives from Adelaide PHN commissioned primary mental health services, mental health peak body organisations, LHNs, and the SA Government. Stakeholders provided feedback in relation to existing Adelaide PHN commissioned primary mental health care services, with a focus on identifying key strengths, concerns, and solutions to concerns, and identifying vulnerable populations within the community. Adelaide PHN went to the open market for redesigned PMHC services, including two hubs and specialist services for culturally and linguistically diverse populations, LGBTIQ+ communities, and children in the north of the region. These services are due to commence on 1 July 2023. Service issues identified in the consultations are provided throughout this chapter. The full consultation report is available on the Adelaide PHN website.

In 2022, Adelaide PHN undertook stakeholder consultations to inform the evaluation and recommissioning of complex youth services scheduled for commissioning and implementation from 2023/24 to 2024/25. The consultations engaged over 70 stakeholders from diverse groups, including young people who had accessed complex youth services, staff working in complex youth services, and external stakeholders. Stakeholders provided feedback in relation to existing Adelaide PHN commissioned complex youth services, with a focus on identifying key successes and challenges of these services, as well as opportunities for the future. Adelaide PHN re-designed the complex youth service and went to the open market for this service in November 2022. The new complex youth service is due to commence on 1 July 2023. The evaluation report is available on the Adelaide PHN website.

## **6.3 Determinants of mental health**

Mental health concerns can be the result of a complex interplay of factors including biological, environmental, cultural, physical, lifestyle and social influences. Determinants of mental health include not only the ability to manage our thoughts, emotions, behaviours and interaction with others, but also include 'social determinants' such as housing, education and employment, and fair and equitable justice (SAMHC 2017). Disadvantage, inequities, and the impact of adverse events experienced in the early years on people's lives can have a significant impact on the mental health and wellbeing of people.

## **6.4 Prevalence of mental health conditions**

At some point in their lives, 45% of South Australians will experience a clinically diagnosable mental health condition (SAMHC 2017). In 2021/22, one in five people (approximately 210,000 people) living in the Adelaide metropolitan area were estimated to be affected by a clinically significant mental health concern (DoH 2021a).

### **6.4.1 Mental health disorders**

In 2017/18, one in five people (approximately 243,600 people) living in the Adelaide PHN region, were estimated to have a mental or behavioural problem. This is consistent with national estimates (PHIDU 2020b).

The prevalence of mental and behavioural disorders varied substantially across the region. In 2017/18, the Local Government Areas (LGAs) with the highest prevalence of people with mental and behavioural problems were Playford (39% higher than the Australian rate), Onkaparinga (19% higher) and Adelaide (7% higher) (PHIDU 2020b).

At the small area level, in 2017/18 the Population Health Areas (PHAs) in the North of the region (Elizabeth/ Smithfield - Elizabeth North (77% higher than the Australian rate), Elizabeth East (58% higher), Davoren Park (43% higher), and the South (Christie Downs/ Hackham West - Huntfield Heights (71% higher), Morphett Vale - East/ Morphett Vale – West (33% higher), Aldinga (30% higher), and Christies Beach/ Lonsdale (29% higher), have the highest prevalence of mental health conditions and behavioural disorders (PHIDU 2022f).

### **6.4.2 Psychological distress**

In 2017/18, 14 in every 100 people living in the Adelaide PHN region (approximately 131,600 people), were estimated to have high or very high psychological distress. This is 9% higher than the estimated national rate (PHIDU 2020b)..

Psychological distress varied substantially across the region. The LGAs with the highest prevalence of people with high or very high psychological distress in 2017/18 were Playford (58% higher than Australian rate), Salisbury (31% higher), Port Adelaide Enfield (23% higher) in the north of the region, and Onkaparinga (20% higher) in the south (PHIDU 2020b).

In 2017/18 the PHAs with the highest prevalence of people with high or very high psychological distress were Elizabeth/ Smithfield - Elizabeth North (109% higher than the Australian rate), Davoren Park (73% higher), Salisbury/ Salisbury North (62% higher), Elizabeth East (61% higher) in the north of the region; Dry Creek - South/ Port Adelaide/ The Parks (57% higher), Parafield/ Parafield Gardens/ Paralowie (38% higher), and Enfield - Blair Athol (35% higher) in the west; and Christie Downs/ Hackham West - Huntfield Heights (75% higher), Christies Beach/ Lonsdale (30% higher), and Aldinga (30% higher) in the south (PHIDU 2020b).

### **6.4.3 Eating disorders**

Eating disorders are serious, complex mental illnesses accompanied by physical and psychiatric complications which may be severe and life threatening. They are characterised by disturbances in behaviours, thoughts and feelings towards body weight/shape and/or food and eating (NEDC 2021a). In Australia, the most common eating disorder is binge eating disorder (47%), followed by other specified feeding and eating disorders (OSFED) (38%), bulimia nervosa (12%), and anorexia nervosa (3%) (Deloitte Access Economics 2012).

The mortality rate for people with eating disorders is up to six times higher than that for people without eating disorders (Arcelus J et al. 2011), and while the risk of premature death relates in part to associated medical complications; suicide has also been identified as a major cause of death (Preti A et al. 2011). Eating disorders commonly occur with other comorbid psychiatric and medical conditions, such as depression, anxiety, substance use disorders, and personality disorders, and physical comorbidities including osteoporosis, hypotension and digestive issues. The presence of a comorbid condition may increase the severity and chronicity of the eating disorder (Blinder BJ et al. 2006).

The elements that contribute to the development of an eating disorder are complex, and involve a range of biological, psychological, and sociocultural factors. Particular groups have been identified as being at high risk for developing an eating disorder and include females (especially during biological and social transition period), children and adolescents, people in competitive occupations, sports, performing arts and activities that emphasise thin body shape and/or have weight requirements, and gender and sexual minority groups (NEDC 2021b).



Among people with a diagnosed eating disorder, only around 23% access appropriate treatment (Hart LM et al. 2011). Many people with eating disorders receive treatment for comorbid conditions without receiving treatment for their eating disorder (Hudson JI et al. 2007).

In South Australia in 2020-21, there were 397 people that received Medicare-subsidised eating disorder services by other allied health services, 185 people received eating disorder treatment plan by a psychiatrist which is the highest number across all the states, 751 received eating disorders treatment plan through a GP, 464 received eating disorders psychological treatment by a clinical psychologist and 154 people received eating disorders psychological treatment by other psychologist (AIHW 2022v).

#### **6.4.4 Suicide and self-harm**

Causes of suicidal behaviour can stem from a complex mix of factors such as adverse life events, social and geographical isolation, socioeconomic disadvantage, mental and physical health, lack of support structures, and individual levels of resilience. In addition to the premature loss of life, suicide can have a profound and lasting negative impact on families, workplaces and communities (DoH 2019b).

##### ***Suicide ideation***

In 2016-18, 6.9% of people living in the Adelaide Metro region aged 18 years and over were estimated to experience suicidal ideation (SA Health 2018b). Based on this estimate, approximately 69,810 people aged 18 years and over in the Adelaide PHN region had experienced suicidal ideation in 2021. The overall prevalence of suicidal ideation has remained constant at the State level over the past ten years (SA Health 2018b).

##### ***Hospitalisations from intentional self-harm***

A suicide attempt is the strongest risk factor for subsequent suicide, with the risk of repetition remaining up to 12 months after an attempt (Christiansen and Jensen 2007).

Data from the AIHW (2022w) indicates that in the Adelaide PHN region the highest overall rates (per 100,000) for hospitalisations from intentional self-harm in 2020/21 were females aged 0-24 years (289.7), females aged 25-44 years (203.8), and people aged 0-24 years (185.7).

In 2020/21 the Statistical Areas 3s (SA3s) with the highest hospitalisation rates from intentional self-harm (per 100,000) in young people aged 0-24 years were Playford (249.1), Marion (243.2), Unley (237.8), Holdfast Bay (218.9) and Port Adelaide - East (200.7) (AIHW 2022w).

The areas with the highest hospitalisation rates from intentional self-harm of people aged 25-44 years were Playford (343.5), Adelaide City (308.3), Salisbury (229.6), Marion (194.5) and Holdfast Bay (168.4) (AIHW 2022w).

##### ***Deaths from suicide and intentional self-harm***

In 2021, there were 162 deaths from suicide in the Adelaide PHN region (AIHW 2022w).

From 2017-2021 the SA3s with the highest suicide rates (per 100,000) were Norwood-Payneham-St Peters (14.6), Marion (14.6), Salisbury (14.0), Playford (13.5), and Onkaparinga (13.0).

Areas with the highest number of deaths by suicide from 2017-2021 were Onkaparinga (113), Salisbury (100), Charles Sturt (78), Marion (72), Playford (61) (AIHW 2022w).

In the five years from 2017-2021, death rates from suicide in the Adelaide PHN region were significantly higher in males compared to females, ranging from 2.6 times higher in Adelaide-South SA4 to 3.6 times higher in Adelaide -West SA4 (AIHW 2022w).

## **At-risk populations**

Aboriginal and Torres Strait Islander people and people from the LGBTIQ+ communities are at higher risk of suicide and self-harm. Please see the *Priority Populations* section below for further information and data relating to suicide and self-harm for these populations.

### **6.4.5 Impact of COVID-19 on mental health and wellbeing**

The potential for COVID-19 to impact mental health and wellbeing was recognised early in the pandemic (WHO 2020b). In addition to concerns about contracting the virus itself, widespread restrictions of movement, social distancing measures, physical isolation, and 'lockdown' measures necessary to contain its spread also negatively impacted mental health (NMHC 2020). The additional stressors of sudden loss of employment, restricted social interaction, and remote working and schooling arrangements have impacted the mental health of many Australians. Stress, confusion and anger are commonplace as a result of the pandemic (Brooks et al. 2020) and, while many people may not experience any long-term concerns, COVID-19 has the potential to contribute to or exacerbate long-term mental conditions (AIHW 2022x).

## **6.5 Mental health services**

Regional service mapping across the stepped care model occurred as part of the development of the TWP, a summary of which can be viewed [online](#). The following section provides a description of the broad mental health service types in the region, levels of activity of these services types where data was available, and a summary of the current issues or challenges that have been identified through needs analysis.

Service utilisation for specific population groups is described in the following section of this chapter, 6.6 Priority populations.

### **6.5.1 Medicare subsidised mental health services**

In the five years from 2016/17 to 2020/21, the overall crude rate of Medicare-subsidised mental health-specific services in the Adelaide PHN region increased by 11%. General practitioner (GP) provided services increased by 10% in this period, clinical psychologist services increased by 18%, while Medicare-subsidised psychiatrist services decreased by 4% (AIHW 2022g).

In 2020/21, 142,519 people in the Adelaide PHN received a Medicare-subsidised mental health service, with 671,227 services provided in total. GPs provided 189,464 of the total services, clinical psychologists 194,769 services, and psychiatrists 136,939 services (AIHW 2022v).

#### **By age**

In Adelaide PHN in 2020-21, 15–24-year-olds and 25–44-year-olds were the age groups with the highest rates of GP-provided, and psychologist- and other allied health-provided Medicare-subsidised mental health-specific services (AIHW 2022g).

#### **By sub-region**

In 2021/22, the SA3s regions with the highest rates of Medicare-subsidised mental health-specific services (per 100 people) by provider type were:

- Adelaide City (15.78), Playford (15.21), Salisbury (14.95), Onkaparinga (14.22) and Port Adelaide - West (13.97) for GP provided services
- Unley (36.35), Mitcham (35.46), Norwood - Payneham - St Peters (31.88), Prospect - Walkerville (31.67) and Burnside (31.19) for allied health mental health care services, and
- Unley (18.81), Adelaide City (17.92), Burnside (16.81), Norwood - Payneham - St Peters (15.77) and Mitcham (14.09) for psychiatry services (AIHW 2022v).

For psychiatry and allied health mental health care the areas with the lowest rates of Medicare-subsidised services correlated with areas of lower socioeconomic status (AIHW 2022v). Service mapping undertaken by Adelaide PHN still identifies a concentration of providers of psychological and psychiatry services in the centre of the Adelaide PHN region (APHN 2017b; APHN et al. 2020). Previous service mapping identified that approximately two-thirds of providers of psychological services, and two-thirds of mental health services were located in the centre of the Adelaide PHN region (NHSD 2015).

### ***Mental health-related prescriptions dispensing***

In the five years from 2016–17 to 2020–21 the SA3s of Adelaide City, Playford, Onkaparinga, Port Adelaide – West and Holdfast Bay had the highest rate of dispensing for mental health-related prescriptions (subsidised and under co-payment) (AIHW 2022y). There is a strong correlation between areas of lower socioeconomic status, particularly in the north of the region, and higher rates of mental health-related PBS prescriptions dispensing within the Adelaide PHN region; 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 the Adelaide PHN region (ACSQHC 2015).

## **6.5.2 Acute mental health services**

### ***Mental health-related emergency department presentations***

From 2016-17 to 2020-21 mental health-related emergency department presentations in Adelaide PHN region increased by 8% (AIHW 2022z). In the Adelaide PHN region in 2020-21 there were almost 19,539 emergency department presentations for mental health, equivalent to a rate of 154.9 per 10,000 people (AIHW 2022z).

There was significant variation in presentation rates across the Adelaide PHN region, from 81.9 per 10,000 people in the SA3 of Burnside, to 234.6 per 10,000 in Adelaide City. The SA3s of Adelaide City (234.6 per 10,000), Marion (208.2), Playford (207.4), and Onkaparinga (201.7) consistently had the highest rates of mental health-related emergency department presentations from 2015-16 to 2020–21 (AIHW 2022z).

### ***Mental health-related hospital admissions***

In 2018/19 in the Adelaide PHN region there were 15,039 admissions for mental health-related conditions, equivalent to a rate of 1,195.3 per 100,000 population (PHIDU 2022c).

There was significant variation in admission rates within LGAs across the Adelaide PHN region, from 794.2 per 100,000 people in Burnside, to 1,704.4 per 100,000 in Adelaide. Rates also were also high in Marion (1,438.2), Playford (1,390.3), Onkaparinga (1,355.5), and Port Adelaide Enfield (1344.7) (PHIDU 2022c).

In 2019-20 there were 13,186 overnight mental health-related admissions, resulting in over 171,466 patient bed days (AIHW 2022aa). There was a large regional variance in rates for overnight admissions, with seven SA3s above the Adelaide PHN rate of 105.7 per 10,000 population. The highest rates occurred in Adelaide City (190.2 per 10,000 population), Holdfast Bay (131.8), Marion (125.9), Port Adelaide - West (122.3) and Playford (118.2) (AIHW 2022aa).

Nationally in 2019-20 the top five principal diagnoses for overnight hospital admissions without specialised psychiatric care were: mental health conditions and behavioural disorders due to use of alcohol (21% of total admissions); other organic mental disorders (21% of total); dementia (10%); mental and behavioural disorders due to other psychoactive substance use (9%); and other specified mental health-related principal diagnosis (7%) (AIHW 2022aa). For overnight admissions with specialised psychiatric care, the top five primary diagnoses were: depressive episode (15% of total); schizophrenia (13%); reaction to severe stress and adjustment disorders (10%); bipolar affective disorders (9%); and mental and behavioural disorders due to other psychoactive substance use (8%) (AIHW 2022aa). In the

Adelaide PHN region in 2015-16 the top three primary condition groups for mental health hospitalisations were schizophrenia and delusional disorders, intentional self-harm, and drug and alcohol episodes (AIHW 2017b).

### 6.5.3 Low intensity services

Low intensity mental health services aim to increase overall community access to evidenced based psychological interventions for people with, or at risk of, mild mental health conditions who do not require the traditional services provided through existing primary mental health care intervention pathways. Low intensity interventions are high quality services that individuals can access quickly and easily, with or without a referral from a General Practitioner. An individual can self-refer or be referred from a relevant community organisation (DoH 2019c).

Adelaide PHN commissions a range of low intensity service options that are evidence based e.g. Flinders University Low Intensity Cognitive Behavioural Therapy (LICBT). Adelaide PHN also actively promotes *Head to Health* and other federally funded phone and web based low intensity services as an alternative and complementary services to our commissioned services.

Recent feedback from a commissioned service provider (progress report) delivering LICBT has been that some clients experience literacy difficulties with the 'wordy' workbooks and that access to online resources (e.g. workbooks or head to health online platform) can be a problem due to technology (e.g. not having a working smart phone), inadequate mobile data, or technological literacy. Insufficient numbers to run planned groups and confidentiality associated with groups has been an issue identified also. Evidence-based brief interventions is also something that has been offered recently and appears to be popular (APHN 2022f).

### 6.5.4 Psychological therapy services

Psychological therapy services provide evidence based, structured short term, low or medium intensity psychological interventions to people with a diagnosable mild, moderate, or in some cases severe mental health condition. They also offer evidence based psychological interventions for people who have attempted, or are at risk of, suicide or self-harm where access to other services is not available or appropriate (DoH 2019d).

Psychological therapy services account for the majority of the primary mental health services commissioned by Adelaide PHN. Services are intentionally located in regions where there are no or few fee-for-service MBS mental health services. Psychological therapy services in the Adelaide PHN region are provided predominantly by mental health accredited Social Workers and psychologists. Mental Health Nurses are a challenge to recruit to in the primary care space (APHN 2022f).

The following issues raised in previously mentioned stakeholder consultations persist:

- Protracted wait times to access psychological therapies (new models such as Choice and Partnership Approach and Brief Interventions have been implemented).
- Workforce shortages (fuelled in part by some preferring to focus on offering assessment services under NDIS which remunerates better).
- NDIS consumers with considerable packages of care are being referred as they are not able to access therapy under the NDIS
- Increasing complexity and severity of presentations in primary mental health (APHN 2021d).

### 6.5.5 Services for people with severe and complex mental health conditions

Primary care, private sector providers, state/territory service providers and the NDIS all play a critical role in providing care for people with severe and complex mental health condition (DoH 2019e). Adelaide PHN commissions service providers that offer high intensity psychological services, and clinical care

coordination which addresses both mental health and physical health needs of people with severe and complex mental health conditions and their families and carers.

The episodic nature of severe mental health requires an integrated approach to care, through the coordination of services as people move to and from State (LHN) services and into the community. Integrated service delivery and a multidisciplinary team model of care is indicated in the NMHSPF as best practice approach when providing to services to people with severe mental health conditions (UOQ 2022).

Anecdotally there appears to be a missing middle i.e. clients that are too complex and/or acute for primary care services but not acute enough for state based mental health services. Adelaide PHN is working to refine its eligibility criteria for people with severe and complex mental health conditions to prevent inappropriate referrals from state based (and other) services (APHN 2022f).

Access to psychiatric assessment and advice, long wait times for services, and attracting psychologists to work within services were the top three concerns raised in stakeholder consultations undertaken by Adelaide PHN in 2021. Additional concerns identified included the cessation of group therapies; barriers to access for consumers with complex needs and/or experiencing crisis; and the lacking collaboration between GPs and hospitals. Difficulties in accessing psychiatric care and the very long wait times for appointments with psychiatrists was a source of considerable stress for consumers and their caregivers (APHN 2021d).

### **6.5.6 Suicide prevention services**

Adelaide PHN commissions both non-clinical and clinical therapeutic suicide prevention interventions for people who are at risk of suicide and/or who have recently attempted suicide. Adelaide PHN also undertakes activities in line with the TWP to formalise arrangements between State-funded mental health services and primary mental health services concerning care pathways, clinical responsibility and follow-up support. Adelaide PHN also supports commissioned service providers and other identified organisations/individuals with training and education regarding suicide prevention.

An imperative of the Australian Government and the Fifth Plan is for consistent follow-up care to be provided no matter the individual's level of risk, functional complexity and impairment, and level of distress. As identified in the TWP, timely and assertive follow up is not consistently provided to people leaving emergency or hospital care. While both Adelaide PHN and LHNs provide follow up care for people who attempt suicide, these services do not have consistent, agreed pathways and service a small percentage of the population due to limited resources and capacity (APHN et al. 2020).

Suicide prevention services in the Adelaide metropolitan region are fragmented and lack consistency and coordination in service provision, with unclear roles and responsibilities across governments and NGOs (APHN et al. 2020). Feedback provided during stakeholder consultations similarly reflected these challenges. The lack of communications after referring a patient to a suicide prevention service was a key concern raised by several stakeholders. Additional concerns included misdirected referrals; post-program support for consumers who lack strong social support; strict eligibility criteria for at-risk clients; and wait times for psychological support and tertiary care (APHN 2021d). Respondents identified a lack of timely access to Adelaide PHN funded psychological therapies by people who are at risk of suicidal behaviour as a concern considering that the majority of people who had received suicide prevention support also required psychological therapies (APHN 2021d).

Adelaide PHN welcomes the forthcoming targeted regional initiatives to suicide prevention from the Commonwealth and will review and redesign our services accordingly to optimise this new (and existing) resources.

## 6.6 Priority populations

Certain groups of people are known to be at higher risk of developing or experiencing mental health conditions because they have greater exposure and vulnerability to risk factors including social, economic and environmental circumstances. These groups are also vulnerable to mental conditions due to access barriers to treatments, or lack of appropriate or available services.

In consideration of the Fifth Plan, the National Agreement, TWP, PHN Primary Mental Health Care guidance and analysis of mental health research, population data, consultation findings and level of service provision, the following priority groups have been identified as belonging to underserved populations and being more vulnerable and at higher risk of poorer mental health in the Adelaide PHN region:

- People who are at risk of suicide and/or who have recently attempted suicide
- Aboriginal and Torres Strait Islander people
- Children, young people and their families, including women in the perinatal period
- People from CALD communities, particularly refugees and asylum seekers, and older people
- People who identify as belonging to the LGBTIQ+ communities
- People with severe mental health conditions requiring psychosocial support and across government coordinated care
- People with alcohol and other drug comorbidities
- People with physical health comorbidities, and
- People experiencing homelessness or transient housing who have a mental health condition.

Please refer to the Stakeholder Consultation report for other populations identified as being at-risk and underserved (APHN 2021d).

Adelaide PHN recognises that vulnerabilities are often intersecting, one person could be experiencing multiple vulnerabilities simultaneously, and for these individuals, the challenges in terms of accessing primary mental health care are compounded as a consequence. Adelaide PHN recognises that groups that are more vulnerable or at-risk require targeted and considered interventions, and therefore targets the delivery of treatment services to priority and underserved populations.

### 6.6.1 Aboriginal and Torres Strait Islander people

Mental and substance use disorders (23%) are the leading cause of total disease burden experienced by Aboriginal and Torres Strait Islander people (AIHW 2021a). Nationally in 2018–19 it was estimated that 24% of Aboriginal and Torres Strait Islander people reported a mental health condition or behavioural disorder, with anxiety the most commonly reported condition (17%), followed by depression (13%) (ABS 2019c).

#### *Psychological Distress*

In 2018–19, an estimated 61% of Aboriginal and Torres Strait Islander South Australian adults reported 'low or moderate' levels of psychological distress, while 39% reported 'high or very high' levels. The rate of Aboriginal and Torres Strait Islander people reporting 'high or very high' levels of psychological distress was 2.3 times the rate for non-Aboriginal and Torres Strait Islander people, based on age-standardised rates (ABS 2019c).

#### *Utilisation of community health and hospital services*

Aboriginal and Torres Strait Islander people have significantly higher utilisation rates of community health and hospital services when compared to non-Aboriginal and Torres Strait Islander people in South Australia. In 2020/21, the rate of community mental health care service contacts was 4.1 times the rate for non-Aboriginal and Torres Strait Islander South Australians (AIHW 2022ab).



Patterns of use by LHNs highlighted:

- Aboriginal and Torres Strait Islander people living in the Central Adelaide Local Health Network (CAHLN) region had four times the rate of use of community mental health services compared to non-Aboriginal and Torres Strait Islander people in CALHN, and were hospitalised for mental health-related conditions at 4.5 times the rate (Gibson et al. 2017a)
- Aboriginal and Torres Strait Islander people in Northern Adelaide Local Health Network (NAHLN) had three times the rate of use of community mental health services compared to non-Aboriginal and Torres Strait Islander people in NALHN, and five times the rate of hospital separations (Gibson et al. 2017b), and
- Aboriginal and Torres Strait Islander people in Southern Adelaide Local Health Network (SAHLN) have almost four times the rate of use of community mental health services compared to non-Aboriginal and Torres Strait Islander people in SALHN, and five times the rate of hospital separations (Gibson et al. 2017c).

From 2016/17 to 2018/19 there were 2,154 mental health-related hospital admissions for Aboriginal and Torres Strait Islander people living in the Adelaide PHN region, equivalent to an annual average rate of 3,286 per 100,000 population, 22% higher compared to the national rate. Mental health was the fourth highest reason for admission behind pregnancy and childbirth, injury, poisoning and other external causes, and respiratory system diseases (PHIDU 2021b). Age standardised rates of mental health related hospitalisations were over 2.5 times higher for Aboriginal and Torres Strait Islander people living in the Adelaide PHN region compared with the rate for all-persons (PHIDU 2021a).

These high rates of service utilisation clearly indicate a burden of mental health issues in the community. There is a need to reduce this burden, 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 a need to expand and/or adapt these services to ensure they are accessible and appropriate for Aboriginal and Torres Strait Islander clients. Barriers in accessing affordable, timely psychology and psychiatry services should be addressed (Gibson et al. 2017d).

### ***Suicide and self-harm***

In 2021, intentional self-harm was the 5<sup>th</sup> leading cause of death for Aboriginal and Torres Strait Islander people in Australia, compared to 15<sup>th</sup> for non-Aboriginal and Torres Strait Islander people (ABS 2021).

From 2017-2021, suicide was the leading cause of death for Aboriginal and Torres Strait Islander children in Australia. Almost one-third (29.7%) of deaths of Aboriginal and Torres Strait Islander children were due to suicide (ABS 2021). Over 75.3% of Aboriginal and Torres Strait Islander children who died by suicide were aged between 15 and 17 years.

From 2017–2021, the age-standardised death rate from intentional self-harm for Aboriginal and Torres Strait Islander South Australians was 95% higher than the rates for non-Aboriginal and Torres Strait Islander South Australians, 24.0 deaths per 100,000 population compared to 12.3 deaths per 100,000 population respectively (AIHW 2021n).

The highest rate of intentional self-harm deaths in Aboriginal and Torres Strait Islander people in South Australia from 2017-2021 was in young people aged 35–44 years (57.7 per 100,000 population), with the second highest rate in the 25–34 age group (34.8 per 100,000 population). For non-Aboriginal and Torres Strait Islander people, the same age groups had the highest rates, however the rate were lower, 17.5 per 100,000 population for 35–44-year-olds and 16.0 per 100,000 population for people aged 25-34 years (AIHW 2021n).



Data for 2012-2016 highlighted differences by LHN:

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

## 6.6.2 Children, young people and their families

### *Children and young people*

Approximately 41,000 children and young people aged 0-17 in the Adelaide PHN are estimated to require treatment for mental health in 2021/22, and this figure is expected to increase to 42,000 by 2024/25. By step of care, in 2021/22 approximately 6,100 children and young people aged 0-17 are expected to require treatment for a severe mental disorder, 9,600 are expected to require treatment for a moderate mental health disorder, while 11,900 are expected to require treatment for mild mental health disorder. A further 13,300 people aged 0-17 years will experience some indication of mental ill health or risk factors for mental conditions 2021/22 and would benefit from early intervention and relapse prevention treatment options (DoH 2021a).

AIHW data (2019d) indicates that almost 1 in 7 (14%) 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% of all 4–17 year olds)
- Anxiety disorders (7%)
- Depressive disorder (3%), and
- Conduct disorder (2%).

Children and young people also experience high levels of mental health comorbidity; 30% of those with mental health disorders, or 4% of all 4–17 year olds, had 2 or more mental disorders at some time in the previous 12 months (AIHW 2019d).

Mental health conditions are estimated to be the leading cause of burden of disease for people ages 24 years and under in South Australia (SADHW 2019).

Nationally, young people are a severely at-risk population, with at least five of the top 10 causes of disability directly related to mental health or AOD use disorders. Rates of high or very high psychological distress in people aged 18–24 increased from 12% in 2011–12 to 15% in 2017–18. In 2020–21, around one-third (32%) of Australians aged 12–24 received a Medicare-subsidised mental health-specific service, an increase from more than one-quarter (28%) in 2019–20 (AIHW 2022ac).

Studies undertaken in Australia and overseas have identified the estimated prevalence of trauma exposure in childhood to be approximately 31% (Price-Robertson et al. 2010; Douglas B and Wodak J 2016; Lewis et al. 2019). If applying this proportion to the Adelaide PHN population, an estimated 82,075 people under 18 years old may be at risk of trauma exposure. Research further shows children from a lower socio-economic background are also more likely to experience mental health conditions (17%) compared with their peers from higher socio-economic backgrounds (12%).

### Emergency department presentations and hospital admissions

The 2015 'The Mental Health of Children and Adolescents' report stated that 1 in 6 (or 17% of) young people aged 4-17 years in Australia with mental disorders had attended an emergency or outpatient

department, or been admitted to hospital due to emotional or behavioural problems (Lawrence et al. 2015).

In South Australia in 2020-21, almost a third (31%) of all mental health-related ED presentations in 2020-21 were for people aged under 25 years (AIHW 2022z). Rates of mental health-related emergency department presentations for children and young people aged between 0 to 24 years were higher than National rates, across each of age groups: 0-11 years (23.4 per 10,000), 12-17 years (316.8 per 10,000) and 18-24 years (266.7 per 10,000) (AIHW 2022z).

In 2020-21, South Australia had the highest number of ED presentations (all ages) in public hospitals with a principal diagnosis of 'Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (ICD-10-AM-code F90–F98), at 8% of all mental health presentations. This was over triple the rate of other states, with a national rate of 3% (AIHW 2022z).

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

### Mental health-related medicines

Rates of dispensing for antipsychotic medication in people aged 17 years and under varied across the Adelaide PHN region, with the higher rates and number of prescriptions dispensed correlating with areas of lower socioeconomic status (ACSQHC 2015).

### Women in the perinatal period

One in five mothers experience perinatal anxiety and depression which can impact on the mother's capacity to be emotionally available, therefore impeding the child's normal emotional development (PANDA 2021). A mother's mental health can also be a barrier to accessing needed services due to anxiety or a lack of confidence or motivation, increasing the need for more assertive or outreach services.

Perinatal mothers with Borderline Personality Disorder (BPD) may have difficulty with relationships, inconsistent behavioural responses to stress, and difficulties in mentalising (understanding the intentions and mind states of others) making parenting difficult (Sved Williams et al. 2018). Research shows that the implication of mothers who have BPD as contributing to high rates of psychopathology found by the time the child enters adolescence and early adult life (Sved Williams et al. 2018). The perinatal period is a critical time for intervention to ensure the mother-child relationship is supported and strengthened to prevent long term child mental health issues. The complexity of BPD-related behaviours require a more specialised approach when working therapeutically with mother and child.

### Service needs

The *Primary Health Networks (PHN) mental health care guidance – child and youth mental health services* identifies children, 0-11 years, as an underserved group when attempting to access preventative, and mild to moderate intensity psychological therapies (DoH 2019f). This was reflected in Adelaide PHN facilitated stakeholder consultations as all groups identified children with mental health issues and their families or carers as a vulnerable group in need of more services. Consultations highlighted the shortfalls in addressing children's mental health needs within the current primary mental health care service landscape, due to limited service offerings in the public system and services offered in the private health system being unaffordable for many families. Service provider respondents identified an observed increase in the number of children developing severe symptoms and the need for early intervention (APHN 2021d).

Additionally, children aged 3-4 years are not eligible for services funded by Adelaide PHN and this was identified as a service gap. Managing high levels of demand and wait lists, the limited pool of clinicians with paediatric specialisation (especially male clinicians), the lack of service visibility, and the fact that too few sessions are offered resulting in recurrent waitlisting and disjointed/interrupted therapy were other key challenges identified (APHN 2021d).

Service mapping suggests there is a significant lack of low to moderate level MBS private psychological services for children and their families, especially in the north and south of the Adelaide PHN region.

There is a lack of available high intensity, integrated, multidisciplinary, wrap around services, often referred to as the 'missing middle' for young people, 12-25 years, with or at risk of experiencing complex mental health conditions and their families who are not eligible for state services or headspace. This missing middle represents a large, underserved cohort that cannot be fully serviced by current Adelaide PHN funding or state-based service provision. Not all young people at risk of or experiencing severe mental health conditions eligible for high intensity services will receive a service from Adelaide PHN complex services (APHN 2022f).

### **6.6.3 People from CALD backgrounds**

South Australia is home to people from more than 200 CALD backgrounds. In the Adelaide PHN region, 363,449 people were born outside of Australia, including 255,805 people who were born in a predominantly non-English speaking country (ABS 2022d). Approximately 44,325 people residing in the Adelaide PHN region in who speak a language other than English at home reported poor proficiency in spoken English (ABS 2022d).

CALD communities and individuals are not homogenous, with different experiences influenced by gender, class, age, religion, sexuality, first or subsequent generation migration experiences, temporary or permanent settler status, forced or voluntary migrant status, among other differences. Additionally, there are cultural differences in understandings of mental conditions and appropriate treatments (Fozdar and Salter 2019).

Australian studies employing culturally sensitive research methodology have shown that people from CALD backgrounds have higher levels of depression and anxiety than their Anglo-Australian counterparts. (Stuart et al. 1998; Kiropoulos et al. 2004).

Refugees and asylum seekers are at greater risk of developing mental health problems and suicidal behaviours than the general Australian population. Prolonged detention is associated with poorer mental health in asylum seekers, particularly among children (AIHW 2018a).

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 face a higher risk of mental and physical health issues (Principe I. 2015).

Factors contributing to increased risk of mental health problems in CALD populations include low proficiency in English, loss of close family bonds, racism and discrimination, the stressors of migration and adjustment to a new country, trauma exposure before migration, and limited opportunity to fully utilise occupational skills (AIHW 2018a).

People from CALD backgrounds experience a range of access barriers to mental health services and are more likely to present to a healthcare provider at a later stage of their mental health journey (Kiropoulos et al. 2005). A significant proportion do not seek help for their mental health condition or are reluctant to do so. Often, they miss out on suicide prevention services because information is not available in their first language, or there is no culturally appropriate service available. They may also find it difficult to use mainstream services because of language and cultural barriers. They may be confused about how services operate, or simply be unaware of the range of services and supports that are available (MHIMA 2014).

Other barriers to access can include: stigma, shame or fear of judgement; Medicare ineligibility, and health care costs; inadequate interpreter services; lack of culturally aware staff and processes; lack of links with other services; high regard for religious beliefs and traditional customs; and perception of mental health problems and mental conditions (Fozdar and Salter 2019).

Commissioned service providers within the Adelaide PHN region highlighted difficulties when seeking an appropriate translator for their clients, especially translators from smaller sized CALD groups, given the many different cultures and languages spoken in the region (APHN 2021b).

#### **6.6.4 Lesbian, gay, bisexual, transgender, intersex, queer and asexual + (LGBTIQA+) communities**

National and international research into the health needs of LGBTIQA+ communities shows that a disproportionate number of LGBTIQA+ people experience anxiety, depression and psychological distress at markedly higher rates than their heterosexual peers, and are at greater risk of suicide and self-harm (National LGBTI Health Alliance and NLGBTIHA 2020; Corboz et al. 2008).

A recent Australian study of the health and wellbeing of LGBTIQA+ young people (Hill et al. 2021) highlights the burden of mental health faced by young LGBTIQA+ people aged 14 to 21 years in South Australia:

- 81% reported high or very high levels of psychological distress, almost 3 times the rate of a comparable cohort in the general population
- 49% reported having ever being diagnosed with generalised anxiety disorder and over two-fifths (45.0%) with depression
- 59% experienced suicidal ideation and 10% attempted suicide in the past 12 months
- 25% had attempted suicide in their lifetimes, and
- 63% reported having ever self-harmed and 38% reported self-harming in the past 12 months.

Overall levels of psychological distress and mental health wellbeing, experiences and outcomes vary greatly within LGBTIQA+ populations, according to gender identity, sexual identity and age. The following mental health issues have been identified in the Australian LGBTIQA+ community:

- Higher rates of suicidal ideation and depression in this community than any other population in Australia; and, rates were even higher among the transgender population (Morris 2016);
- 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);
- LGBTIQA+ young people who experience abuse and harassment are more likely to attempt suicide, have thoughts of suicide, and are more likely to have self-harmed (National LGBTI Health Alliance and NLGBTIHA 2020);
- LGBTIQA+ people are 14 times more likely to die by suicide than heterosexual people (Morris 2016);
- Lesbian women were more likely to engage in self harm and attempt suicide than gay men, but gay men were more likely to have experienced suicide ideation (Morris 2016);
- Homosexual or bisexual people (28%), as well as people who were not sure/other (23%), were more likely to be experiencing high or very high psychological distress compared with heterosexuals (11%) (AIHW 2018b);
- The LGBTIQA+ population were twice as likely to be diagnosed with a mental health disorder, with 41.1% aged over 16 years meeting the criteria for a mental health disorder in the last 12 months (Morris 2016);
- A South Australian survey on LGBTIQA+ health identified that 74% of transgender respondents reported seeking psychological or medical help in relation to their transgender status (DCSI 2017); and
- Older South Australian LGBTIQA+ people face challenges associated with social isolation, housing, aged care and health and wellbeing. Mental health challenges such as suicide ideation were linked with social isolation (COTA and SARAA 2018).

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

Adelaide PHN currently funds mental health care services and supports for young people (ages 12 and over) and adults who are transgender or gender diverse at risk of or experiencing mild to moderate mental health conditions within the Adelaide metropolitan region. High demand has been managed through the provision of brief interventions with a focus on clients with gender-related concerns.

### **6.6.5 People with alcohol and other drug comorbidity**

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

Population estimates indicate that more than one-third of individuals with a substance use disorder have at least one comorbid mental health condition and this rate is even higher for those in alcohol or drug treatment programs (Marel et al. 2016). Illicit drug users in South Australia report high levels of psychological distress at more than twice the Adelaide PHN average rate (NDARC 2014), and 41% of participants in the *2017 South Australian Drug Trends Report* self-reported mental health problems in the six months prior (Karlsson 2018).

Based on literature reviews and secondary analysis of various data sets, Roche and colleagues reported that the main drugs of concern for people with mental health conditions are alcohol, tobacco, cannabis, methamphetamine, and pharmaceutical drugs, including painkillers, analgesics and opioids (Roche, Fischer, et al. 2017).

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

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

### **6.6.6 People with physical health comorbidities**

People living with a mental health condition are more likely to die prematurely as their mental health conditions overshadow their physical needs, resulting in physical health conditions being undiagnosed and untreated (APHN et al. 2020). An analysis by the Australia Bureau of Statistics indicated that the age-standardised mortality rate for persons who lived in the Adelaide PHN region and accessed MBS and/or Pharmaceutical Benefits Scheme (PBS) subsidised mental health-related treatments was 70% higher than the overall Adelaide PHN age-standardised mortality rate (ABS 2017b).



Of all Australians with psychosocial disability, almost 2 in 5 (38%) reported profound levels of core activity limitation, and a further 1 in 5 (22%) reported severe levels of core activity limitation. Of the remaining people with psychosocial disability, 10% reported moderate levels of core activity limitation, 18% reported mild core activity limitation, and 9% reported school or employment restrictions. Just 4% of all people with psychosocial disability reported no core activity limitation, schooling or employment restrictions (ABS 2015b).

In 2014-15, 16% of all Australians (3.6 million people) reported co-existing long-term mental and behavioural and physical health conditions. In addition, people with co-existing mental and physical health conditions were more likely to be unemployed, have a lower level of educational attainment, and be living in a lone-person household compared with those with physical health conditions only (ABS 2015b).

In South Australia, the rate of profound or severe activity limitation (a limitation to self-care, mobility or communication, or restricted in schooling or employment) in people with a mental or behavioural disorder (28%) is almost twice the rate in the general population (15%) (PHIDU 2014; ABS 2014).

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 2015b). In 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 2015b).

People with two or more mental and behavioural conditions only were five times as likely as the general adult population to report high or very high levels of psychological distress, 56% compared with 12% (ABS 2015b).

### **6.6.7 People with severe mental conditions requiring psychosocial support and government coordinated care**

In 2021/22 approximately 40,500 people in the Adelaide PHN region are estimated to have a severe mental health condition (DoH 2021a). The needs of people with severe mental conditions are not homogenous, with level of severity determined by a range of factors including risk of harm, symptom severity, and functioning levels. Some people have episodic illness which can be supported through time-limited clinical services in the primary care setting. Others have more persistent mental conditions 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 2018).

Nationally, the most common disorders of people living with psychotic conditions were schizophrenia (47.0%), bipolar (17.5%), schizo-affective disorder (17.5%) (DoH 2011). Almost one in five (18.4%) people with a severe mental condition reported difficulty with reading and/or writing, and the majority of people living with severe mental health conditions have co-existing physical conditions, and higher rates of health risk factors such as smoking, drug and alcohol use, obesity and low physical activity. People with severe mental conditions were also more likely to have thoughts of suicide and have attempted suicide (DoH 2011).

Access to psychiatric assessment and advice, long wait times for clinical psychology and psychiatry services, and attracting psychologists to work within services were the top three concerns raised by stakeholders in relation to services for people with severe and complex mental conditions in the Adelaide PHN region (APHN 2021d).

To address the mental, physical and social needs of people experiencing severe mental health conditions the NMHSPF best practice care package identifies the importance of providing a range of services, including psychiatry, psychological therapies, GP, nurse, psychosocial and clinical care coordination services. However as reported in the TWP (APHN et al. 2020) there is currently little coordination between

Adelaide PHN and LHNs when delivering services to people experiencing more episodic severe mental health conditions in the Adelaide metropolitan region. An outcome of the TWP is the joint development of step-up and step-down pathways to ensure a seamless transition between Adelaide PHN and LHN services for people with severe mental health conditions.

### 6.6.8 People experiencing homelessness

People experiencing homelessness are more likely to have poor mental health compared to the general population, and mental health problems are both a cause and consequence of homelessness (Flavel et al. 2021). Homelessness studies show that 48% of homeless people experience a mental health condition and 73% experience a physical health issue. Based on the *2016 Census of Population and Housing: Estimating Homelessness* report, there were 4,505 homeless persons within the Adelaide PHN region. The Statistical Area 3 level data showed that Adelaide had the highest number of homeless persons (562, 10%), followed by Salisbury (539, 9%) and Onkaparinga (444, 7%) (ABS 2019b).

There are many state and NGO services that provide a range of homelessness services in the region, however mental health conditions can create barriers to health seeking which is often experienced by people who are homeless. Service delivery that encourages engagement and the building of trust is critical for this cohort to seek health care.

## 6.7 Mental health workforce

A variety of health and social care professionals provide mental health-related services to people living in the Adelaide PHN region. Service mapping has identified that some mental health providers and services, particularly psychologists and psychiatrists, are concentrated in the centre of the Adelaide PHN region, however health needs analysis identifies that the greatest burden of mental health occurs in the north and south of the region.

The workforce shortages mentioned throughout this document apply here.

In the past two years Adelaide PHN has considered 69 requests from commissioned service providers to have a staff member exempted from Adelaide PHN credentialing requirements. These are frequently for people who are in the process of applying for accreditation (e.g. with AHPRA or AASW). Adelaide PHN considers these requests on a case-by-case basis and if approved ensures suitable supervision and workforce development plans are in place and requires undertakings that people only work within their scope of practice.

In 2022, focus groups facilitated by the Office of Chief Psychiatrist explored with GPs and other mental health service providers across South Australia identified the following barriers in relation to mental health shared care (OFCP 2022):

- Difficulty in identifying and accessing appropriate mental health services, due to constant change in the mental health service landscape
- Appropriate psychosocial support services that meet the needs of people with severe mental illness
- Health workforce capacity to provide appropriate care to people with severe mental health conditions, with no financial incentive to support general practice to manage patients with mental health conditions (i.e. the lack of an Medicare MBS item number)
- Absence of a model of care for shared mental health care
- Absence of a definition of shared mental health care and lack of understanding of any clear/formalised processes/ agreements.

### General practitioners

As stated in the *General Practice Health of the Nation 2022* Report, “for the sixth consecutive year, GPs reported that mental health issues were the most common reason for patient appointments. Mental health,



particularly youth mental health, was also the patient health issue causing GPs the most concern for the future. GPs are carrying a large share of the mental health workload, with 38% of GP consultations incorporating a mental health component, and patients reporting they are more likely to see a GP for their mental health concerns than any other healthcare professional. The report also presents evidence that the amount of mental health work undertaken by GPs is significantly underestimated in Medicare statistics.” (RACGP 2022b).

In 2020, there were 1,689 general practitioners employed in the region, 470 in the SALHN region, 739 in CALHN region and 480 in NALHN region (DoH 2021c).

### ***Psychologists***

In 2020, 1,240 psychologists worked in the region, 82% of which (1,017, 848.9 FTE) had a role as a clinician in the areas of mental health intervention, counselling, or assessments. The majority of these psychologists worked in the CALHN region (653, 64%), 231 within the SALHN region (23%), and 131 in NALHN region (13%) (DoH 2021c). The number of psychologists practising psychological therapies working in the region had grown by 18% from 2016 to 2020 (DoH 2021c).

In 2020, half of the clinical psychologists in the region worked primarily in group private practice (26%) or solo private practice (24%), with 8% in other government department or agency, 7% in a hospital, and 7% in a community mental health service (DoH 2021c).

### ***Psychiatrists***

The number of psychiatrists working in the region has grown by 9% from 2016 to 2020 (DoH 2021c). In 2020, 262 psychiatrists (242.3 FTE) worked in the region, 48 within the SALHN region (18%), 168 in CALHN region (64%) and 46 in NALHN region (18%) (DoH 2021c).

In 2020, 30% of the psychiatrists in the region worked primarily in a hospital, 24% in a community mental health service, 17% in solo private practice, 16% in group private practice and 9% in an outpatient service (DoH 2021c).

### ***Mental health nurses***

The number of mental health nurses working in the region has grown by 11% from 2016 to 2020 (DoH 2021c). In 2020, 1,579 mental health nurses worked in the region, with the majority (67%) working in a hospital setting and 20% working in community health care services (DoH 2021c).

### ***Social workers***

As at November 2022, there were 1,715 members of the Australian Association of Social Workers in South Australia, 1,355 of those members are considered to be working in metropolitan Adelaide (AASW SA 2022). Nationally, 29% of social workers were employed in the mental health field (AASW 2022), assuming this is consistent within Adelaide, this would be equivalent to almost 400 mental health social workers the region in 2022.

Accredited Mental Health Social Workers (AMHSWs) are highly trained and educated mental health professionals and are one of the few designated allied health professional groups eligible to provide private mental health services to people with diagnosable mental health conditions or people ‘at risk’ of developing mental health conditions under the Commonwealth Medicare initiative. There are currently more than 2,200 AMHSWs working across Australia, with approximate 60% working in metropolitan areas; no data is currently available to quantify the local AMHSW workforce (AASW 2019).

### ***Occupational Therapists***

The most recent data (01 January 2021 to 31 March 2021) available from the Occupational Therapy Board of Australia, states that of 1,987 occupational therapists are registered in SA, 1,927 are practicing and 5 are undertaking postgraduate or supervised practice (OTB 2021). In 2020, 142 OTs (131.8 FTE),

equivalent to 11% of OTs working in the Adelaide PHN region at this time had a scope of practice in mental health (DoH 2021c).

### **6.7.1 Primary mental health care workforce challenges**

The primary mental health workforce needs significant investment to ensure all staff are appropriately trained and remunerated and that primary mental health care services are adequately resourced and sufficiently staffed (RANZCP 2021). There is an impending shortage of mental health nurses and limited capacity for effective care of low-prevalence mental disorders in the primary care sector (COAG 2017). In addition, the representation of Aboriginal and Torres Strait Islander peoples within the primary mental health workforce is an area which needs additional investment to promote cultural safety (RANZCP 2021). There is also a need to consider the ongoing mental health impacts of the COVID-19 pandemic on the population, particularly those experiencing socio-economic disadvantage, and the implications of the pandemic to counteract an overwhelmed mental health workforce (RANZCP 2021).

A recent review identified some of the key issues impacting on the quality, supply, distribution and structure of the mental health workforce, including workforce shortages due to challenges associated with attracting and recruiting into mental health careers and retaining existing staff (Cleary et al. 2020). Job satisfaction, turnover intention and burnout are major issues for the mental health workforce (Cleary et al. 2020; Foster et al. 2021). Consequently, the mental health workforce needs to be developed with the right size, distribution and skill mix to meet consumer needs, and investment is required to promote positive workplace cultures and opportunities for professional development and effective supervision (Cleary et al. 2020; Delgado et al. 2021).

There is also a significant need to invest in and support the Lived Experience primary mental health care workforce (COAG 2017). Lived Experience workers, regardless of their role within a health service, are 'change agents', who support personal change in service users and cultural and practice change within the service (Byrne et al. 2021). A well supported Lived Experience workforce benefits people accessing services, families, service providers and the broader community (Byrne et al. 2021). Tangible benefits to primary mental health service providers include improved engagement with service users, more sustainable treatment outcomes, a reduction in critical incidents and the need for urgent care, and results in flow-on benefits for the health workforce, improving staff retention and wellbeing (Byrne et al. 2021).

Summative reviews of Adelaide PHN primary mental health care commissioned service providers emphasise the relationship between workforce issues and the challenges these pose to service delivery, specifically: the challenges to recruit adequately credentialed service delivery staff who also have appropriate skills, knowledge, and experience in gender diversity; the lack of interpreting support for CALD service users and limited competence in culturally safe service provision; ongoing staffing vacancies and increased client complexity for severe and suicide prevention services have impacted ability to achieve targets; and the challenges of filling certain positions at the full FTE (APHN 2021b).

In stakeholder consultations in 2021, commissioned service providers raised concerns that there was a limited pool of clinicians in certain specialisations (i.e., paediatric psychology); difficulties attracting psychologists to work within services due to the workload, remuneration and service location; the dwindling resources and opportunities to support professional development; and the difficulties in accessing psychiatric assessment and advice. Among lived experience stakeholders who were involved in the consultations, there was a desire for access to a diverse team to support their mental health journey, including Lived Experience workers. There was also a strong desire for waitlists for psychological and psychiatric support to be reduced to facilitate a timelier journey towards improved mental health (APHN 2021d).

Recent consultations with stakeholders of services for youth with complex mental health needs identified opportunities for improvement related to: providing integrated care for consumers; workforce recruitment challenges, staff stressors and training opportunities (APHN 2022g).

## 6.8 Barriers to service integration

A national review of mental health services identifies that the mental health system in Australia has fundamental structural deficiencies (NMHC 2014). Services are fragmented and delivered within a complex system that involves multiple providers often operating in isolation of each other (NMHC 2014). The mental health sector in the Adelaide metropolitan region reflects the concerns of the rest of the country as services operate in isolation and lack coordination and integration. For consumers and carers, a fragmented system creates frustration and poor treatment outcomes (APHN et al. 2020).

The lack of coordination and integration between mental health services, and between mental health and other primary health services has been consistently raised in Adelaide PHN membership and stakeholder consultations since 2016 (APHN 2016a, 2016d, 2016b, 2020c, 2021a, 2021d).

The implementation of the Initial Assessment and Referral Tool nationally and within the Adelaide PHN region will assist somewhat by applying a consistent and evidence-based methodology to ensure people are referred to the right service for them the first time and do not require transfer of care.

Adelaide PHN has also gone back to market for its PMHC services to include a Hub model to address some of the common barriers to integration.

An overarching concern raised in recent stakeholder consultation was that the Stepped Care Model is complex and difficult to navigate when seeking to identify primary mental health care services and program options that are best suited to a consumer's needs. Stakeholders noted that it was challenging to access and filter information about the available services, referral pathways, integrated pathways and eligibility criteria, and expressed a desire for clearer information (APHN 2021d).

The lack of visibility and knowledge of services can create barriers for consumers, especially vulnerable groups, when accessing services. A lack of visibility of Adelaide PHN services also creates barriers for State and stakeholder services to integrate with the funded services. The Adelaide PHN funds a number of community-based NGOs to implement services under their own corporate brand, therefore it can be difficult for the community, GPs, LHNs and other community services to identify and have a comprehensive overview of services funded by the Adelaide PHN. Clinicians working in state government-funded services acknowledged they had very little knowledge and poor awareness of Adelaide PHN-funded services. Other stakeholders identified that the ever-changing landscape of primary mental health care services creates challenges in terms of keep up-to-date and avoiding inappropriate referrals (APHN 2021d).

Stakeholders reported that very few Adelaide PHN-funded services have developed integrated pathways with other funded services, and minimal clinical or professional integration to ensure integrated care management was identified between Adelaide PHN funded services (APHN 2021d).

The feedback and experiences shared by mental health stakeholders in the region highlighted that integration is critical to effectively navigating the primary mental health care service landscape, but that it is time and resource intensive, involving effective communication and coordination at the interface between Adelaide PHN's commissioned primary mental health care services and LHNs via community mental health services and hospitals. Additionally, stakeholders highlighted that integration is reliant on the maintenance of professional relationships and networks (APHN 2021d).

In focus groups conducted to support the evaluation of Adelaide PHN's commissioned services for young people with complex mental health, participants acknowledged that achieving integrated care can be challenging because building trust and the partnerships that support integration take time to achieve. Additional barriers to integration identified included different administrative platforms and organisational requirements around consent, which made sharing clinical notes difficult and impacts on a young person's care (APHN 2022g).

## 6.9 Opportunities and priorities – Mental Health and Suicide Prevention

Table 7 summarises the priorities arising from the analysis of mental health and suicide prevention needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. All twelve priorities were unchanged from the 2021 Needs Assessment.

**Table 7 Mental Health and Suicide Prevention Priority Statements for the Adelaide PHN, 2022**

Priority	Priority area	Priority sub-category	Expected Outcome
Aboriginal and Torres Strait Islander people can access timely, culturally safe and appropriate primary mental health care services	<i>Mental Health</i>	<i>Aboriginal and Torres Strait Islander Health</i>	Aboriginal and Torres Strait Islander people are able to access primary health care services as required
Children at risk of, or experiencing mild to moderate mental health conditions and their families/carers have access to appropriate primary mental health services	<i>Mental Health</i>	<i>Other - Children and families</i>	People in PHN region access mental health services appropriate to their individual needs
LGBTIQA+ communities can access safe, inclusive and appropriate primary mental health care services	<i>Mental Health</i>	<i>Vulnerable population (Non-First Nations specific)</i>	People in PHN region access mental health services appropriate to their individual needs
People from underserved and hard to reach populations experiencing mental health conditions have access to timely, appropriate and integrated primary mental health services	<i>Mental Health</i>	<i>Vulnerable population (Non-First Nations specific)</i>	People in PHN region access mental health services appropriate to their individual needs
People at risk of, or experiencing mild to moderate mental health conditions can access primary mental health services through a range of modalities	<i>Mental Health</i>	<i>Access</i>	People in PHN region access mental health services appropriate to their individual needs
People experiencing severe mental health conditions have access to appropriate supports, services and coordinated care	<i>Mental Health</i>	<i>Access</i>	People in PHN region access mental health services appropriate to their individual needs
Responsive and appropriate psychosocial support services that meets the needs of people with severe mental health conditions	<i>Mental Health</i>	<i>Care coordination</i>	People in PHN region access mental health services appropriate to their individual needs

<b>Priority</b>	<b>Priority area</b>	<b>Priority sub-category</b>	<b>Expected Outcome</b>
Timely, region specific, cross-sectoral suicide prevention services for people who are at risk of suicide and/or who have recently attempted suicide	<i>Mental Health</i>	<i>Continuity of care</i>	Health care providers in PHN region have an integrated approach to mental health care and suicide prevention
People experiencing mental health conditions are supported by a workforce with the skill mix that meets a diverse range of needs	<i>Mental Health</i>	<i>Workforce</i>	PHN commissioned mental health services improve outcomes for patients
Enhance service and clinical integration between mental health care providers, and with State services	<i>Mental Health</i>	<i>System integration</i>	Health care providers in PHN region have an integrated approach to mental health care and suicide prevention
Integration between primary mental health services and alcohol and other drug treatment services to improve continuity of care and outcomes	<i>Mental Health</i>	<i>System integration</i>	PHN commissioned mental health services improve outcomes for patients
Ensure visibility of Adelaide PHN commissioned services and eligibility criteria to GPs, state, community services and to underserved groups to enhance access	<i>Mental Health</i>	<i>Continuity of care</i>	People in PHN region access mental health services appropriate to their individual needs

## 7 Alcohol and other drugs

As stated in the South Australian Specialist Alcohol and Other Drug Treatment Service Delivery Framework (SANDAS 2018): *“Alcohol and other drug issues impact the health, social, and economic wellbeing of individuals, families and the whole community. Harms from alcohol and other drug use include injury, preventable diseases, mental health issues, risky behaviour, violence and other criminal behaviour. Harms also include social, family and financial problems.”*

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

The *National Framework for Alcohol, Tobacco and other Drug Treatment 2019-2029* aims to ensure that people seeking AOD treatment can access high quality treatment appropriate to their needs, when and where they need it (COA 2019a). The Framework outlines six treatment principles for organisations delivering AOD treatment services:

- Person-Centred
- Equitable and Accessible
- Evidence-informed
- Culturally Response
- Holistic and Coordinated
- Non-Judgmental, Non-Stigmatising and Non-Discriminatory (COA 2019).

The Adelaide PHN expects that organisations delivering funded AOD treatment services will adhere to these principles when designing, implementing, and evaluating all aspects of treatment (APHN 2020b).

Under the National Quality Framework for Drug and Alcohol Treatment Services, from 29 November 2022, AOD services in South Australia are required to have accreditation with at least one accreditation standard (COA 2019b). Adelaide PHN expects all commissioned service providers to hold or be actively working toward one of the accreditation standards (APHN 2020b).

### 7.1 Stakeholder / Commissioned Service Provider Consultations - 2022

In 2022, Adelaide PHN conducted a series of targeted consultations with key stakeholders including, Drug and Alcohol Services SA (DASSA), the South Australian Network of Drug and Alcohol Services (SANDAS), the Multicultural Communities Council of SA (MCCSA), Community Access & Services SA (CAASA) and its commissioned service providers to:

- Update its understanding of non-residential AOD treatment service delivery gaps and needs within the Adelaide PHN region.
- Explore enhancement opportunities to support primary health interventions in AOD treatment services.

Consultation included a series of stakeholder meetings and a brief online survey circulated to all Adelaide PHN-funded AOD treatment service providers. The consultations found that:

- People from culturally and linguistically diverse (CALD) communities within the Adelaide PHN region face barriers to AOD treatment services, mostly due to a lack of CALD-specific treatment services in the region.
- There is an imperative to support peer workforce development.
- Families and friends of clients (including CALD clients) require specialist support.
- Existing Adelaide PHN commissioned service providers require intercultural competency training to assist to work with clients from CALD communities (APHN 2022n)



## 7.2 Contributing to State and National Strategic Policy

In 2021, Adelaide PHN was invited by DASSA to contribute to the review of the 2017-2021 South Australian AOD Strategy and the development of the new Strategy. This included providing input on what had worked well and identifying potential activities for the new Strategy.

In early 2022, Adelaide PHN was invited by the National Centre for Education and Training on Addiction (NCETA), on behalf of the Department of Health and Aged Care to submit a written response to the development of the next iteration of the National AOD Workforce Development Strategy. In its submission, Adelaide PHN identified several workforce challenges within the region including an ageing cohort of AOD workers and a limited peer workforce. Adelaide PHN is using its submission and the findings from its 2022 consultations to inform a peer workforce development initiative.

## 7.3 Adelaide PHN Alcohol and Other Drug Treatment and Quality Framework 2021-2024

The Framework provides commissioned service providers with information and guidance on the delivery of quality AOD services within the Adelaide PHN region (APHN 2020b). It draws on the expertise, experience, capabilities, knowledge, and data of key stakeholders and translates the Needs Assessment into an outcomes-based service model (APHN 2020b). The Framework aligns with Adelaide PHN and Commonwealth strategic and performance frameworks including the Adelaide PHN Service and Clinical Governance Framework, National Framework for Alcohol, Tobacco and Drug Treatment 2019-2029 and the National Quality Framework for Drug and Alcohol Treatment Services (APHN 2020b).

The Framework was used by Adelaide PHN to inform its AOD Treatment Services redesign in 2020-2021, including a series of consultations that subsequently informed the procurement of AOD Treatment Services for the period 2021-2023. Key themes that emerged from the consultations included:

1. The lived experience peer workforce is an under-developed resource. Treatment services present a key setting to support training and skills development
2. Complexity is often the norm. Treatment interventions should be delivered with care coordination and practical based support
3. Working with young people is a key opportunity for harm reduction over the life course, particularly for cannabis use
4. Aftercare support is not adequately available in primary care, however, it presents a key opportunity for relapse prevention and long-term harm minimisation
5. Ongoing cultural awareness and safety strategies are essential components of AOD treatment services
6. Integration opportunities for primary AOD treatment services outside of their own sector need to be further developed
7. Consistency in treatment definitions and ensuring there is adequate and appropriate performance and outcome measurement are key to improving the quality of data collected (APHN 2020b).

Commissioned service providers are required by Adelaide PHN to use the Framework as a reference when developing and delivering AOD services.

In late 2020, Adelaide PHN participated in a statewide *AOD Health Needs Assessment* (HNA) conducted by Drug and Alcohol Services SA (DASSA). The HNA found that, within the Adelaide Metropolitan region, areas of high need for AOD issues/services were:

- Outer Northern suburbs – Elizabeth, Pooraka, Davoren Park, Smithfield, Salisbury and Paralowie
- North-western suburbs – Enfield/Blair Athol, The Parks, Port Adelaide
- Outer southern suburbs – Christies Downs, Hackham West/Huntfield Heights, Christies Beach (DASSA 2020a).

Commissioned AOD service providers, who commenced 1 July 2021, are required to provide services across the Adelaide PHN region with a specific focus on the above areas identified by the HNA.

## 7.4 Impact of COVID-19 on AOD Service Provision

The ongoing COVID-19 pandemic impacted AOD treatment service provision along with other health services in the Adelaide PHN region during the first half of 2021-22. To address this situation and reduce the impact on service provision, Adelaide PHN-funded commissioned service providers were supported to continue providing quality care to their clients. This included adapting their service delivery modalities by offering more telehealth (online and telephone) appointments instead of face-to-face interventions.

Despite services changing their service modalities, there were nevertheless constraints on clients being able to access telehealth services which were compounded by staff becoming unwell or being restricted due to others' COVID-19 status (AIHW 2022ad). This situation commenced returning to "normal" with the easing of COVID-19 restrictions in the second half of 2021-22.

## 7.5 Priority drugs of concern

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

Using a population health approach, the Adelaide PHN acknowledges that the following drug types cause the most harm in the Adelaide PHN region: alcohol; methamphetamines; non-medical use of pharmaceuticals including opioids, benzodiazepines, analgesics, and anxiolytics; cannabis; and other drugs of concern such as tobacco, ecstasy and cocaine (APHN 2020b). With the availability of new data, these priority drug types will be reviewed and may change over time based on national evidence and local circumstances.

### 7.5.1 Alcohol

Alcohol consumption has resulted in significant fiscal and health costs in Australia. In 2017-18, nationally the total cost of alcohol use was estimated to be \$66.8 billion. This includes:

- \$18.2 billion in tangible costs e.g., health service costs associated with emergency department and hospital admissions; worker absence and occupational injuries; crime; road traffic accidents.
- \$48.6 in intangible costs e.g., years of life lost from premature death; lost quality of life (Whetton et al. 2021).

Nationally, alcohol is also associated with over 5,000 deaths and more than 150,000 hospitalisations every year (DoH 2017b). Alcohol-related harm has a significant impact on Australian society with almost 222,600 Australians estimated to have been the victims of an alcohol-related physical assault in 2020-21 (AIHW 2020c). There is well-known association between rates of alcohol consumption and domestic violence, with alcohol and drug use playing a substantial role in family and domestic violence (Mayshak et al. 2018). Alcohol is the most common substance involved in polydrug use with more than 80% of people who recently used cannabis, cocaine, ecstasy, or meth/amphetamine reporting that they also used alcohol at the same time (AIHW 2020c).

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

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

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

Wastewater analyses of AOD use in the Adelaide region show that compared to the period July to December 2021, average alcohol consumption rates increased in January to June 2022. However, the consumption rates during this period were still lower than the rates recorded between 2016-2019 (DASSA 2021).

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

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

Alcohol consumption also varied by demographic characteristics:

- More males drank at lifetime risky levels than females, 21 per 100 compared to 7 per 100 respectively in 2017-18 (PHIDU 2020b)
- 25-59 year olds were more likely to drink at lifetime risky levels (approximately 1 in every 2, or 46%), compared to 1 in 3 12-24 year olds (40%), and 1 in 5 persons aged 60 years and over in 2013 (Roche et al. 2016)
- Rates are increasing in older people (50+ years) and young women (18-35 years), and decreasing in teenagers and the general population (SANDAS 2018) and
- Between 2013 and 2019, there was an overall increase in risky drinking among people aged 50+ years and alcohol-related hospitalisations for women with increased length of stay over time, notably among those aged 50-64 years (Fischer et al. 2021).

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

Nationally, in 2020–21, alcohol was reported as a drug of concern (either principal or additional) in almost half of all treatment episodes (45% or 101,800 episodes). From an Adelaide PHN perspective, alcohol was the principal drug of concern in 35% (or 2,388 episodes) of closed treatment episodes, up from 31.9% in 2019-20 and has been steadily increasing (from 23.9%) since 2016-17 (AIHW 2022ad).

Nationally, alcohol intoxication contributed the highest rates of alcohol and other drug-related ambulance attendances between 2015 and 2021. In 2021, alcohol accounted for nearly 3 in 5 drug-related hospitalisation (57% or 86,400 hospitalisations) an increase from 2019-20 (53% or 74,500) (AIHW 2022ae).

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

In 2020, there were 1,452 alcohol induced deaths recorded in Australia. Alcohol was recorded as the fifth highest risk factor (4.5% of total burden) contributing to the burden of disease in Australia in 2018 (AIHW 2022ae).

There has been a small decrease over time in the estimated rate of alcohol-related deaths in South Australia, from 3.4 per 10,000 population in 2005 to 3.1 per 10,000 in 2011. Men comprised 68% of all alcohol-related deaths from 2005-2011, and alcohol-related mortality rates among men were more than double that of women (DASSA 2018). In 2018, almost 100 deaths in South Australia were attributed to alcohol use, equivalent to approximately 1,700 Years of Potential Life Lost, premature mortality due to alcohol use (ABS 2019d). Despite reductions in alcohol consumption among young teenagers, alcohol is the leading cause of death and disability in young adults and emergency room presentations among this cohort are also increasing (Bowden et al. 2021).

### 7.5.2 Meth/amphetamine

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

After alcohol, amphetamines are the most common drug of concern in South Australia with prevalence steadily increasing across metropolitan Adelaide (DASSA 2016). Analysis of wastewater indicates that methamphetamine is the predominant stimulant consumed in metropolitan Adelaide and consumption levels fluctuate over time, showing increases from 2012-2017, and from mid-2018 to mid-2019 (DASSA 2020b). Use declined in 2020 largely due to COVID-19 related supply restrictions before increasing again in 2021 (DASSA 2021). This trend continued into the latter half of 2021 and during January to June 2022 consumption rates were similar to those recorded in 2019 (DASSA 2021).

Higher rates of methamphetamine use in South Australia, compared to other states may be partly due to availability (including local manufacture) (Bowden et al. 2021).

According to the National Drug Strategy Household Survey, the number of people using methamphetamine has remained low in South Australia (1.0% in 2019), this has decreased from 2016 by 0.9% (AIHW 2020h). However, compared with 2010, the proportion of people reporting that crystal methamphetamine or 'ice' was their main form of meth/amphetamine used in the previous 12 months has increased from 38% in 2010 to 78% in 2016 (AIHW 2017c). As crystal methamphetamine is the most potent form this has led to an increase in harms and people seeking treatment (SANDAS 2018).

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

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

In 2020-21, amphetamines (including methamphetamine) were the second most recorded (after alcohol) principal drug of concern (33.6% or 2293 episodes) in closed treatment episodes among people in the Adelaide PHN region (AIHW 2022ad).

### 7.5.3 Non-medical use of pharmaceuticals including opioids and benzodiazepines

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

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

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

In South Australia, recent use of painkillers and opioids for non-medical purposes declined from 4.3% in 2016 to 2.9% in 2019 (AIHW 2020h).

Within the Adelaide PHN region, use of opioids/painkillers in the last 12 months ranged from 1% in Adelaide-Central SA4 to 5% in the SA4s of Adelaide-South and Adelaide-West (Roche et al. 2016). There was minimal variation in use of opioid/painkillers by gender, with males 4% and females 3%, but prevalence is higher among persons aged 12-24 years compared to those aged 25 years and over (Roche et al. 2016). Alternative pain treatment options are often lacking for people living in low socio-economic or regional areas (Bowden et al. 2021).

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

Opioids and benzodiazepines are the main drug groups associated with unintentional drug-induced deaths in Australia. Deaths involving other prescription medications – such as anti-convulsant medications (e.g., gabapentinoids) and anti-psychotics (particularly atypical anti-psychotics e.g., Quetiapine) – have increased markedly in the last few years, although they account for only a small proportion of all unintentional drug-induced deaths. Between 2014 – 2019 there were 691 drug-induced deaths of people from the Adelaide PHN region, 422 of them being unintentional (Penington Institute 2021).

#### *Patterns of opioid prescription dispensing*

Rates of PBS prescriptions dispensed for opioid medicines have decreased between 2020-21 and 2016-17, however they are higher in Adelaide PHN (53,999 per 100,000 population) compared to the national rate (48,481 per 100,000). In 2020-21, there were 805,507 opioid prescriptions dispensed in Adelaide PHN, a reduction from 903,761 prescription in 2016-17 (ACSQHC 2022).

There were substantial variations in the rate of dispensing of opioid medicine prescriptions across the region. In 2020-21 the rate of dispensing in the Statistical Area Level 3 (SA3) with the highest rate (Playford) was 3.1 times higher than the SA3 with the lowest rate, Burnside SA3 (30,580 per 100,000 population) (ACSQHC 2022). Playford SA3 had the highest age-standardised rate for dispensed

prescribed opioids in South Australia and the highest rate nationally as well, with 93,850 prescriptions per 100,000 population (ACSQHC 2022).

There is also a clear social gradient in the age-standardized rate of dispensed prescribed opiates; SA3 areas with a lower socio-economic status have substantially higher rates of PBS dispensed prescribed opioids (ACSQHC 2022; Roche et al. 2016).

### ***Patterns of anxiolytics prescription dispensing***

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

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

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

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

## **7.5.4 Cannabis**

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

Cannabis is the most common illicit drug used in the Adelaide PHN region and use has remained relatively stable since 2007 (Roche et al. 2016). In South Australia in 2019, the prevalence was 11% of the general population (AIHW 2020h). Analysis of wastewater suggests that average consumption levels in metropolitan Adelaide fluctuated over 2019 and 2020, but on average appeared to have remained consistent with 2018 consumption levels. Overall average consumption declined from 2012 to 2017 (DASSA 2020b). Cannabis consumption in the Adelaide PHN region increased substantially in mid-2020, before declining in early 2021 and increasing again in mid-2021 (DASSA 2021). Average cannabis consumption levels in 2021 and 2022 were the highest since reporting began in 2012 (DASSA 2021).

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

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

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



### 7.5.5 Other drugs of concern

#### **Ecstasy**

Analysis of wastewater suggests that within metropolitan Adelaide overall average ecstasy consumption levels increased substantially in mid-2020, before declining in late 2020 and early 2021 (DASSA 2021). In 2021 and 2022, ecstasy consumption decreased to the lowest rate since sampling began in 2012 (DASSA 2022).

At the state level, ecstasy use increased between 2018 and October 2020, before declining in late 2020 (ACIC 2021).

In SA, ecstasy use in 2019 was 1.2% this has decreased from 2016 by 0.4%. Ecstasy was the fifth most used illicit drug by people aged 14 and over in South Australia in 2019 (AIHW 2020h).

#### **Cocaine**

Cocaine use has increased in South Australia, reaching 2.7% in 2019 an increase of 0.5% from 2016. It is now the second most commonly used illegal drug in Australia after cannabis. Its use in South Australia remains below the national average (AIHW 2020h).

Analysis of wastewater suggests that cocaine consumption levels were increasing in metropolitan Adelaide, with the July 2020 consumption level the highest since 2014. Since then, levels of use have declined (DASSA 2021). In South Australia, cocaine remains relatively expensive, potentially reducing the number of users (Bowden et al. 2021).

#### **Tobacco**

Tobacco remains a significant cause of death and disability in Australia. Tobacco smoking also carries the highest burden of drug-related costs on the Australian community (DoH 2017a). Nicotine was the most common secondary drug of concern in data collected from local treatment services (SANDAS 2018). Latest prevalence for tobacco smoking rates in the Adelaide PHN were consistent with the national rates in 2019; 11% of people were daily smokers equivalent to approximately 137,200 people. This is an 11% increase since 2016 (AIHW 2020i). Almost two-thirds (64%) of the Adelaide PHN have never smoked, a minimal 3% decrease since 2016 (AIHW 2020i).

## 7.6 Priority Populations

A number of population groups experience disproportionate levels of ill-health, disability and disparate harms (direct and indirect) associated with AOD use (DoH 2017a). In the Adelaide PHN region, and in line with the *National Drug Strategy 2017-2026*, they include Aboriginal and Torres Strait Islander people, people with mental health conditions, culturally and linguistically diverse populations, young people, people identifying as lesbian, gay, bi-sexual, transgender, intersex, queer or asexual + (LGBTIQ+) and people in contact with the criminal justice system (DoH 2017a; APHN 2020a, 2020c; Purdie et al. 2010).

The *Adelaide PHN Alcohol and Other Drugs Treatment and Quality Framework* also recognizes that some groups are more vulnerable or at-risk and require targeted and considered interventions and the PHN therefore targets the delivery of treatment services to priority populations (APHN 2020b).

The following section describes the burden of alcohol and substance use on priority populations and some of the specific barriers these specific groups face to accessing treatment.

### 7.6.1 Aboriginal and Torres Strait Islander people

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

In 2021, Aboriginal and Torres Strait Islander people comprised 1.9% of the total Adelaide PHN population (profile.id 2022), however they represented 11% of all AOD-related emergency department (ED) presentations (2015/16), 9% of all AOD-related hospital separations (2015/16), 14% of specialist AOD treatment episodes (2014/15) and 3% of Alcohol and Drug Information Service (ADIS) calls in 2015 (Roche, Fischer, et al. 2017).

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

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

The Adelaide PHN has a specific mandate from the Commonwealth Government to increase access to appropriate AOD treatment services for Aboriginal and Torres Strait Islander people (APHN 2020b).

In 2018-19, 32% of Indigenous people aged 15 and over in South Australia reported substance use in last 12 months, the highest rate among all the states (AIHW 2021o).

## **Alcohol**

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

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

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

The age-standardised rate of hospitalisation relating to alcohol use for Aboriginal and Torres Strait Islander South Australians was 12.4 per 1,000 people in 2015-2017, and significantly higher (11 times) the hospitalisation rate for non-Aboriginal and Torres Strait Islander South Australians (1.5 per 1,000 people) in the same period (AIHW 2022af). In 2015-16, Aboriginal and Torres Strait Islander people accounted for 12% of all alcohol-related ED presentations and 17% of all alcohol-related treatment episodes in Adelaide (Roche, Fischer, et al. 2017).

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

## **Cannabis**

A 2022 national review of cannabis use among Aboriginal and Torres Strait Islander people found that:

- Although detailed epidemiological data is lacking, the available research demonstrates that among Aboriginal and Torres Strait Islander people cannabis use prevalence is high, and among some communities, cannabis use is normalised; prevalence among young people is high; and there are significant rates of cannabis use dependence.
- The co-use of cannabis and tobacco is particularly noteworthy.
- The comorbidity of cannabis use and mental health disorders has implications for the prevention and treatment of cannabis related harms.
- Cannabis is related to a range of psychosocial harms including engagement in the criminal justice system, violence, early withdrawal from education, and lack of employment, as well as the impacts on mental health.
- There is a lack of evidence to identify or review best practice approaches in cannabis prevention, and treatment at the individual, family and community level.
- There is a need for the development of culturally safe prevention and treatment resources that can address cannabis related harms.
- A range of promising opportunities already exist including school-based prevention, health promotion resources, and increasing capacity in mental health and AOD services to better meet the needs of cannabis related presentations (Whetton et al. 2021).

The findings of the review are applicable to both the South Australian and Adelaide PHN contexts.

## **Tobacco**

The proportion of Aboriginal and Torres Strait Islander South Australians who currently smoke has significantly declined since 2001, however rates are still more than double the proportion of non-Aboriginal and Torres Strait Islander South Australians who smoke (Roche, Fischer, et al. 2017).

In 2018-19, 33% of Aboriginal and Torres Strait Islanders aged 15 years and over living in the Adelaide PHN were daily smokers, three times the overall rate of 11% for the region (ABS 2020c; AIHW 2020i). Aboriginal and Torres Strait Islander women living in the Adelaide PHN were also more likely to smoke during pregnancy compared to non-Aboriginal and Torres Strait Islander women, 45% compared to 9% from 2017 to 2019 (PHIDU 2022d).

In 2018–19, 53% of Aboriginal and Torres Strait Islander South Australians aged 15 and over who reported being a current smoker had tried to quit or reduce smoking; consistent with the national rate of 52% (AIHW 2022ag).

## **Non-medical substance use**

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

Substance use was more prevalent for Aboriginal and Torres Strait Islander males than females (41.4% compared with 24.7% in 2018-19) in South Australia (AIHW 2021o).

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

Aboriginal and Torres Strait Islander people, rates for Aboriginal people were 2.4 times higher for methamphetamines and tranquilisers and 2.3 times higher for pain-killers and opioids (AIHW 2020h).

National estimates indicate that in 2019, Aboriginal and Torres Strait Islander people were almost three times as likely to die from an unintentional drug-induced death, 20.0 deaths per 100,000 population, compared to 5.9 deaths per 100,000 population for non-Aboriginal people. Nationally, the rate of unintentional drug-induced deaths among Aboriginal and Torres Strait Islander people increased between 2001 and 2019 (from 9.5 to 20.0 deaths per 100,000 – the equal highest rate during this period) (Penington Institute 2021).

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

### **Service gaps**

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

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

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

An online survey of Adelaide PHN commissioned AOD treatment service providers in 2022, identified specialist support for family members, partners and friends of clients experiencing AOD issues as a service gap for family members, partners or friends of Aboriginal and Torres Strait Islander people (APHN 2022n).

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

## **7.6.2 Children and young people**

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

Nationally, in 2018, alcohol and illicit drug use were the leading causes of total burden of disease in males aged 15–24 years and the second and third leading causes (respectively) for females (AIHW 2022ae). While tobacco smoking and the use of alcohol and illicit drugs is declining among young people, the consumption of alcohol at risky levels remained high in 2019 (AIHW 2022ae).

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

- 1 in 3 young people (40%) drink alcohol at risky levels

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

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

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

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

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

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

### 7.6.3 Culturally and linguistically diverse communities

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

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

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

In 2022, consultations with stakeholder and commissioned service providers identified that:

- There is a lack of specialist AOD services to meet the needs of people from CALD backgrounds in the Adelaide PHN region.
- There is limited capacity among current AOD CSPs to meet the needs of people from CALD backgrounds (APHN 2022n).

This has resulted in a lack of culturally appropriate AOD service options for people from CALD communities in the Adelaide PHN region which the PHN is addressing in 2022-23 (APHN 2022n).

#### **7.6.4 Lesbian, gay, bisexual, transgender, intersex, queer and asexual + (LGBTIQ+) communities**

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

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

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

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

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

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

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

A lack of access to appropriate, safe, and inclusive AOD treatment services, and the lack of dedicated LGBTIQ+ AOD treatment services in the region were needs identified by stakeholders who were consulted (AIHW 2020g). Stigma and discrimination were also noted as substantial barriers to accessing local AOD treatment services, as was the lack of appropriately and inclusive trained service providers and a peer workforce. The invisibility of substance uses prevalence and the needs of the LGBTIQ+ communities due to inadequate data collection also needs to be addressed (AIHW 2020g).

The *Adelaide PHN Alcohol and other Drugs Treatment and Quality Framework* acknowledges LGBTIQ+ communities as a priority group / population requiring improved access to targeted and considered interventions.



### 7.6.5 Older people

Harmful use of prescription medications, effects of illicit drug use and alcohol use is increasing in older people (60+ years) in Australia. Older people can be more susceptible to alcohol, tobacco, and other drug problems as a result of difficulties with pain and medication management, isolation, poor health, significant life events and loss of independent living (DoH 2017a). The largest increase in drug-induced suicides over time are occurring among older Australians, with people aged 60+ years accounting for one-third of all such deaths in 2019 (Penington Institute 2021).

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

Recent national trend data indicate that there is an ageing cohort of people who use drugs; the proportion of older people recently using illicit drugs doubled between 2001 to 2019 from 7% to 13%, and the proportion of older people who have recently used cannabis has increased over time (AIHW 2020j). It has been stated that as well as alcohol, opioids, analgesics, anxiolytics (particularly benzodiazepines) and cannabis were the main drugs of concern for older people residing in the Adelaide PHN region (Roche, Fischer, et al. 2017).

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

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

To better understand the emerging AOD treatment needs for older residents, Adelaide PHN commissioned the National Centre for Education and Training on Addiction (NCETA) in 2020 to undertake an *AOD Treatment Services Mapping, Research and Planning Project*. The aim of the study was to gain further insight into substance use among older persons with a particular emphasis on alcohol, opioids/analgesics, and anxiolytics substance use. Analysing data from the 2013 and 2019 National Drug Strategy Household Surveys, the study found that, among Adelaide PHN residents aged 50+ years:

- Risky drinking (consumption of more than 4 drinks in a session) among those aged 50-64 years increased between 2013 and 2019
- Larger proportions of South Australians aged 50+ years consumed alcohol at risky levels daily/most days, weekly, monthly, and yearly than their national counterparts
- There were substantial shifts in drinking locations over time with an increase in the proportion of people mainly drinking at restaurants/cafes (46%-53%) or at friends' homes (34%-41%)
- Cannabis use increased amongst people aged 50+ years (2013: 4%; 2019: 5%), particularly amongst 50–64-year-olds (2013: 7%; 2019: 8%)
- 2.3% reported painkiller/pain reliever and opioid non-medical use in 2019 (Fischer et al. 2021).

The study also found that while older people are under-represented in AOD treatment services, the evidence suggests that they respond well to appropriate interventions. Responses to this issue should not be confined to tertiary treatment services with primary health care, harm reduction and generalist and specialist health services also having important roles to play (Fischer et al. 2021).

In terms of specific service changes or enhancements, the study explored the following options, and preferred strategies and recommendations were identified:

- Option 1 – Stand-alone services for older people with AOD problems
- Option 2 – (Preferred option) Enhancing capacity within existing models of health service provision to better cater for the needs of older people with AOD problems (Fischer et al. 2021).

In examining the findings of this study, Adelaide PHN has implemented the Reach & Refer program which aims to support general practice to routinely screen for alcohol consumption and intervene when patients (aged over 50 years) need support to address risky or of harmful patterns of alcohol consumption. Specifically, Adelaide PHN is working with a commissioned service provider and participating GP practices from across the Adelaide metropolitan area to provide counselling and care coordination by AOD Nurses located onsite at the participating clinics.

### 7.6.6 People in contact with the criminal justice system

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

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

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

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

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

In 2018, 31% of South Australian prisoners used illicit drugs in prison and nine percent injected drugs while in prison (AIHW 2019f). Nationally in 2018, 8% of people discharged from prison reported being on opioid substitution therapy (OST), and most (88% of those on OST, or 7% of all people discharged) planned to continue OST after release from prison (AIHW 2019f).

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

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

### 7.6.7 People with mental health or physical health comorbidity

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

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

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

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

Co-morbidity complicates treatment and services for both conditions. They can also co-occur with physical health conditions (e.g., cirrhosis, hepatitis, heart disease, and diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain (DoH 2017a). It is important to note that people with substance misuse disorders with dual diagnoses or co-morbidities are at greatest risk of poor outcomes (APHN 2020c).

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

Based on literature reviews and secondary analysis of various data sets, it has been reported that 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, Fischer, et al. 2017).

Adelaide PHN has commissioned a service provider to deliver a program to adults experiencing co-occurring AOD use and mental health issues. This is done in collaboration with another service provider and the program prioritises older Australians, First Nations people and people from Culturally and Linguistically Diverse communities. The program uses a collaborative approach to case management that sees all team members consulting with the assigned worker(s) about ensuring the best outcomes for the client whilst drawing on their collective skills, wisdom and lived experience. Clients can receive up to 12 sessions with an AOD Practitioner, or a Comorbidity Clinician, or a combination of both, complemented by peer support from either service provider, depending on the client's need (APHN 2022h).

#### **Alcohol use**

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

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

## **Tobacco use**

Tobacco smoking rates in South Australians who had been diagnosed with 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, Fischer, et al. 2017).

## **Use of other drugs**

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

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

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

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

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

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

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

## **7.7 Priority actions**

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

- Treatment services actions
- Primary care workforce actions
- System integration actions (APHN 2020c).

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

### **7.7.1 Treatment services actions**

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

Currently within the Adelaide PHN region, specialist AOD treatment services are delivered by service providers including SA Health, non-government organisations, not-for-profits, private hospitals and private services (SANDAS 2018). Hospitals (emergency and specialist units), mental health providers and family and child protection workers also provide AOD interventions as part of their general services (SANDAS 2018). The local AOD treatments workforce includes a wide range of health and human service professions including clinicians, case-managers, AOD workers, peer-support workers and volunteers, social workers, Aboriginal and Torres Strait Islander health workers, general practitioners, addiction medicine specialists, nurses, pharmacists, psychologists, psychiatrists and allied health workers (SANDAS 2018).

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

### ***Choice of services for Aboriginal and Torres Strait Islander people***

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

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

To this end, the *National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy* identifies the need to ‘Build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander community-controlled services and its workforce, as a part of a cross-sectoral approach with the mainstream AOD services to address harmful AOD use’ (IGoD 2015). Both community-controlled AOD services and mainstream services that are culturally safe and appropriate, are needed to ensure Aboriginal and Torres Strait Islanders people can choose the service that suits their needs.

Adelaide PHN acknowledges that where mainstream organisations are providing services to Aboriginal and Torres Strait Islander people, they need to adapt their programs to consider specific cultural needs and adapt interventions and activities, which when underpinned by culturally specific practices, are more relevant to the person seeking treatment and therefore more effective (Gomez et al. 2014; APHN 2020b).

### ***Culturally safe and appropriate services and interventions***

Aboriginal and Torres Strait Islander people need access to culturally appropriate programs and services, which work to improve their health and wellbeing by preventing and reducing the impacts of substance use on individuals and communities (IGoD 2015). It is important that all health services, such as AOD services, understand and respect the diversity of culture that exists for Aboriginal and Torres Strait Islander people. Aboriginal cultures are many and varied but share elements that are important across all cultures, including an emphasis on spirituality; connection to ‘country’ as place and as the embodiment of spirit and creation; networks of family, kin and community, and the reciprocal social obligations between members of those networks including inter-generational and gender relations; and common ways of relating to each other in social interactions (Gomez et al. 2014).

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

Current AOD services in the Adelaide region appreciate and understand their responsibility in this area but acknowledge that further work is needed to maintain and improve cultural responsiveness. Of note is



that stakeholders feel that training for mainstream providers needs to inform the development of culturally safe practices which focus on potential individual biases and actions, rather than simply improving cultural awareness. Areas of specific focus for further development include Aboriginal workforce, data management, and intake processes (APHN 2020b, 2020c).

### ***Person-centred treatment services***

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

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

The *Adelaide PHN Alcohol and other Drugs Treatment and Quality Framework* reinforces the need for treatment services and interventions to be person-centred and recognizes that this is ongoing, as services need to be responsive to the changing needs of individuals and the population (APHN 2020b).

### ***Family-informed strategies***

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

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

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

Consultations with key stakeholders and commissioned service providers in 2022 identified the importance of and need for identified specialist support for family members, partners and friends of clients experiencing AOD issues as a service gap for the following priority population groups:

- family members, partners or friends of Aboriginal and Torres Strait Islander people
- family members, partners or friends of people who have been in contact with the criminal justice system
- family members, partners or friends of young people (APHN 2022n).

Adelaide PHN is using the findings of this survey to provide commissioned service providers with increased support for clients' family members partners or friends (APHN 2022n).



## ***Measuring performance and outcomes***

The *National Drug Strategy* (DoH 2017a) has determined that it is a priority for the AOD sector to improve the development and sharing of data to measure performance and evaluate outcomes. This concurs with the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy* (IGoD 2015) which states that meaningful performance measures with effective data systems supporting community-led monitoring and evaluation is a priority area.

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

*Adelaide PHN's Alcohol and other Drugs Treatment and Quality Framework*, has identified a series of short-term outcomes which underpin the Project Schedules that we use with commissioned service providers (APHN 2020b). These include, but are not limited to:

- People accessing Adelaide PHN funded AOD services have reduced substance use and associated harms
- People accessing Adelaide PHN funded AOD services report improved health and social functioning
- People accessing Adelaide PHN funded AOD treatment services report positive experiences (APHN 2020b).

Adelaide PHN has mandated its AOD commissioned service providers to collect client outcomes data using the Australian Outcomes Profile (ATOP). The ATOP is an evidence based 22 item instrument that assesses various parameters of substance use and general health and wellbeing over the preceding four weeks (APHN 2021e). It is a patient reported outcome measure (PROM) and clinical risk screening tool, eliciting responses directly from clients and is designed to be incorporated into routine clinical care in AOD treatment settings. The ATOP is usually administered either face-to-face or by telephone by a clinician or researcher and requires minimal training for administration or interpretation.

The ATOP has not been validated for cultural appropriateness when used with Aboriginal and Torres Strait Islander people and as such, Adelaide PHN has provided the additional option of the Alcohol and Drug Outcome Measure (ADOM) (APHN 2021e). The ADOM was developed by Te Pou and Matua Raki in New Zealand and has been validated for use with Māori. Aboriginal Community Controlled Health Organisations in Australia have adopted the ADOM for use with Aboriginal and Torres Strait Islander people to record changes in their AOD use, physical and psychological health, and social and emotional wellbeing over time (APHN 2021e).

## ***Peer workforce***

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

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

Additional consultations with stakeholders and commissioned service providers in 2022 identified that the lived experience and peer workforce continues to be a valuable but under-developed resource. Key

stakeholders suggested that an AOD peer workforce development strategy is needed in South Australia, and that supporting the development of this workforce is essential for the creation of appropriate care teams (APHN 2022n). In its submission to the stakeholder consultations into the review and revision of the *National Alcohol and Other Drug Workforce Development Strategy* (NAODWFDS), Adelaide PHN identified the need for:

- Available and accessible education, training and professional development for new and established peer workers
- Strategies to be implemented to support the recruitment and retention of peer workers
- Training and professional development to support peer workers develop particular knowledge, skills or abilities (APHN 2022o).

The stigma of utilising and disclosing lived experience is still a barrier to workforce participation (APHN 2020c). Defining and supporting pathways from 'service user' to 'peer worker' was recognized as an important aspect of growing the workforce in Victoria's AOD treatment sector (Department of Health and Human Services (DHHS) 2018). Adelaide PHN's key stakeholders have identified that an AOD peer workforce development strategy is needed in South Australia (APHN 2020c).

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

### 7.7.2 Primary care workforce actions

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

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

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

In 2022, following consultations with key SA AOD stakeholders, Adelaide PHN has identified a need to continue to work with DASSA and other stakeholders to build the capacity of the primary health care sector across the Adelaide PHN region to identify and respond to patients experiencing pain management and prescribed opioid health related issues more effectively.

In its response to the call for submissions to review and revise the *National AOD Workforce Development Strategy*, Adelaide PHN highlighted the upskilling of the primary health sector to identify and deliver consistent care to people experiencing AOD issues as a key priority (APHN 2022o).

### **Consistent prescribing practices**

Primary health care workers, including GPs need support to deliver consistent care to people with substance use issues. This has been recognised by the Australian Government's investment in training and education for GPs through the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine. In 2021-22, Adelaide PHN appointed an AOD GP Support Project Officer to support the uptake of the RACGP's online training for GPs for a period of 12 months.

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

In South Australia there is an imbalance in the prescriber – client numbers. On a snapshot day in 2021, there were 3,334 clients receiving pharmacotherapy in SA, a number that has increased since 2011. This represented a rate of 19 per 10,000 of the SA population (compared to 23 per 10,000 nationally) and which is same as 19 per 10,000 in SA in 2011. In 2021, 48.6% of SA pharmacotherapy clients received methadone; 47.0% received buprenorphine/naloxone; 3.6% received long-acting injectable buprenorphine; and 0.8% received buprenorphine (AIHW 2021p).

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

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

### ***Future of Opioid Agonist Prescribing***

Opioid agonist therapy (OAT) is the cornerstone of the treatment of opioid use disorder. One of the most significant challenges facing the provision of OAT services in Australia is the paucity and ageing of opioid agonist prescribers. While this issue has not been examined in South Australia, in NSW opioid agonist therapy (OAT) prescribing is increasingly concentrated in a small group of mature prescribers, and new prescribers are not being retained (Jones et al. 2021).

The situation is likely to be the same in South Australia. There is an ageing cohort of OAT prescribers in this State as elsewhere in Australia. In 2020, in South Australia, there were 261 OAT prescribers, five of whom had 101 or more clients each and a further 12 prescribers who had between 51 and 100 clients each (AIHW 2021p).

The loss of OAT prescribers through retirement, ill-health or a reduction of working hours would place the ongoing provision of OAT in the Adelaide PHN area at risk. This is particularly the case if prescribers with a large client caseload are lost to the field.

### ***Awareness for screening, early intervention, and referral***

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

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

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

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

### **Reducing stigma**

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

In recent consultations numerous stakeholders, including treatment providers, client/family, peak bodies and academics, all identified that the stigma associated with substance use is often a deterrent to seeking treatment. Most clients and providers surveyed identified stigma as a major barrier to service access (APHN 2020c).

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

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

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

## **7.7.3 System integration**

Central to system integration are coordination of care and establishing and maintaining partnerships with key stakeholders both within the AOD sector and the broader health sector. Both issues are explored in further detail below.

### **Coordination of care**

Adelaide PHN previously facilitated a community workshop on mental health and AOD in which participants identified that a key principle and element of service delivery *is a system which enables service provision to be integrated ensuring continuity of care* (APHN 2016c). Consultations also identified

that MH and AOD services lacked non-flexible pathways and are confusing systems for the most vulnerable and at-risk consumers (APHN 2016c). Participants from all Adelaide PHN membership groups prioritised the importance of connection of services and care coordination as elements of best practice. Whilst this is a generic statement it also includes and is relevant for AOD treatment services. Other consultations have also prioritised the importance of simplifying mental health services and improving integration with AOD services (APHN 2016d).

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

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

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

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

### **Partnerships**

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

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

In consultations with Adelaide PHN, GPs, client / family representatives, and others reported an increase in societal factors impacting upon AOD use, including homelessness, unemployment, and financial insecurity. Stakeholders felt this had been exacerbated by the COVID-19 pandemic. Eight out of fourteen providers reported that access to social support, such as housing and employment, was a main concern relating to the inequality of services for their client group. Additionally, LHNs, and police / corrections

representatives reported a rise in domestic violence associated with an increase in substance misuse (DASSA 2020a).

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

It is therefore imperative that Adelaide PHN-funded AOD treatment service providers demonstrate partnerships and ongoing relationships with linked services to ensure that clients have a clear understanding of:

- Service and system navigation
- Clear referral pathways
- Linkages and referrals to a range of services which include not only AOD specialist treatment services, but also mental health services, general health services (e.g., general practices) and social services (APHN 2020b).



## 7.8 Opportunities and priorities – Alcohol and Other Drugs

Table 8 summarises the priorities arising from the analysis of alcohol and other drugs treatment needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. All five priorities were unchanged from the 2021 Needs Assessment.

**Table 8 Alcohol and Other Drugs Priority Statements for the Adelaide PHN, 2022**

Priority	Priority area	Priority sub-category	Expected Outcome
Priority populations have access to high quality alcohol and other drug treatment services and interventions	<i>Alcohol and Other Drugs</i>	<i>Access</i>	People in PHN region are able to access appropriate drug and alcohol treatment services
PHC providers can identify and support people with substance abuse issues and understand the scope of AOD treatment services and PHC services.	<i>Alcohol and Other Drugs</i>	<i>Continuity of care</i>	People in PHN region are able to access appropriate drug and alcohol treatment services
People requiring AOD treatment services in Adelaide are supported by a sufficient, safe, skilled and appropriate workforce	<i>Alcohol and Other Drugs</i>	<i>Safety and quality of care</i>	Decrease in harm to population in PHN region from drug and alcohol misuse
Integration and partnership between AOD and Primary Health Care services improves continuity of care and experiences	<i>Alcohol and Other Drugs</i>	<i>System integration</i>	Health care providers in PHN region have an integrated approach to drug and alcohol treatment services
LGBTIQA+ communities can access safe, inclusive and appropriate alcohol and other drugs treatment options	<i>Alcohol and Other Drugs</i>	<i>Vulnerable population (Non-First Nations specific)</i>	People in PHN region are able to access appropriate drug and alcohol treatment services

## 8 Health Workforce

*Adelaide PHN supports the provision of a skilled and accessible health care workforce which meets the needs of people living in metropolitan Adelaide. Adelaide PHN commissions accredited professional development opportunities, mentoring initiatives, and direct support programs to general practice, specialists, allied health, and pharmacy to build capacity and improve capability.*

*Adelaide PHN partners with local stakeholders to improve system integration and navigation and provide opportunities for professional networking. Partnerships may take the form of co-funding and/or providing support to programs like HealthPathways South Australia. Our practice support team conducts regular visits to local health care providers to help connect providers with information and resources, offer guidance about current opportunities and support the implementation of quality improvement activities. Our digital health team assist providers with support, education and resources including the expansion of My Health Record, the Practice Incentives Program (PIP), and secure messaging.*

### 8.1 Primary care landscape

Primary health care is usually a person's first point of contact with health system. Primary health care includes a broad range of activities and services, from health promotion, prevention and screening, early intervention, to treatment and management of acute and chronic conditions.

The primary healthcare system has four main purposes:

- to provide the right care at the right time, at the right place, ensuring a healthier population
- to provide cost-effective, community-based care, and minimise hospital-based care
- to act as both an enabler and gateway to other services to ensure they are provided in a timely way, but only when needed, and
- to coordinate care between different health providers and different parts of the health care system, ensuring a seamless, integrated, effective experience for people - and minimising costly fragmentation, duplication, or gaps in care (AIHW 2016b).

Primary health care services are delivered in settings such as general practices, community pharmacies and health centres, allied health practices, and via digital communication technologies such as telehealth and video consultations (AIHW 2016b).

### 8.2 Primary care workforce

The scope and nature of primary health care is wide-ranging and services are provided by a broad range of health professionals including general practitioners, nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, pharmacists, dentists, and Aboriginal health workers (AIHW 2016b).

A brief snapshot of selected health professions in the Adelaide PHN region is provided below.

#### **General Practice**

In 2021/2022 there were 330 General Practices in the region, 80 in the SALHN region, 151 in CALHN region, and 99 in NALHN region (APHN 2022d).

#### **General practitioners (GPs)**

GPs are central to primary care, they are a gateway to specialist health services, and they have significant role in coordinating services for people with complex care needs at home and in the community (Swerissen et al. 2018).

From 2016 to 2020 the number of general practitioners in the region had grown by six percent. In 2020, there were 1,689 general practitioners employed in the region, 470 in SALHN region, 739 in CALHN region and 480 in NALHN region (DoH 2021c).

Data collected by the Adelaide PHN indicates the number of general practitioners in the region has decreased by 14% in the last two years between 2020 to 2022, primarily in the southern and central regions. In 2022, there were 1,443 general practitioners employed in the region, 588 in CALHN region, 507 in NALHN region and 348 in SALHN region (APHN 2022d)

In 2021–22 GPs provided over 9.04 million Medicare-subsided attendances to 1,125,612 people, and almost 456,000 attendances in the after-hours period to 234,393 people in Adelaide PHN (AIHW 2022g).

### **Nurses in general practice.**

Nurses undertake a wide range of tasks within general practice, including immunisation, wound management, health assessments, care planning, chronic disease prevention and management, annual cycles of care, administration and practice management, clinical services, patient education and nurse-led clinics. More recently nurses have been undertaking a variety of tasks relating to the COVID-19 Pandemic, this includes but is not limited to, assessment, screening for COVID-19 and administering COVID-19 vaccinations.

The number of nurses working in general practice in the region had grown by 20% percent from 2016 to 2021. In 2021, 673 (520.6 FTE) nurses were employed in general practices in the region, 211 (150.9 FTE) in the SALHN region, 270 (213.4 FTE) in CALHN region and 192 (156.3 FTE) in the NALHN region (DoH 2021c).

In 2021–22 almost 275,000 Medicare-subsidised services to over 150,000 people in Adelaide PHN were provided by nurse practitioners (22,453 services) and nursing and aboriginal health workers (252,033 services) (AIHW 2022g).

### **Pharmacy**

In 2022, there were 326 Pharmacies in the region, 87 in the SALHN region, 152 in CALHN region, 87 in NALHN region (APHN 2022d).

### **Community pharmacists**

Pharmacists' main role in the primary care sector is to prepare, dispense and provide advice on medicines (Swerissen et al. 2018). In South Australia, community pharmacists can also provide COVID-19 vaccines included on the TGA Australian Register of Therapeutic Goods, as well as vaccinations for Influenza, Diphtheria-tetanus-pertussis (dTpa) and Measles-mumps-rubella (MMR) to eligible people (NCIRS 2021a, 2021b).

Community pharmacies are playing an important role in the provision of COVID-19 vaccines to vulnerable groups in South Australia. Adelaide PHN noted the need to support and enhance this activity by funding The Pharmacy Guild of Australia and Pharmaceutical Society of Australia (PSA) to extend COVID-19 immunisation training to untrained pharmacists and pharmacy interns.

The number of community pharmacists working in the region has grown by 11% from 2016 to 2020 (DoH 2021a). In 2020, 833 community pharmacists worked in the region, 220 in SALHN, 385 in CALHN and 228 in NALHN (DoH 2021c).

### **Allied health professionals**

Care teams involving GPs, pharmacists, nurses and allied health professionals, are central to better-integrated care, particularly for people who are at risk, or have complex and chronic conditions (Swerissen et al. 2018). The scope and role of allied health in primary health is varied; some allied health professionals such as sonographers provide support services for medical practitioners. Others

such as physiotherapists, podiatrists, dietitians, exercise physiologists and psychologists provide services either directly to patients or on referral from a medical practitioner. Others such as chiropractors and osteopaths are relatively independent of medical practitioners (Swerissen et al. 2018).

From 2016 to 2020, the overall number of allied health professionals in the region has increased (DoH 2021c).

In 2022 there were over 1300 allied health professionals in the APHN region (APHN 2022d).

In 2021–22, 1,402,524 allied health attendances were provided through Medicare to 504,653 people in Adelaide PHN region (AIHW 2022g).

## **Mental health**

### **Clinical psychologists**

In 2020, 1,240 psychologists worked in the region, 82% of which (1,017, 848.9 FTE) had a role as a clinician in the areas of mental health intervention, counselling, or assessments. The majority of these psychologists worked in the CALHN region (653, 64%), 231 within the SALHN region (23%), and 131 in NALHN region (13%) (DoH 2021c). The number of psychologists practising psychological therapies working in the region had grown by 18% from 2016 to 2020 (DoH 2021c).

In 2020, half of the clinical psychologists in the region worked primarily in Group private practice (26%) or Solo private practice (24%), with 8% in an Other government department or agency, 7% in a Hospital, and 7% in a Community mental health service (DoH 2021c).

### **Psychiatrists**

The number of psychiatrists working in the region has grown by 9% from 2016 to 2020 (DOH 2021a). In 2020, 262 psychiatrists (242.3 FTE) worked in the region, 48 within the SALHN region (18%), 168 in CALHN region (64%) and 46 in NALHN region (18%) (DoH 2021c).

In 2020, 30% of the psychiatrists in the region worked primarily in a Hospital, 24% in a Community mental health service, 17% in Solo private practice, 16% in Group private practice and 9% in an Outpatient service (DoH 2021c).

### **Mental health nurses**

The number of mental health nurses working in the region has grown by 11% from 2016 to 2020 (DoH 2021c). In 2020, 1,579 mental health nurses worked in the region, with majority (67%) working in a Hospital setting and 20% working in Community health care services (DoH 2021c).

### **Social workers**

As at November 2022, there were over 1,715 members of the Australian Association of Social Workers in South Australia, 1,355 of those members are considered to be working in metropolitan Adelaide (AASW SA 2022). Nationally, 29% of social workers were employed in the mental health field (AASW 2022), assuming this is consistent within Adelaide PHN, this would be equivalent to almost 400 mental health social workers the region in 2022.

Accredited Mental Health Social Workers (AMHSWs) are highly trained and educated mental health professionals and are one of the few designated allied health professional groups eligible to provide private mental health services to people with diagnosable mental health conditions or people 'at risk' of developing mental health conditions under the Commonwealth Medicare initiative. There are currently more than 2,200 AMHSWs working across Australia, with approximate 60% working in metropolitan areas; no data is currently available to quantify the local AMHSW workforce (AASW 2019).

### ***Occupational Therapists***

The most recent data (01 January 2021 to 31 March 2021) available from the Occupational Therapy Board of Australia, states that of 1,987 occupational therapists are registered in SA, 1,927 are practicing and 5 are undertaking postgraduate or supervised practice (OTB 2021). In 2020, 142 OTs (131.8 FTE), equivalent to 11% of OTs working in the Adelaide PHN region at this time had a scope of practice in mental health (DoH 2021c).

### ***Aboriginal primary health care service providers***

Primary health care for Aboriginal and Torres Strait Islander people is delivered by a range of providers, including Aboriginal and Torres Strait Islander specific providers and organisations, and general health service organisations (Swerissen et al. 2018).

Aboriginal Community Controlled Health Services (ACCHO) are primary health care services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community; in the Adelaide PHN region there is one ACCHO.

### ***Aboriginal and Torres Strait Islander health practitioners***

Aboriginal employment in the health sector is a key enabler in improving Aboriginal population health, yet Aboriginal people remain under-represented (Health Performance Council (HPC) 2017). Aboriginal health practitioners are a distinct class of registered health professionals, providing clinical and primary care for Aboriginal people, their families and community groups (Health Performance Council (HPC) 2017).

In 2020 there were 26 Aboriginal and Torres Strait Islander health practitioners (AHPRA registered) working in the region, 7 in SALHN region, 11 in CALHN region and 8 in NALHN region (DoH 2021c). This is twice the number working in the region in 2016.

## **8.2.1 Workforce distribution**

The population of the Adelaide PHN region, if divided by the three Local Health Network boundaries, is fairly evenly distributed with 30% of the population living in the southern region, 37% in the central region and 33% in the northern region (profile.id 2022). While some professions are distributed across the region in line with the population distribution, including general practitioners, community pharmacists, practice nurses and Aboriginal Health Practitioners, other professions including Psychologists, Dental Practitioners, Occupational Therapists, and Physiotherapists are not evenly distributed and tend to be centrally focussed (DoH 2021c).

## **8.3 Identified areas for improvement and current barriers**

Since 2016, Adelaide PHN has conducted a range of consultations and workshops with our advisory groups, primary health care providers, clinicians from acute and specialist health services, consumers, carers, people with lived-experience, and representatives from peak-bodies, to gain insights from, and about, the local health workforce for the purposes of the Needs Assessment., as are outcomes of internal program review processes, feedback from internal subject matter experts, and statistics from a range of local and national data sources. The following presents a summary of the needs and issues identified from the above-mentioned sources.

### **8.3.1 Emerging issues for General Practitioner workforce**

Adelaide PHN continues to hear from General Practitioners and/or General Practices that workforce shortages, inadequate MBS rebates and the limitations of the Distribution Priority Area (DPA) is having an impact on recruitment of appropriate clinical staff. Further to this, time for GPs to be able to provide appropriate care is becoming more challenging as the workforce continues to decrease while

the demand for GP service continues to remain steady and/or grow putting substantial pressure on the current workforce.

MBS continues to be at the forefront of discussions with a recent emergency summit being held by the RACGP which called for an immediate and substantial increase in Medicare patient rebates and the bulk-billing incentives (RACGP 2022b).

The RACGP, Australia's largest representative body for GPs survey highlights that almost half of all GPs surveyed were noted as saying that it is financially unsustainable for them to continue working as a GP.

RACGP 2022 *General Practice: Health of the Nation* report highlights concerning issues that have arisen, including:

- burnout among the profession
- unsustainable workload and mounting administrative and regulatory burden impacting on the provision of patient care
- a declining interest in the profession as a preferred career path and a declining willingness from current GPs to recommend the profession as a career.
- worsening workforce issues with increasing numbers of GPs intending to retire or cease practicing over the next 10 years
- underfunding of general practice and the unsustainability of general practice as a business (RACGP 2022b).

Key findings from the *General practice workforce report 2022* (Deloitte 2022) highlight that workforce shortages in some regions are already impacting on accessibility of services, timeliness of service and employment and retention. The report also forecasts a 37% deficit in workforce (in terms of GP supply and demand for services) in major cities in Australia. The modelling estimates that over the next decade (2021-2032) major cities will experience decreases in the supply of GPs (15% reduction in FTE) and GP clinical hours, while demand for GP services is expected to increase by 47% in the same period (Deloitte 2022).

The *National Medical Workforce strategy 2021-2031* (DoH 2022b) notes that substantial barriers exist in the attraction, recruitment and retention of Aboriginal and Torres Strait Islander people in health workforce, including financial hardship, limited pathways across education and employment sector, lack of flexible and accessible learning opportunities, and racism and discrimination.

### 8.3.2 Provision of person-centred health care

Person-centred, or patient-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers (ACSQHC 2011). Person-centred care is the active engagement of people as partners in their care to improve their overall wellbeing, and not focusing solely on individual conditions (APHN 2019c).

Person-centred care relies on health professionals and services to put the patient at the 'centre' of healthcare. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care. Person-centred care helps empower individuals and supports self-management by actively involving people in decision-making regarding their care (Metusela et al. 2020).

A key component of a person-centred health system is the Patient Centred Medical Home. Care provided by a medical home is comprehensive, person-centred, coordinated, accessible and focused on quality and safety (RACGP 2019). This model of care is underpinned by multidisciplinary team-based care; patients build a relationship with their GP and a medical home team and work together to improve their health outcomes and health care experience. As a person's health needs change the



care team expands, access to services outside of general practice are enhanced, communication with patients improved and care is coordinated and monitored for quality (PC 2021).

### ***Barriers to person-centred health care***

#### **Practitioner knowledge and skills**

From the community and consumer perspective, the primary health workforce in Adelaide PHN region often lacked the skills and knowledge to provide truly safe and quality health care services. Specific areas previously identified by for improvement included disability, children's health including developmental and behavioural issues, and the needs of specific population groups including Aboriginal and Torres Strait Islanders, older people, and people from culturally and linguistically diverse background (APHN 2016b, 2017a, 2021a).

The 2023 NA update for Adelaide PHN will have a focus on Health Workforce and undertaking consultation activities with primary care providers, our Councils, and the community will be key to this. Previous consultations with Adelaide PHN Councils determined that the health literacy of health professionals was also a barrier to person centred health care (APHN 2016a, 2016c, 2016b, 2016d, 2017a, 2021a). (Council members commented that improving health literacy would have the following positive impacts:

- Increased access to appropriate, available services
- Improve access to and application of contemporary evidence-based practices
- Improved consumer awareness and uptake of preventative measures, particularly early intervention for chronic diseases
- Reduced unwarranted variation in care
- Improved communication with consumers through use of plain language
- Better understanding of the health needs of people with disabilities, and
- Improve the cultural safety of services, including specialist services.

Practitioners identified potential clinical skills gaps in the region in relation to mental health specifically support for low-intensity interventions; immunisation; and alcohol and other drugs, and a lack of awareness of the National Disability Insurance Scheme (NDIS) and how it can support patients (APHN 2018c).

Primary health workforce knowledge on immunisation, myths and realities, funded and non-funded vaccines, vaccine catch-up programs and best approaches to vaccine hesitant people is often lacking. Access to education and mentoring from people with clinical expertise and quality communication and presentation skills is essential for primary health care providers. It is important they have greater understanding of the vast vaccination landscape across General Practice, Community Health, Local Council and Pharmacy as this informs patients of choice for opportunistic vaccination (APHN 2022f).

#### **Workforce capacity and structural limitations**

Adelaide PHN has commissioned a number of small-scale programs in general practice, based on the principles of the Patient Centred Medical Home model, to encourage preventive care, reduce the burden of chronic conditions and improve the quality of primary care in the region. While these activities reported successful outcomes, general practices encountered a number of barriers and challenges when implementing a patient-centred model: competing demands, time constraints and staffing capacity, and faced difficulties recruiting and retaining patients in the programs (APHN 2021b).

Feedback from general practices participating in the Health Care Homes trial, identified that the program's bundled payment method enabled a previously unseen level of flexibility to the way primary care was provided to patients (APHN 2021b). Once program funding ceased however and the

participating general practices needed to revert back to the traditional MBS Fee-for-Service Model, services attached to the bundled payment model could no longer be sustained. For example, money from the bundled payment was utilised to fund group falls and balance classes run by Exercise Physiologists and Physiotherapists. Aside from the MBS Items for group sessions for patients with Diabetes, MBS items do not extend to these forms of group care and the services cannot be sustained. Thus, the MBS Fee-for-Service Model served as a barrier to general practices implementing a patient centred medical home model (APHN 2021b).

It is recognised nationally that dominant funding arrangements in the health system are a barrier to providing integrated person-centred care to people with chronic conditions (PC 2021), and Scott (2021) notes that current fee-for-service payment model rewards high through-put, “template” “one size fits all” type care and procedural work, more than holistic care.

Further, there are limited financial incentives for healthcare providers to offer support for self-management, as the fee-for-service model does not reward for successful efforts to build people’s self-management skills, manage chronic conditions, or stop them from entering hospital, rather its value is based on time and complexity of the service provided rather than its impact on health outcomes (PC 2021). And while over 40 special Medicare Benefits Schedule (MBS) payments oriented at preventive health and management of specific chronic conditions are available, they are inflexible, complicated and relatively narrow in their focus (PC 2021).

### **8.3.3 Coordinated and integrated care**

Adelaide PHN has commissioned a number of programs based on the principles of the Patient Centred Medical Home model. Well-functioning care teams within these programs have been shown to improve practice efficiency, quality of care, and staff satisfaction. Patients of the programs also reported much improved physical and mental health outcomes (APHN 2021b, 2021f).

Formalised approaches to collaboration within teams and between organisations can significantly improve health outcomes. Collaborative models differ, reflecting local needs and operating environments. But success commonly depends on dedicating time, space and resources for collaboration. This includes having designated workers and activities to promote collaboration, clear governance and accountability mechanisms, and funding contributions from all partnering organisations (PC 2021).

Within general practice, collaboration can involve teamwork including a general practitioner (GP), nurse and allied health professionals. Self-management, education, and care coordination often do not require a GP and may be better performed by another care team member – practices can draw on the expertise of a variety of clinical and non-clinical team members to ensure that patients receive the care they want and need (APHN 2021b). Well-coordinated team-based care also brings together clinicians from acute and primary care, public and private health systems and encourages GP referrals to a broad range of community services. Across organisations, collaboration can involve co-operation and coordination by health workers, managers and leaders (PC 2021).

#### ***Barriers to coordinated and integrated care***

##### **Communication and information sharing**

A lack of timely and quality clinical communication between person, primary and acute health services is an issue that has been consistently raised in consultations and workshops with our membership groups, consumers, clinicians and providers (APHN 2016a, 2016c, 2016d, 2016b, 2016e, 2021a).

For consumers, poor communication reduces transparency, restricts understanding, and results in consumers being unempowered (APHN 2016c, 2016d, 2016b, 2016e, 2021a).

The lack of timely clinical communication about patients and associated issues, and issues with general communication around service changes and availability were identified as a substantial barrier to collaboration between GPs and their acute sector colleagues (APHN 2019b, 2021a).

Previously identified challenges of providing timely and quality clinical communication between providers included (APHN 2019d, 2021a).

- Inflexible methods and limited options – primary and acute medical professionals agreed that a range of communication options are required (emails, phone calls, hot lines, formal letters, web portal access) as the communication method needs to suit the requirements of the situation
- Unclear point of contact – such as a contact person within the hospital, dedicated phone numbers or a web-enabled access point. A real need and strong desire from clinicians across sectors/systems for streamlined and seamless two-way communication without barriers such as unclear pathways
- Lack of automated and interoperable clinical software
- Poor quality clinical communication – inaccurate, irrelevant content, inconsistent and patient needs not clearly addressed
- Not inclusive and/or ongoing – particularly during and after an emergency department presentation or hospital admission to support continued and informed involvement in multi-disciplinary discussions
- No options based on urgency – having available options for urgent contact, as well as improving timelines for ‘non-urgent’ communication, such as discharge summaries, referrals etc

Further, there are few financial incentives for collaboration, and barriers —such as professional and information silos, strategic and policy misalignment, and funding constraints —make it difficult for workers, managers and leaders to collaborate (APHN 2021a; PC 2021).

### Access and navigation

Practitioners recognise that access to primary health care was an area of concern and identified that a range of people in the Adelaide PHN region cannot access services that meet their needs. This includes services for underserved groups and populations, at-home palliative care, services in the after-hours period, as well as overall preventive care and condition management (APHN 2018c, 2019b, 2021a).

Access to acute and specialist services was also identified as an issue. GPs reported the services were unevenly distributed and difficult to refer patients to, either because of inconsistent eligibility criteria, complicated and challenging pathways and referral process, financial cost, or length of waiting time (APHN 2019b, 2021a). Access to services is also hampered by the lack of clear processes and follow-up once a person is discharged from a service (APHN 2019b).

Access to urgent mental health care was highlighted as difficult, and there were often long waiting times for other mental health services, including those commissioned by the Adelaide PHN (APHN 2019b, 2021a).

A lack of respectful and productive relationships between all parties (primary and acute care clinicians), a lack of collaboration and trust, and no unified forward-thinking strategy for better health outcomes were also identified as challenges that need to be overcome (APHN 2019b, 2019d, 2021a).

### 8.3.4 Appropriateness of primary health care

To provide effective health care, health services must be accessible, responsive, and culturally respectful. Issues and needs relating to the accessibility and appropriateness of primary health care in our region, particularly for Aboriginal and Torres Strait Islanders people, people from culturally and linguistically diverse backgrounds, and LGBTIQ+ communities, have been raised in all Adelaide

PHN consultations conducted between 2016 to 2021. The workforce-specific issues are summarised below.

### ***Aboriginal and Torres Strait Islander people***

In previous consultations, the lack of respect and sensitivity from service providers and the need to ensure that health services particularly Adelaide PHN commissioned services are culturally safe for Aboriginal people were reoccurring theme across multiple community consultations (APHN 2016d, 2016e, 2017d, 2018b, 2021a).

This finding was reiterated in the *Aboriginal and Torres Strait Islander Health Needs Assessment for the Adelaide Primary Health Network* (Hossain et al. 2022).

Consultations with Adelaide PHN membership groups and Aboriginal community stakeholders identified a range of workforce-related barriers that impact the delivery of, and access to, health services for Aboriginal people (APHN 2016a, 2016b, 2021a).

They included financial barriers; limited cultural sensitivity and safety; poor perceptions about care and experiences of racism; poor support, communication and coordination between services; long wait times, and poor follow up.

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

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

National data (AIHW 2017d) identified the following areas of focus for workforce to improve services to Aboriginal and Torres Strait Islander people:

- Improved support and service delivery for immunisation
- Improved understanding and use of the many health assessments available for Aboriginal and Torres Strait Islander people to support earlier identification and management of chronic conditions and encouragement of person self-management,
- Earlier identification of mental health and AOD conditions enabling opportunities to refer to services for ongoing treatment and support
- Improvements in undertaking preventative health checks enabling earlier detection of chronic conditions, as well as
- Improvements in chronic disease management using clinicians across systems and sectors to deliver and support this approach.

### ***Culturally and linguistically diverse communities***

Key stakeholders representing the multicultural sector, primary health care and research identified that primary health care providers, including general practice don't have the support, training and capacity to deliver culturally safe and culturally appropriate services to refugee and new arrival populations (APHN 2017e, 2017a, 2021a, 2022b).

Further, the lack of formalised partnerships and referral pathways between the migrant health sector and primary health care services impact access and effectiveness of services. System integration of

primary health care services for refugees and new arrivals would improve access and delivery of culturally appropriate and sensitive primary care services to these populations (AIHW 2017b).

### ***Lesbian, gay, bisexual, transgender, intersex, queer and asexual + (LGBTIQA+) communities***

In previous Adelaide PHN consultations a number of workforce-specific barriers to the accessibility, appropriateness and effectiveness of primary health care in our region for members of the LGBTIQA+ community were raised. Specifically, service providers:

- lacked cultural competency when engaging with LGBTIQA+ people, resulting in misgendering, asking inappropriate questions, and using inappropriate language
- have limited knowledge of the specific health needs of LGBTIQA+ people
- provided services that did not adequately meet communities' needs, and
- have limited capability to connect, integrate or refer consumers to appropriate services (APHN 2020a).

These issues are reflective of national and international research (DoH 2019a; Mullens et al. 2017; SARAA 2019; Penelope Strauss et al. 2017; Waling et al. 2019; Strauss et al. 2017).

Fear of and experiences of stigma and discrimination as a barrier to accessing primary health services was also a reoccurring issued identified in recent consultations with Adelaide PHN Councils and stakeholders (APHN 2020a, 2022b; HCQ 2022).

Consultations also highlighted that some LGBTIQA+ communities, specifically transgender, gender diverse and intersex people, as well as older people and men who have sex with men, have unique health and service needs which require dedicated and specific LGBTIQA+ services and models of care (APHN 2020a).

### **8.3.5 Continuous quality improvement to improve health outcomes**

The use of data to support and inform continuous quality improvement in general practice is supported nationally (DoH 2021d). Monitoring the quality of care is central to person-centred care, and data driven improvement is one of the four foundational elements of High-Performing Primary Care (Bodenheimer et al. 2014).

In 2021/22, 72% of General Practices in the Adelaide PHN region participated in the Practice Incentives Program Quality Improvement (PIP QI) incentive a payment to general practices for collecting and submitting data on specific key performance indicators (KPIs) for activities that support continuous data driven quality improvement in patient outcomes and the delivery of best practice care (APHN 2022) The 2021-22 Adelaide PHN results indicated that as an aggregate group, general practices in the region are generally consistent with the Australian average across the 10 Quality Improvement Measures of the PIPQI (AIHW 2022ah).

As suggested by the high engagement in PIP QI, general practices are aware of the benefits of using data to improve processes and outcomes. However, feedback from providers highlighted time, administrative and service constraints, and the limited capacity of clinicians are substantial barriers to effectively utilizing their clinical, operational, and experience data to inform and develop quality improvement activities and implement appropriate data driven improvement strategies within their practices (APHN 2018c, 2021b).

### 8.3.6 Workforce development

Structural and system issues and changes in practice requirements impact general practices' ability to provide holistic, person-centred, and integrated care for their patients, and Adelaide PHN needs to be mindful of this in its practice support activities.

The current way the medical workforce is trained, organised and funded significantly reduces the ability of the medical workforce to meet population needs for healthcare (Scott 2021). Flexibility and adaptation are central to overcoming these challenges (DoH 2019g). Approaches that allow healthcare professionals to fully utilise and extend their skills are beneficial for consumers, practitioners, and the health system. However, implementing these approaches requires overcoming entrenched workforce norms and established practices (PC 2021).

Adelaide PHN, and all PHNs, have a responsibility to contribute to the provision of a skilled primary health care workforce which meets the needs of the community, the health care system and changing models of care through supporting health care providers to improve their skills.

The GP Roundtables held in 2018-2019 identified that general practitioners require education, training and business support for them and their practice teams. Further interrogation of the information gathered at the Roundtables, and additional information from the Adelaide PHN Council members highlighted specific areas of workforce support and development (APHN 2019a, 2021a).

- Future and reforms
  - Information on State and Commonwealth initiatives
  - Vision for general practice and primary health care
  - New models of care and innovation / disruption
- Professional development
  - Education and training for general practices teams, including GPs, PMs, PNs and front of house staff
  - GP only networking
  - Access to quality resources and development opportunities in local areas, via webinars
- Working together
  - Team-based care between health care providers (including but not limited to general practice, nursing, pharmacy, allied health, mental health providers), both primary and tertiary, public and private
  - Relationships with other organisations – GP bodies, LHNs, NGOs.

### Immunisation

Australia's national aspirational immunisation coverage target is 95% for children at 5 years of age. Reaching this aspirational target will give Australia enough herd immunity to stop the spread of measles and other vaccine-preventable diseases. Currently at State- and PHN-level, both South Australian and Adelaide PHN report that 96% of 5-year-old children are fully immunised and 97% of Aboriginal and Torres Strait Islander children are fully immunised at 5 years of age (DOHAC 2022d).

General Practice Nurses (GPNs) are an integral part of immunisation program service delivery. According to the NCIRS Annual Immunisation Coverage Report (2021), 85% of childhood immunisations are delivered through General Practice in South Australia, with nurses taking responsibility for administering many of the vaccines. Additionally, Local Council Immunisation Services provide the second highest number of childhood vaccines, and almost all adolescent vaccines. It is important for GPNs and Council Immunisation Nurses to be equipped with sufficient



knowledge of the immunisation program recommendations to provide appropriate education to patients and opportunistic intervention (Halcomb and Hickman 2016).

According to the Australian Nursing and Midwifery Federation, nurses have a professional responsibility to promote the benefits of immunisation to inform decision making, provide evidence-based information, understand how to respond to myths and answer questions professionally and confidently and to advocate for populations and communities who face barriers to accessing vaccines (ANMF 2020).

It has taken over two decades of assisting General Practices to achieve this high immunisation coverage, and it is important for General Practices and Local Councils to develop sustainable systems for vaccinating children, adolescents, and adults which must be continued in the context of a changing health care environment. High vaccination coverage cannot be maintained with one-time or short-term efforts. This must be accompanied by a high-quality program where vaccines have been stored and administered according to best practice by providers who have the required skills, confidence and competence.

Immunisation programs will continue to expand and become more complex as more vaccines are developed and improved vaccines replace existing vaccines, ultimately resulting in schedule changes. Ongoing support for General Practices and Local Councils to develop and implement strategies to increase and sustain vaccination coverage is necessary to create lasting, effective immunisation delivery systems. General Practice Nurses and Local Council Nurses will continue to require support, mentoring, education and training to confidently provide a safe, efficient and effective vaccine program. As the Adelaide PHN has a broad lens over the entire vaccine landscape, it is well positioned to ensure quality and timely immunisation support and education are available.

### 8.3.7 Living with COVID-19

The COVID-19 pandemic has had an impact on both consumers and health practitioners in terms of the number of medical services, type of services, and the way in which services are delivered. To reduce the risk of COVID-19 transmission and ensure consumers could still access services during the peak of the pandemic, the government introduced telehealth MBS items so providers could consult by telephone and video conference, and increased schedule fees for bulk billing incentive items for non-referred services. Changes to prescribing and dispensing of PBS medicines were also implemented to increase safety of prescribing doctors, dispensing pharmacists and consumers from contracting COVID-19 while consumers could have continued access to their medicines (AIHW 2020f).

Adelaide PHN, together with Country SA PHN, worked with both Commonwealth and State departments of health to advocate for primary health care and implement supports to ensure the highest quality of care and safety for our community. Since March 2020, Adelaide PHN has supported stakeholders through integration and partnership; communication and information sharing; capacity building, support and engagement, and service procurement.

Since the inception of COVID-19 the Adelaide PHN directly supported the workforce in six broad categories: vaccines, personal protective equipment (PPE), testing, telehealth, communication, and the ever-changing COVID-19 landscape and the associated restrictions. The workforce needs in each of these categories were:

#### Vaccines

- Expression of interest, on-boarding practices
- Eligibility criteria
- Redistribution of excess doses
- RACF in-reach program
- Home visit coordination
- Roll-out – when practices are on-boarding
- Vaccine Clinic Finder amendments

## PPE

- Requests from GP, Pharmacy, Allied Health
- Fit testing/fit checking questions
- Questions re guidelines for PPE wearing
- Provide PPE to GP Respiratory Clinics and Commonwealth Vaccination Clinics

## Testing

- EOI, establishment and support of GP Respiratory Clinics
- Encouraging and supporting general practices to increase testing capacity

## Telehealth

- General questions
- MBS items numbers to be used
- Providing HealthDirect Video Call licenses and support

## Communication

- Webinars
- To the point bulletin
- Primary Links
- Attendance at the State COVID Control Centre

## Emergency directions and restrictions

- Answer any questions related to national and state restrictions at the point in time, eg when to wear masks, cleaning, isolate, social distance, lockdowns etc.

Since 2020, the Adelaide PHN dispatched over 200,000 pieces of PPE to local providers; delivered regular updates via our dedicated website resources, COVID-19 bulletins and COVID-19 sections of our Primary Links newsletters and webinars; and provided ongoing support to the COVID-19 vaccine roll-out to over 200 general practices, four Commonwealth Vaccine Clinics, one Aboriginal Community controlled health service and 198 pharmacies delivering a range of COVID-19 vaccines to the community. Adelaide PHN also supported residential aged care facilities (RACFs) with access to in-reach services.

Targeted support was provided to vulnerable populations by commissioning services and programs that supported the following:

- access to in-home care for those unable to leave their homes due to respiratory symptoms and were unable to access a general practitioner or COVID status and/or due to COVID quarantine requirements
- in-home vaccinations for those who are homebound
- coordination of vaccinations at disability support homes
- vaccination support and provision at events and,
- subsequent vaccination of vulnerable populations through general practices (APHN 2022f).

The Adelaide PHN also partnered with SA Health to expand access for people to respiratory assessments, IV antiviral medication and oral antiviral treatment by co-funding initiatives and expanding operating hours via the Commonwealth funded General Practice Respiratory Clinics.

As Scott (2021) concludes, the impact of COVID-19 on the workforce, service provision and how the population interacts with health professionals long-term is still unclear but going back to what it was before COVID-19 does not seem to be an option. The pandemic has highlighted how flexible the health workforce (and the health care system) needs to be to meet patients' needs in an uncertain

world (Scott 2021). The COVID-19 crisis demonstrates the importance of placing primary health care at the core of health systems, both to manage an unexpected surge of demand and to maintain continuity of care for all (OECD 2021).

Therefore, Adelaide PHN will need to continue to support our local GPs, general practice staff, pharmacy, allied health and other primary health care providers working across Adelaide to better understand the strategy for living with COVID-19 in the Adelaide PHN region, to ensure providers adequately respond to local needs and utilise all available resources, including digital technologies, multi-layered workforces, local services and appropriate infection control policies and procedures. We need to maintain and adapt the systems and structures currently in place to continue to support the primary health workforce in preparedness to manage ongoing infection rates in the community, while maintaining appropriate access, healthcare services and models of care for all people living in the APHN region.

## 8.4 Opportunities and priorities – Health Workforce

Table 9 summarises the priorities arising from the analysis of the health workforce needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. All four priorities were unchanged from the 2021 Needs Assessment.

**Table 9 Health Workforce Priority Statements for the Adelaide PHN, 2022**

Priority	Priority area	Priority sub-category	Expected Outcome
Support practitioners to improve communication and build relationships with other health care providers	Health Workforce	Continuity of care	PHNs support general practices and other health care providers to provide quality care to patients
Support primary health care providers to adopt and implement patient-centred models of care	Health Workforce	Care coordination	PHNs support general practices and other health care providers to provide quality care to patients
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	Health Workforce	Appropriate care (including cultural safety)	Local Workforce has suitable cultural and clinical skills to address health needs of PHN region
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in an ever-changing health landscape	Health Workforce	Emergency response	PHNs support general practices and other health care providers to provide quality care to patients

## 9 Digital health

*As outlined by the Australian Digital Health Agency (2020): “The benefits of digital health are significant and compelling....The improvements to care, experiences and outcomes from the use of digital health are notable: improved access to information to support safer clinical decision making and fewer adverse drug events; improved care coordination and reduced hospital admissions; reduced duplication of diagnostic investigations; and improved health service planning that anticipates demand for healthcare services. Digital health solutions can also enable a more person-centred model of care by empowering people with access to their own health information. Used effectively digital health technologies can support a sustainable health system that delivers safe, high-quality, and effective health services.”*

The national strategic priorities for digital health focus on improving capability, adoption and use of digital health technologies, and standards to improve interoperability. National initiatives focus on privacy, security and risk management; consumer understanding of digital health benefits and their privacy rights; health care professional understanding of how to use digital health tools; Secure Messaging Delivery program; and commitment, corporation and collaboration to promote and support behavioural and structural system changes (ADHA 2017).

In metropolitan Adelaide, Adelaide PHN has been advancing digital health transformation in the local healthcare system through the provision of education, training, and support; advocacy; partnership; and commissioned activities. Our efforts are building the digital health capabilities of the health workforce and encouraging and enabling general practices and other health care providers implement a number of national, state-based and other digital health initiatives such as My Health Record, Electronic prescribing, Telehealth, Secure messaging, Clinical extraction tools, and Electronic shared care planning tools.

### 9.1 Digital health landscape

Primary health care providers in the Adelaide PHN region are reasonably well connected to digital health and actively participate in digital health initiatives. The following provides a snapshot of some of the digital health activities of primary health care providers, primarily general practices, in the region.

#### 9.1.1 Clinical information systems and extraction tools

Primary health care services in the Adelaide region use a wide range of clinical information systems to collect, store and manage data that supports patient care, operational management, and quality improvement. In 2021/22, 97% of the general practices in the region are computerised and use clinical information systems, the most common being *Best Practice* (52%), *Medical Director* (32%), and *Zedmed* (10%) (APHN 2022i, 2022j).

Many practices are using clinical auditing tools to analyse their patient data to improve quality and safety, and in 2021/22 Adelaide PHN provided 243 PenCS licences to general practices within our region. The PenCS clinical audit tool (Cat4) allows practices to participate in the national Practice Incentive Payment for Quality Improvement (PIP QI), a payment to general practices for collecting and submitting data on specific key performance indicators (KPIs) for activities that support continuous data driven quality improvement in patient outcomes and the delivery of best practice care. In 2021/22, 72% of practices in our region participated in the PIP QI (APHN 2022j).

#### 9.1.2 My Health Record

My Health Record is Australia's national electronic health record. My Health Record is an online repository for documents and data containing information about an individual's health and healthcare. My Health Record can be easily accessed by individuals, doctors, specialists or hospitals, allowing timely access to health information to assist decision making, diagnosis and care coordination. The

information can come from various sources including the consumer themselves, their healthcare providers and Medicare (My Health Record 2021).

Increasing the use of My Health Record within our region remains a digital health priority for Adelaide PHN, and we are working closely with the Australian Digital Health Agency, and the South Australian Local Health Networks to connect specialists, general practices, residential aged care facilities and community health organisations to My Health Record. As of October 2022, there have been 429 registrations from general practices across the region to participate in My Health Record since its inception (APHN 2022k).

As of September 2022, 354 pharmacies in the region had registered for the My Health Record (APHN 2022k) and SA Health's pathology service, SA Pathology, Clinpath and Australian Clinical Labs are also connected to the My Health Record system.

The private hospitals and clinics are also progressing in relation to My Health Record, with 118 specialists registered for the My Health Record. Adelaide PHN is currently sitting in the top 10 of PHNs for specialist engagement across the country (APHN 2022k).

### 9.1.3 Telehealth

Telehealth has the potential to solve not only issues arising during pandemics, but also improve access to healthcare for vulnerable and underserved populations. The use of telehealth could also make the system more responsive and flexible to patients' needs. At the onset of COVID-19 in March 2020, new telehealth items were funded from to support a virtualised treatment approach to help protect patients and health providers from COVID-19 by removing the need for physical meetings (Scott 2021).

In January 2022, the MBS telehealth items introduced on a temporary basis in response to the COVID-19 pandemic were made permanent by the Australian Government (DoHAC 2022b). The decision by the Commonwealth Government to make the telehealth MBS items permanently available is aimed at improving access to healthcare particularly for vulnerable and underserved populations. As of October 2022, 94% of General Practices that responded to an Adelaide PHN survey about the use of telehealth (i.e., 233 of 247) reported that they offered telehealth consultations to their patients. There were 330 General Practices within the Adelaide PHN region during the period in view.

In late 2021/22, 749 health care providers from various health care organisations including general practice, specialists, allied health, community health centres and aged care facilities, had Adelaide PHN facilitate access to Healthdirect's Video Call Platform, a telehealth service that supports safe service delivery and safeguarded the wellbeing of patients throughout the pandemic (HealthDirect Australia 2022).

While continuing to promote the use of telehealth by General Practitioners, there is scope to further expand Adelaide PHN's Telehealth Access program to other healthcare professional and organisations. In December 2021, Primary Health Networks received funding to support the Australian Government's response to the Royal Commission into Aged Care Quality and Safety. A cardinal activity under PHN's Aged Care Schedule is to support Residential Aged Care Facilities (RACFs) to increase availability and use of telehealth care for aged care residents. As of June 2021, there were 150 RACFs within the Adelaide PHN region, which we aim to fund to have appropriate telehealth facilities and equipment to enable their residents to virtually consult when needed with their primary health care professionals, specialists, and other clinicians.

### 9.1.4 Secure Messaging

Secure messaging is a key aspect of the National Digital Health Strategy and is a core foundational capability required to enable interoperability and safe, seamless, secure, and confidential information sharing across all healthcare providers. Secure Message Delivery (SMD) is an approach to digital health communication using widely supported information technology standards (ADHA 2017).



As stated by the ADHA (2020), the provision of contemporary healthcare involves patients interacting with multiple healthcare professionals in different locations and patients moving between general practices. The exchange of patient information across the healthcare sector is therefore a requirement of modern healthcare provision. Therefore, providers need to be able to receive, review and incorporate health information from other sources into their existing local health records efficiently and in a manner that supports patient confidentiality, quality clinical handover and effective continuity of care (ADHA 2020).

Since mid-2020 Adelaide PHN has been supporting health providers in the region to adopt secure messaging services through a collaborative project with SA Health. According to the September 2022 SMD adoption report from Digital Health SA (APHN 2022l), 74% of GPs (i.e. 407 of 625) across SA are confirmed to have successfully adopted SMD with 16% (130) pending confirmation and 10% (88) without a secure message address in Health Link's directory. The rate of adoption for general practices within the Adelaide PHN region followed a similar trend with 266 of 360 (74%) general practices in the metro area having SMD activated in their Clinical Information Systems to receive specialist letters and discharge summaries from the hospitals in South Australia.

HealthLink is the digital asset of choice for secure messaging for SA Health as well as for primary health care providers with over 270,000 referral letters sent and received within SA as of October 2022 (APHN 2022m). Our internal mapping of secure messaging applications used by primary care providers also corroborates the dominance of HealthLink as the preferred platform for secure message delivery. According to Adelaide PHN data retrieved as of 15th November 2022, General Practices stated that they were set up with one or more secure messaging platforms, with 98% of General Practices (i.e., 324 of 330) having HealthLink software, 26% with Argus software (85 of 330), 19% with Medical Objects software (63 of 330) and 16% with ReferralNet software (53 of 330) (APHN 2022m).

To further normalize the use of interoperable Secure Messaging systems across the region, there is need for Adelaide PHN to provide guidance to healthcare organisations, including General Practices, on how to set up robust governance, policies, and processes that encourage the consistent use of these channels by healthcare providers and their staff.

### **9.1.5 Electronic Prescribing**

Electronic prescribing has benefits to patients, providers and at a system level by reducing the administrative burden for healthcare providers and organisations; reducing prescription and transcription errors; reducing community and healthcare provider exposure to infectious diseases (such as COVID-19) and ensuring continuity of care (ADHA 2021).

Throughout 2020/21 Adelaide PHN engaged with general practices and over 300 pharmacies to offer support specific to fast-track implementation of the national electronic prescribing program (APHN 2021f). As of November 2022, 87% of General Practices (i.e., 288 of 330) reported that they were participating in Electronic Prescribing (APHN 2022j).

## **9.2 Identified areas for improvement and current barriers**

Since 2016, Adelaide PHN has sought advice and feedback via surveys, consultations and workshops from our Clinical, Community Advisory and Network Leadership groups, primary health care providers, and clinicians from acute and specialist health services about the digital health needs in the region. These findings, combined with outcomes of internal program review processes, intelligence from internal subject matter experts, and statistics from a range of local and national data sources also provide insights about the digital health needs in the region. The following section provides a summary of the key issues and needs identified.

### 9.2.1 Low uptake and inconsistent or incorrect use of digital health tools

Despite improvements in the adoption of digital health tools and initiatives in the region in the past few years, particularly in general practice and more recently pharmacy, wide variation exists in the utilisation of these tools within and across the different health professions.

Adelaide PHN's needs analysis for digital health identified the following key needs in terms of use of digital health solutions:

- Rate of uptake of Digital Health tools is low
- Digital Health tools are not being used correctly, consistently and to full functionalities
- There is an under-utilisation of Digital Health systems to support integration
- There is an inconsistency with the quality of clinical communication
- GPs are not receiving timely access to discharge summary.

From previous analysis of secure messaging vendor data (APHN 2020e), we are aware that most General Practices and Specialists have the HealthLink Secure Messaging System, however only 27% of General Practice and 50% of Specialists use this platform to send information out. Of the survey respondents from General Practice, 43% reported that they do not send anything via Secure Messaging, and 10% were unaware that their practice had access to the HealthLink platform. Another survey around uptake of secure messaging by healthcare providers will be conducted in 2023 to assess the current state.

While secure messaging overall has increased, certain components such as eRequesting, a process that transfers requests from general practice clinical information systems directly to the pathology or diagnostic imaging provider via secure electronic communication, need more attention. In September 2022, 43.3% of general practices had eRequesting for Clinpath and or Australian Clinical Labs enabled (APHN 2022j). Similarly, in 2022 the number of cross views of data in the My Health Record (MyHR) has increased substantially (approximately 150%) since 2020/2022 (APHN 2022k).

Functional, integrated technology that facilitates clinical communication was identified in consultations with LHN and GP representatives as an important issue and opportunity for health system integration (APHN 2019d). However, a lack of timely and quality clinical communication between person, primary and acute health services is an issue that has been consistently raised in previous consultations and workshops with our membership groups, consumers, clinicians, and providers (APHN 2016a, 2016d, 2016b, 2019b, 2019d, 2021a).

However, a lack of timely and quality clinical communication between person, primary and acute health services is an issue that has been consistently raised in consultations and workshops with our membership groups, consumers, clinicians, and providers (APHN 2016a, 2016b, 2016c, 2019a, 2019b).

The lack of timely clinical communication about patients and associated issues, and issues with general communication around service availability and changes was identified as a substantial barrier to collaboration between GPs and their acute sector colleagues (APHN 2019b, 2021a). Data for Australia from a survey of Primary Care Physicians on hospital care coordination suggests that only 24% of information needed to continue managing a patient were received within 48 hours (TCF 2019). This need can be addressed by continued improvements in the appropriate and consistent use of digital health technologies, like secure messaging and My Health Record, to send timely discharge summaries, and will support patient transitions between hospital care to their general practitioner and care team.

## 9.2.2 Barriers to digital health adoption

### *Awareness of tools and understanding of benefits*

A lack of awareness and understanding of digital health tools, including limited understanding of how these tools can create more efficiency for practices and assist with better patient experience was a barrier identified in Adelaide PHN region.

Similar barriers to the uptake of technology in general practice were identified nationally, specifically a mistrust of technology, lack of GP interest in technology, and a lack of belief that technology can improve the management of health information and lead to better health outcomes (ADHA 2020).

In the Adelaide PHN for example, 12% of practices reported that they were aware of My Health Record but were not planning to use it, and two percent of practices indicated they were not aware how it could benefit their work and their patients. Despite this, only 5% of practices requested assistance from the Adelaide PHN in using My Health Record (APHN 2018c). Another survey around awareness and use of My Health Record by healthcare providers will be conducted in 2023 to assess the current state.

A lack of awareness of the benefits was identified as a barrier to practice participation in data quality improvement activities and the national Practice Incentive Program (PIP QI) (APHN 2018c).

### *Workforce capability and capacity*

Feedback from providers and the digital health team highlighted time, administrative and service constraints, and the limited capacity of clinicians are substantial barriers to effectively implementing and consistently using digital health tools (APHN 2018c, 2021b). This in line with the feedback from consultations with LHN and GP representatives where it was identified personal behaviours and administrative capacity restricted the uptake of digital solutions (APHN 2019d). Another survey around workforce capability and capacity of healthcare providers will be conducted in 2023 to assess the current state.

### *Limitations of current systems and technologies*

Interoperability is another factor impacting the rate of uptake of digital health tools in the Adelaide PHN region.

Consultations in 2019 with LHN and GP representatives identified interoperability, the inability of the large array of health platforms to communicate with one another, as the biggest issue restricting collaboration and integration, as it prevented the flow of information directly between the software of the acute system and that being used in primary care (APHN 2019d). The use of different coding and terminology across general practice clinical information systems also makes it difficult to transfer, compare and analyse data between systems. This is a barrier to effective data exchange, semantic interoperability, research and quality improvement (RACGP 2020).

Interoperability, set up time, and cost were also identified by general practices as barriers to them effectively implementing digital secure messaging services (APHN 2020d). This is reflective of the barriers identified for general practices in the *ADHA roadmap* (2020) –the high cost of investment in expensive technologies, systems and support, and lack of education and training for practice staff in using technology.

According to the MBS data for 2021/22, South Australia ranked 5th of 8 states and territories in Australia in terms of MBS Telehealth item claims despite the telehealth policy changes during and after COVID-19 (DoHAC 2022c). De Guzman (2022) argues that although permanent funding is necessary for telehealth sustainability, other factors such as presence of time pressures, consumer preferences and perceived capacity to provide high-quality patient care virtually must be considered to encourage long-term telehealth adoption and sustainable change in primary care in Australia. White (2022) supports the view that more needs to be done to improve telehealth going forward.

Specifically, there is a need to effectively train clinicians to competently utilize and be confident using this telehealth and educate patients on necessary skills and etiquette.

### 9.3 Opportunities and priorities – Digital Health

Table 10 summarises the priorities arising from the analysis of digital health needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. All four priorities were unchanged from the 2021 Needs Assessment.

**Table 10 Digital Health Priority Statements for the Adelaide PHN, 2022**

Priority	Priority area	Priority sub-category	Expected Outcome
Primary health care providers have access to resources and support to improve digital health literacy	Digital Health	Practice support	Health care providers are aware of the digital health systems and technologies
Primary health care providers are supported to adopt and fully implement digital health technologies	Digital Health	System integration	PHNs support health care providers to use digital health systems to improve patient care and communication
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	Digital Health	Continuity of care	PHNs support health care providers to use digital health systems to improve patient care and communication
Primary care providers are supported to use digital health tools that improve safety and quality of care	Digital Health	Safety and quality of care	Digital health enables better coordinated care and better informed treatment decisions

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