



**Australian Government**  
**Department of Health**



An Australian Government Initiative

# Primary Health Networks Program Needs Assessment Report

This Primary Health Network's (PHN's) Needs Assessment report was submitted to the Department of Health on **15 December 2021**, and approved on **25 March 2022**.

**Name of Primary Health Network**

***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

ABS	Australian Bureau of Statistics
ADHA	Australian Digital Health Agency
ADIS	Alcohol and Drug Information Service
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
Adelaide PHN	Adelaide Primary Health Network
ASD	Autism Spectrum Disorders
ASR	Age-Standardised Rate
BBV	Blood-Borne Viruses
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
COPD	Chronic Obstructive Pulmonary Disease
ED	Emergency Department
FTE	Full Time Equivalent
DASSA	Drug and Alcohol Services South Australia
DHW	SA Department for Health and Wellbeing
dTpa	Diphtheria-tetanus-pertussis
DOH	Department of Health (Commonwealth)
GP	General Practitioner
HNA	Health Needs Assessment
HPG	Health Priority Group
HPN	Health Priority Network
IRSD	Index of Relative Socioeconomic Disadvantage
LGA	Local Government Area
LGBTIQ+	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
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
NPA	National Priority Area
OST	Opioid Substitution Therapy
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
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
SA	South Australia
SA2	Statistical Area Level 2
SA3	Statistical Area Level 3
SA4	Statistical Area Level 4
SALHN	Southern Adelaide Local Health Network
SG	Steering Group
STI	Sexually Transmitted Infections
SMD	Secure Message Delivery
TWP	Towards Wellness Plan
WCH	Women's and Children's Hospital
WG	Working Group

# 1 Narrative

## 1.1 Needs Assessment process

### 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.

### Background

Since 2015 Adelaide PHN has completed eight NA reports by triangulating health, service and community<sup>1</sup> needs, and input from Adelaide PHN membership<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 on the reports can be found on Adelaide PHN website.

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

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

### 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 process from 2021, and aims to improve the iterative and relevant annual NA by documenting and guiding the processes and procedures including the evidence informed methodologies and tools.

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<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 Health Priority Network

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

The NA is overseen by the Adelaide PHN Needs Assessment Steering Group (the Steering Group, SG). The core functions of the SG is to provide oversight and make recommendations on strategic decisions including on:

- Project tasks and deliverables
- Assign tasks and responsibilities
- Identify and act upon continuous quality improvement opportunity
- Identify strategic integration and engagement opportunities
- Project timelines and risks

The SG is represented by functions across the Adelaide PHN and provides an opportunity for any interim NA working groups to report to.

### ***Adelaide PHN Needs Assessment WG***

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 was reflective of experiences in the region, and to support any additional data collection systems.

## **2021 Process Outline**

The following section outlines the key phases of work.

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

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

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

As outlined in the Framework, the Steering Group undertook a scoping review to determine the National Priority Areas (NPAs) that would undergo a comprehensive update; in 2021, four NPAs were selected for a comprehensive update: Mental Health and Suicide Prevention; Digital Health; Workforce and Older People and Aged Care.

The Steering Group recommended that a major update to the Aboriginal Health NPA could not occur until Adelaide PHN has established appropriate consultation pathways and identified key community stakeholders. Members identified a number of potential individuals and organisations (such as Aboriginal Health Council of South Australia and Wardliparingga Research Unit) that we could approach to partner with us to undertake this work. Members will continue to further scope and plan this activity in preparation for the Needs Assessment update that will be submitted in 2022.

Population Health has also been identified for a major update in 2022, however, minor updates were made based on information available.

Alcohol and Other Drugs undertook a major update in 2020, so did not require any major updates.

### ***Data Collection and Analysis***

Data collection occurs throughout a calendar year, but for inclusion in the 2021 year quantitative data collection ceased in September. Data sources included, externally sourced data (including commonwealth and state health data), publicly available data, Adelaide PHN developed data sets

(including commissioned service provider data). Qualitative data such as consultation and summative reviews of services were also included in the data collection. Qualitative data collection for inclusion in the 2021 NA ceased in October.

Data was collected, collated and sorted by NPA and is stored and documented using a triangulation matrix identifying the key learnings from each data source. Once data is sorted, health needs analysis and service need analysis were undertaken by NPA.

The findings from the health need analysis and service need analysis, separately describe the needs in the region. The WG support the needs assessment by supporting the triangulation and bringing together the findings of each analysis type by key theme to formulate key need statements.

### **Application and Use**

The outputs from the previous phases of work are a set of needs, identified in a systematic way. Before they can be used for decision making, these needs were rated and ranked using a modified Hanlon method.

The priority setting describes decisions about the allocation of resources between the competing claims of different services, different patient groups or different elements of care.

WG members and the Adelaide PHN Membership were invited to use a modified Hanlon method (which had been previously developed with membership) to score and rank the need statements.

These need statements were then considered and re-grouped, leading to the final priority statements.

The final priority statements are considered by each WG to identify options and opportunities for action, including identified outcomes and leading partners. In 2021, the Adelaide PHN decided to promote further integration and strategic alignment, the outcomes for the priority statements were taken from the PHN Program Performance and Quality Framework.

### **Membership involvement**

The Adelaide PHN membership groups are the key target audience for consultations to help inform and identify opportunities for improvement across the seven national priority areas. In 2020, the membership were consulted via online surveys to inform the redesign process and help inform the priority setting process and identify any new needs of the communities in the region.

Specifically, the Adelaide PHN call upon the Adelaide PHN membership group to support the Needs Assessment. The Adelaide PHN membership consists of the Aboriginal Community Advisory Council, the Community Advisory Council, the Clinical Council, and the Network Leadership Group, representing, professionals, clinicians, peak bodies, communities, lived experience

In 2021, the membership contributed to the NA in two different ways.

- Participation in a facilitated workshop. The workshop looked at key factors influencing needs and priorities in the region, to support refining of needs and to provide contextual factors.
- Prioritisation process. The Adelaide PHN membership were invited to participate in the prioritisation of identified needs

Outside of these specific consultations, the Adelaide PHN Needs Assessment also considered findings from engagement and consultations which are part of business as usual.

Specific consultations for mental health were undertaken as a part of re-commissioning of Adelaide PHN commissioned primary mental health care services. The consultations included a stakeholder survey and a range of focus groups.

The consultations engaged over 100 stakeholders from diverse groups, including people with lived experience of mental illness, GPs, mental health clinicians, and representatives from Adelaide PHN primary mental health care CSPs, 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. Stakeholders had the opportunity to identify the vulnerable populations within the community in the context of mental health.

### **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 in a community 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, thus has the role of identifying and actioning a continuous quality improvement process. As part of the 2021 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.

Learnings from these reviews are considered and actioned ahead of planning for the 2022 NA.

### **Gaps and Limitations**

The Adelaide PHN has taken every step to include all information and data relevant to the health and wellbeing of the community.

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. Notably, there is some information that is only available at a national or state level and cannot be reported on at a local level. Further access to data specific to population cohorts such as Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds, older people, and children and young people, will provide additional insight into the needs of the Adelaide metropolitan community. Additionally, throughout the report there is mention of data five years and older, such population data from the 2016 Census of Population and Housing; while this is not ideal, it is the most up to date and recent data currently available.

In previous years Adelaide PHN has conducted large surveys of both General Practice and Allied Health providers in the region, however these were not conducted in 2020 or 2021, primarily due to reduced workforce capacity, and reorientation of resources in our organisation because of COVID-19. Adelaide PHN is currently considering possible alternate mechanisms for how best to engage with our health workforce, the results of which will be included in future NA updates.

As part of the review of the Adelaide PHN NA and NA process, including the development of the NA Framework, a data collection framework will be developed to better understand the gaps in data, supplementary data collections processes and opportunities to collect, collate and analysis these data sources. This may include partnering with key stakeholders and research institutions such as the South Australian Health and Medical Research Institute (SAHMRI), Local Health Networks and general practices.

Additionally, the Adelaide PHN continues to work towards incorporating findings from commissioned service activity.



## 2 Adelaide PHN region

### 2.1 Our region and people

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

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

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

### Population

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

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

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

### Demographic profile

#### *Children and young people*

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

#### *Older people*

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

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

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



### ***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.

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

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

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

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

#### ***Demographics***

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

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

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

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

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

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

#### ***Language and literacy***

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

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

Nationally, 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).

***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; if this proportion was reflective of the Adelaide PHN region, in 2016 there would have been approximately 28,300 people aged 18 years and identifying as gay, lesbian or other sexual orientation (ABS 2017a).

## 3 Population Health

### 3.1 Health status

#### Health risk factors

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

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

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, risk factor prevalence data shows that substantial geographical variation exists within 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 the Australian and Adelaide PHN rates (PHIDU 2021a).

#### Smoking

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

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

#### Physical inactivity

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

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

#### Unhealthy weight

In 2015, 6 in every 10 South Australians aged 18 years and over (62%) were overweight or obese (unhealthy weight), and this proportion has increased from 54% since July 2002 (SA Health 2015c).

Recent data (between July 2016 and March 2018) also shows similar trends – 61.4% of South Australians were overweight or obese (SA Health 2018a).

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

### **Vegetable consumption**

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

### **Fruit consumption**

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

### **Children and young people**

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

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

## **Early intervention and preventive health**

### **Cancer Screening**

#### **Bowel cancer screening**

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

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

#### Breast cancer screening

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

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

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

#### Cervical cancer screening

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

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

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

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

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

#### Promotion of national cancer screening programs

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

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

The Survey showed that two-thirds of respondents reported participation in cervical screening within the last three years (N=1,231) and of these respondents (n=814) reporting participation in cervical screening, over a third (38%) booked an appointment because of a letter from their GP, a quarter (25%) due to a

discussion with their GP, nearly a fifth (18%) because of a letter from the Cervical Screening Register and just over 10% after a text message from their GP (SA Health 2019a).

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

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

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

### **Childhood immunisation**

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

The overall immunization rates for children in the Adelaide PHN region had increased in the year to 30 June 2021, with 95.4% of children aged 12-<15 Months fully immunized, 93.0% of children 24-<27 Months, and 95.9% of children 60-<63 Months. These rates were a slight increase on the previous period. (DOH 2020, 2021)

Although overall rates are generally high and meet the National target of 95%, coverage still varies across the region for each age group. Adelaide City and Port Adelaide – West were the SA3s with consistently lower coverage rates across the three age groups.

For the 12-<15 Month group, four SA3s were below the national target: Port Adelaide – West (92.7%); Adelaide City (93.5%); Holdfast Bay (94.2%); and Playford (94.4%). Coverage rates were low for 24-<27 Months, with only one SA3 meeting the national target, Holdfast Bay (96.2%). The SA3s with the lowest rates were Adelaide City (86.5%); Port Adelaide – West (88.8%); Burnside (90.6%); Campbelltown (SA) (92.0%); Charles Sturt (92.1%); and Playford (92.8%).

For 60-<63 Months group, five SA3s were below the 95% target: Adelaide City (82.9%); Unley (93.6%); Norwood - Payneham - St Peters (94.1%); West Torrens (94.2%); Holdfast Bay (94.5%).

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

Since 2019, Adelaide PHN has been working collaboratively with SA Health (Communicable Disease Control Branch) in providing General Practice data to assist in the monitoring and surveillance of recent outbreak of infectious Syphilis among Aboriginal and Torres Strait Islander people living in South Australia. Consequently, Adelaide PHN is contributing to inform SA Health – Sexually Transmissible Infection (STI) and Blood Borne Virus (BBV) policy and service planning for Aboriginal and Torres Strait



Islander people in SA. In 2020, the PHN will work with the CBC Branch to inform quality improvement initiatives for Adelaide Metropolitan General Practitioners. Furthermore, Adelaide PHN is a member of the SA Sexually Transmissible Infection and Blood Borne Virus Advisory Committee (SASBAC), a high-level committee, which monitors, BBV and STIs across metro, regional and remote South Australia.

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

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

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

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

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

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

In the Adelaide 2018 Gay Community Periodic Survey (Broady et al. 2019), nearly three-quarters of men who have sex with men (71.3%) reported knowing that post-exposure prophylaxis (PEP) was available. PEP awareness has increased over time, from 59.2% in 2011 to 71.3% in 2018. There has also been a rapid increase in the awareness of pre-exposure prophylaxis (PrEP), from 25.5% in 2014 to 77.7% in 2018. Increased awareness of post-exposure prophylaxis and pre-exposure prophylaxis (PrEP) among men who have sex with men didn't translate to uptake: there was only a 2.5%-point increase from 2014 to 2018 in non-HIV-positive men taking PEP (5%), and the use of PrEP in non-HIV-positive men was 16% in 2018, however this was a substantial increase on 1% in 2014. The proportion of non-HIV-positive men who reported taking a prescribed course of PEP in the six months prior to the survey increased from 2.4% in 2014 to 4.9% in 2018.

The increase in PrEP use was more dramatic, with the proportion of non-HIV-positive men who reported PrEP use increasing from 0.8% in 2014 to 16.1% in 2018. Among men who reported taking a prescribed course of PrEP in the six months prior to the 2018 survey, more than half obtained PrEP through a trial or study (59.2%) and one in four obtained it from a chemist (25.4%) (Broady et al. 2019). Men who obtained PrEP from a chemist are assumed to have received a prescription for PrEP from their doctor, reflecting the listing of PrEP on the Pharmaceutical Benefits Scheme in 2018. The listing of PrEP on the PBS has opportunities for the Adelaide PHN in providing further support (e.g. education) to General Practitioners in the region.

## Chronic Conditions

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

The most recent data available for the Adelaide PHN region (2017-18) indicates that the chronic conditions with the highest prevalence rates were arthritis, asthma, chronic kidney disease (2011-12), diabetes mellitus, heart, stroke and vascular disease and osteoporosis. At the region (PHN) level, chronic condition prevalence was consistent with average Australian rates. However, within the Adelaide PHN region substantial geographical variation exists, with rates in the northern, western and southern areas, specifically in the Local Government Areas of Playford, Salisbury, Port Adelaide Enfield, and Onkaparinga, consistently and significantly higher than the Australian and Adelaide PHN average rates (PHIDU 2021a).

The following section present the prevalence rate for Adelaide PHN, the national comparison rate and the sub-regions with the highest rates for selected chronic conditions.

### Diabetes

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

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

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

### Cardiovascular conditions

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

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

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

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

### Respiratory conditions

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

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

### Asthma

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



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

#### **Chronic Obstructive Pulmonary Disease (COPD)**

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

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

#### **Musculoskeletal system conditions**

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

#### **Arthritis**

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

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

#### **Osteoporosis**

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

#### **Kidney disease**

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

#### **Comorbidities**

Comorbidities are a growing challenge for health professionals and patients in managing their chronic conditions in Australia. In 2016, 25% of the Adelaide PHN population had two or more chronic conditions, and 16% had three or more (BEACH 2016).

A joint Adelaide PHN and Country SA PHN HealthPathways Consumer survey (N=110) targeting consumers (i.e. those with chronic conditions and carers) reported that for Adelaide PHN participants (n=101), chronic pain, mental health, arthritis, asthma, diabetes and COPD were the top conditions respectively for HealthPathways prioritization. Other conditions reported included Myalgic Encephalomyelitis/Chronic Fatigue Syndrome or ME/CFS, Fibromyalgia, and Hashimoto's Thyroiditis (APHN 2018a).

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

## Chronic pain

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

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

This study highlights the high levels of pain with extreme effects on day-to-day life (one in 20 people), the complex inter-relationship of the factors including educational achievement and work status associated with chronic pain, and the impact that these factors have on the people experiencing disabling pain in the longer term. Based on SA population, approximately 250,000 people experience chronic pain, of these approximately 70,000 have severe pain requiring input from a tertiary chronic pain service.

Approximately one in ten of these patients experience pain related to cancer. There are around 3,000 new cases referred to chronic pain services each year (Currow et al. 2010).

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

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

## Cancer

### Prevalence

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

### Cancer Incidence

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

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

- Adelaide City: 26% higher for breast cancer for women (all ages) and 39% higher for women aged 50 to 69 years old; 6% higher for prostate cancer
- Burnside: 18% higher for breast cancer for women (all ages) and 17 % higher for women aged 50 to 69 years
- Prospect-Walkerville: 46% higher for breast cancer for women (all ages) and 62% higher for women aged 50 to 69 years old; 11% higher for colorectal cancer (all ages); 9% higher for lung cancer
- Unley: 6% higher breast cancer for women (all ages)
- Playford: 5% higher for colorectal cancer (all ages) and 11% higher for people aged 50 to 74 years; 47% higher for lung cancer

- Port Adelaide – East: 20% higher for lung cancer
- Port Adelaide – West: 13% higher for colorectal cancer (all ages) and 8% higher for people aged 50 to 74 years; 29% higher for lung cancer
- Salisbury: 10% higher for colorectal cancer for people aged 50 to 74 years; 16% higher for lung cancer
- Holdfast Bay: 8% higher for breast cancer for females aged 50 to 69 years; 8% higher for prostate cancer
- Marion: 8% higher for breast cancer for females (all ages) and 5% higher females aged 50 to 69 years; 8% higher for prostate cancer
- Onkaparinga: 5% higher for breast cancer for females (all ages)
- West Torrens: 7% higher for breast cancer for females (all ages)

### Cancer Mortality

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

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

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

## 3.2 Health service utilization

### General Practice visits

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).

Between July 2016 to March 2018, the top three SA3s with the highest proportion of participants visiting a general practitioner (in the past 12 months) were: Port Adelaide-West (95%), Adelaide City (94%), Norwood-Payneham-St Peters (93%) respectively (SA Health 2018a). For the same reporting period, 31.4% of participants indicated visiting a general practitioner in the past four weeks (SA Health 2018a).

### **After-Hours services**

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

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

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

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

In 2017-18, 29% of Adelaide PHN residents, approximately 360,000 people, had used an After-Hours GP service, with 25% using a non-urgent service and nine percent an urgent service. Over 800,800 services were delivered in the after-hours period in 2017-18 equivalent to an ASR of 65 services per 100 people (AIHW 2019h).

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

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

### **Use of HealthDirect helpline**

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

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

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

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

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

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

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

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

### **Potentially preventable hospitalisations (PPH)**

A collaborative project with SA Department for Health and Wellbeing (DHW), the Health Performance Council (HPC), Adelaide PHN, and Country SA PHN followed the Grattan Institute's Perils of Place report (Duckett & Griffiths 2016) methodology to analyse PPAs for the SA population from hospital data for the 2004 to 2018 period. A summary of the findings for metropolitan Adelaide are presented below. For the full report and detailed analysis by condition see [South Australian Areas to Act Report: a South Australian Review of Potentially Preventable Admissions](#).

### **Hotspots**

'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 hot enough (a rate of at least 50% above the state average), persistently hot (hot for a specified number of years) and therefore considered likely to stay hot.

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 et al. 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 et al. 2020).

### **PPH conditions**

Based on the number of hotspots identified for each PPA condition, the top 10 PPA conditions in SA were identified. The top 10 conditions were:

- 1. Chronic obstructive pulmonary disease – 22
- 2. Convulsions and epilepsy – 20
- 3. Diabetes complications – 18
- 4. Angina – 17
- 5. Other vaccine-preventable conditions – 15
- 6. Asthma - 15
- 7. Congestive cardiac failure – 14
- 8. Dental conditions – 14
- 9. Ear, nose and throat infections – 13
- 10. Cellulitis – 12 (DHW et al. 2020).

### **Children and young people**

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

### **Lower urgency care**

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

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

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



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

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

## **Factors impacting service use and provision**

### ***Health literacy***

Numerous studies have shown that people with low health literacy are at higher risk of worse health outcomes and adverse health behaviours. 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 2020).

As summarized by the AIHW (2020) 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. The development and delivery of understandable and effective population health messages during such large-scale outbreaks must consider the health literacy levels among the population particularly of vulnerable sub-populations.

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).

### ***Access, integration and coordination***

In 2019-20, 27% of people could not access their preferred GP in the preceding 12 months, and 18% who saw a GP in the Adelaide PHN region waited longer than they felt was acceptable to get an appointment (ABS 2020b).

Access, integration, coordination and navigation barriers are consistently raised as an issue in consultation with APHN membership groups (APHN 2016a, 2016d, 2021a) and during APHN facilitated GP's Roundtable Workshops with GPs in the region (APHN 2019d). A summary of the barriers and specific needs raised under each theme are provided below:

#### ***Timely access and navigation***

- Urgent mental health care was difficult to access and that there were often long waiting times for other mental health services, including commissioned ones
- Access to services is hampered by challenging pathways and referral processes, including eligibility criteria, lack of clear processes and follow-up
- Limited availability of primary health services and community-based after- hours services
- Limited knowledge of what services are available for people experiencing chronic pain.
- A need for better pathways for consumers to enable navigation through the primary health care system (particularly for the socially isolated, at risk families, mental health, and vulnerable populations)

- Too complex for consumers and users in navigate system properly – consequently the inability to access information or programs pertinent to them
- The importance of consumers and carers knowing about services and how to access them
- The need to improve coordination and access to primary health care services and programs and build the capacity of the primary health care workforce (incl. GPs) to meet the needs of at risk and vulnerable people.
- Staff to be adequately trained to enable timely and accessible services
- Affordability and cost of accessing health services despite the availability of quality and quantity of chronic disease services.
- GPs identified that a range of people in the Adelaide PHN region cannot access services that meet their needs. This includes services for underserved groups and populations as well as overall preventive care and condition management.

#### Integration and coordination

- Lack of system integration e.g. standardized access and integration processes between primary care and both public and private hospital services
- Need to increase integration through coordination and communication between services and practitioners
- Integrated approaches are the key need for (improving) care coordination, integration and navigation
- Less fragmentation and more cooperation and linkages both within the primary health care sector and between primary and intermediate care settings
- The need to coordinate pathways to primary health care
- Coordination of care and systems and where health providers communicate and share information about patients in minimising the duplication of information
- A primary health care service model which is interagency and interdisciplinary, particularly for people with additional needs e.g. living with a disability
- Inclusive of and supportive of formalised carers and care coordinators.
- Currently a lack of a unified / interfacing communication system and culture of care coordination
- Primary health system is not responsive – conditions need to escalate before able to access services, and currently there is a lack of holistic discharge planning
- More integrated digital systems across services

#### Collaboration with acute services

In line with the findings of the Adelaide PHN membership group consultations presented above, a lack of collaboration was also identified an issue during Adelaide PHN facilitated workshops with GPs and representatives from the three Local Health Networks (APHN 2019d). A lack of timely clinical communication about patients and associated issues, and general communication around service availability and changes, as well as geographical maldistribution, length of waiting time or a complicated referral process were identified as additional access barriers for consumers to acute services (APHN 2019d).

Further findings from these consultations are provided in the Workforce chapter.

### 3.3 Primary care needs for priority populations

#### Children and young people

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



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

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

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

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

In a Position Statement on the 'Early Intervention for Children with Developmental Disabilities' (RACGP 2013), the RACGP emphasized that access to early intervention support services for children with developmental disabilities, including ASD, maximises positive life-long outcomes. However, early intervention can be highly dependent on obtaining a diagnosis (Taylor et al. 2016).

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

### **Culturally and Linguistically Diverse Communities**

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

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

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

Consultations with local stakeholders representing the multicultural sector, primary health care and research identified that refugee and new arrival populations have limited understanding of the Australian

health system and lack access to appropriate and timely primary health care services. Low health literacy also limits their ability to make informed decisions about their health and health care (APHN 2017c). Inclusion and empowerment; access and equity; quality and capacity building were identified as key principles of care for persons from CALD backgrounds (Principe 2015).

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

### **Lesbian, Gay, Bisexual, Transgender, Intersex, 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 (2019h). To better understand the health and service needs of this population and build upon the evidence presented in previous Needs Assessment submissions, the Adelaide PHN undertook an environmental scan of recent relevant literature, conducted consultations with the Adelaide PHN memberships groups and interviews with several 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 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 (Australian Government Department of Health 2019), 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 et al. 2018; Australian Government Department of Health 2019).

There is a large and consistent evidence base showing that a range of social, psychological and economic factors are recognised as increasing the risk of adverse impacts on physical and mental health, and contribute to the higher health burden and poorer outcomes in 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 et al. 2018; Leonard et al 2012; Strauss et al 2017). In line with the above, fear of and experiences of stigma and discrimination as a barrier to accessing primary health services was a reoccurring issued identified in recent Adelaide PHN membership and stakeholder consultations (APHN 2020a).

Consultations also raised a number of workforce-specific barriers to the accessibility, appropriateness and effectiveness of primary health care in our region. They included service providers: lacking cultural competency when engaging with 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 (Australian Government Department of Health 2019; Mullens 2017; SARAA 2019; Strauss et al 2017; Waling et al. 2019).

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

### 3.4 Opportunities and priorities – Population Health

Table 2 summarises the priorities arising from the analysis of population health needs identified in the Adelaide PHN region. Three priorities were unchanged from the 2020 Needs Assessment, and seven new priorities were identified for Population Health, fully replacing the remaining Population Health priorities from 2020.

**Table 2 Population Health Priority Statements for the Adelaide PHN, 2021**

Priority
Children, young people and their families have timely access to early intervention, prevention and support services
People at risk of developing or living with chronic or complex conditions receive timely and appropriate interventions, care, support and management
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access culturally safe and appropriate primary health care services in a timely way
Integration, coordination and partnerships between primary and acute care to improve continuity of care and health outcomes
Primary health care workforce have knowledge, skills and capacity to safely support and meet the specific needs of LGBTIQA+ communities
LGBTIQA+ communities can access safe, inclusive and appropriate mental health services and alcohol and other drugs treatment options
LGBTIQA+ communities can access safe, inclusive and appropriate primary health care services
People in the Adelaide PHN region understand how to access a variety of primary care services when and where they need them
People in the Adelaide PHN have awareness of and timely access to preventative and early intervention services
People in the Adelaide PHN region receive holistic and person-centered care that is responsive to individual circumstances

## 4 Aboriginal and Torres Strait Islander Health

The information contained in this Chapter reflects content that was provided in 2020/21. While this Chapter has not been updated for 2021/22 it will be reviewed comprehensively and updated in 2022/23 in consultation with Adelaide PHN's advisory groups and other key stakeholders.

### 4.1 Health status

#### Health risk factors

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

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

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

#### Chronic conditions

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

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

The all-cause mortality rate was also higher for Aboriginal and Torres Strait Islander populations in South Australia compared to the population as a whole, 9.2 deaths per 1,000 population compared to a rate of 6 deaths per 1,000 from 2010-2014 (ABS 2016). The six leading causes of death for Aboriginal and Torres Strait Islander people in SA in 2013-2017 were:

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

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

- Age-standardised death rates for some chronic diseases in 2011–2015 were higher for Aboriginal and Torres Strait Islanders than for the general population: more than 4 times as high for diabetes (74 compared with 18 per 100,000); and twice as high for digestive diseases (46 compared with 21 per 100,000); and

- The incidence rate for Aboriginal and Torres Strait Islander people with end-stage kidney disease increased from 24 per 100,000 in 1997, to 40 per 100,000 in 2014.
- Aboriginal and Torres Strait Islander people had a higher age-standardised rate of hospitalisation for injury from July 2013 to June 2015 compared with non-Aboriginal and Torres Strait Islander people (47 compared with 24 per 1,000). The most common injuries resulting in hospitalisation were: assaults (22%), falls (19%), and complications of medical and surgical care (14%) of all hospitalisations.

## Cancer Screening Participation

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

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

A growing body of evidence indicates that Aboriginal and Torres Strait Islander women are under-screened (AIHW 2019i).

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

## Child and Youth Health

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

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

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

The immunisation rates for Aboriginal and Torres Strait Islander children living in the Adelaide PHN region have significantly increased since 2013-14, Aboriginal and Torres Strait Islander children still have a lower rate of fully immunised children at 1-, and 2-years of age, compared to non- Aboriginal and Torres Strait Islander children in the region (DOH 2020, 2021).

The overall immunization rates for Aboriginal and Torres Strait Islander children in the Adelaide PHN region had increased in the year to 30 June 2021, with 92.4% of children aged 12-<15 Months fully

immunized, 89.2% of children 24-<27 Months, and 96.5% of children 60-<63 Months. These rates were an increase on the previous period (DOH 2020, 2021).

For Aboriginal and Torres Strait Islander children, over a third (37.6%) aged 5-17 years in South Australia were overweight or obese. This percentage is higher when compared to non-Aboriginal and Torres Strait Islander children and to the national average for Aboriginal and Torres Strait Islander children (32.8%) (HPCSA 2018). Compared to other states and territories, South Australia is ranked second highest (HPCSA 2016). The AHPC national data indicated that unhealthy weight in childhood is a significant issue for Aboriginal and Torres Strait Islander children and young people (AHPC 2017).

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

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

## 4.2 Mental Health

Note: this section is duplicated in the Mental Health Chapter: Priority Populations - Aboriginal and Torres Strait Islander people.

Mental and substance use disorders (19%) are the leading cause of total disease burden experienced by Aboriginal and Torres Strait Islanders people (AIHW 2016e). Nationally, in 2018–19, among Aboriginal and Torres Strait Islander people it was estimated that 24% reported a mental health or behavioural condition, with anxiety the most commonly reported mental health condition (17%), followed by depression (13%) (ABS 2019b).

### *Psychological Distress*

In 2018–19, an estimated 61% of South Australian Aboriginal and Torres Strait Islander adults reported 'low or moderate' levels of psychological distress, while 36% 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 2019b).

### *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 2019/20, the rate of community mental health care service contacts was 3.6 times the rate for non-Aboriginal and Torres Strait Islander South Australians (AIHW 2021a).

Patterns of use by Local Health Network 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. 2017b),
- 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. 2017c), 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. 2017d).



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 annual average 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. 2017a).

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

In 2020, suicide was the 5th leading cause of death for Aboriginal and Torres Strait Islander people in Australia, compared to 13th for non-Aboriginal and Torres Strait Islander people (ABS 2021).

From 2016-2020, suicide was the leading cause of death for Aboriginal and Torres Strait Islander children in Australia. Almost one-third (32%) of deaths of Aboriginal and Torres Strait Islander children were due to suicide (ABS 2021). Over 73% of Aboriginal and Torres Strait Islander children who died by suicide were aged between 15 and 17 years.

From 2016–2020, the age-standardised death rate from intentional self-harm for Aboriginal and Torres Strait Islander South Australians was 65% higher than the rates for non- Aboriginal and Torres Strait Islander South Australians, 20.9 deaths per 100,000 population compared to 12.7 deaths per 100,000 population respectively (AIHW 2021b).

The highest rate of intentional self-harm deaths in Aboriginal and Torres Strait Islander people was in young people aged 35–44 years (54.1 per 100,000 population), with the second highest rate in the 25–34 age group (23.8 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, 18.2 per 100,000 population for 35–44 year olds and 17.3 per 100,000 population for people aged 25-34 years (AIHW 2021b).

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. 2017b),
- 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. 2017c), 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. 2017d).

## **4.3 Alcohol and Other Drugs**

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

### **Overview**

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



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

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

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

## **Alcohol**

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

As presented below, Aboriginal and Torres Strait Islander people living in Adelaide PHN, South Australia or Australia experience harms associated with alcohol use at a rate much higher than non-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 2020). Although this is a reduction since 2012-13 of 23% and 55% respectively (Roche et al. 2017a), rates for short-term risk for Aboriginal and Torres Strait people are still substantially higher than total region rates of 27% (AIHW 2020c).

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

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

## **Tobacco**

The proportion of 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 et al. 2017a).

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

In 2014-15, 76% 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; this is higher than the national rate of 69% (AIHW 2017e).

### **Non-medical substance use**

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

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

Nationally, cannabis was the most common recently used substance by Aboriginal and Torres Strait Islander people (16%) (as it was for the non-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 2020c). Compared to rates of use 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 for pain killers and opioids (AIHW 2020d).

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

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

### **Service gaps**

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

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

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

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

## 4.4 Use of primary health services

### Uptake of Aboriginal and Torres Strait Islander Health Checks

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

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

### Factors impacting service use, provision and health outcomes

#### Access

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

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

#### Cultural safety and appropriateness

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

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

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

## 4.5 Opportunities and priorities – Aboriginal and Torres Strait Islander Health

Table 3 summarises the priorities arising from the analysis of Aboriginal and Torres Strait Islander needs identified in the Adelaide PHN region. Six priorities were unchanged from the 2020 Needs Assessment, and one new priority was identified for mental health, replacing the previous mental health-related priority from 2020.

**Table 3 Aboriginal and Torres Strait Islander Health Priority Statements for the Adelaide PHN, 2021**

Priority
Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non- Aboriginal and Torres Strait Islander children.
Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people
Accessibility to and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people.
Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people
Awareness of timely access to appropriate services (including after-hours services) for Aboriginal and Torres Strait Islander people
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate AOD treatment services

## 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 2021c).*

*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 (COTA 2021)*

### 5.1 Demographic Profile

In Australia, if present trends continue, 25 percent 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 (2020c) 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

#### 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 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).

## 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* (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).

## 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 2021d). 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 2021d).

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 2021d).

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 2021d).

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).

## 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) (British Geriatrics Society 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 A 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 et al. 2017a).

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 et al. 2017b). 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 2020).

## 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)

## **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 (AIHW 2020g).

### **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 2021c). 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 2021c).

## **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 2021e). 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 and Masud 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 2020c). In 2017/18 328 people living in metropolitan Adelaide died as a result of a fall (AIHW 2021e). 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 2021e).

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 and Masud 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**

### **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 2017f).

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 2021h).

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 2021h).

### **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 2021h).

### **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 2021h). 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 2021h).

### **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 2021c).

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 2021h).

## **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 (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 2021h).

### **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.

## **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 2018b).

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 (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 (2020a) 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. 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 2019c). 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 2020g)

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 2021b). 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 2021b).

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 2021b).

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 (2021g) 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 2021d). 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 2021c). 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 2021b, 2021c). 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).

### **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 2021d). 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 2021d).

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 2021d). The pandemic has also raised issues about staff working at multiple sites, and levels of staff training in infection prevention and control (DOH 2021d).

The 2020 Aged Care Workforce Census (DOH 2021d) 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 2021d).

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

Table 4 summarises the priorities arising from the analysis of the needs identified in the Adelaide PHN region. Four new priorities were identified for Older People and Aged Care replacing the previous priorities from 2020.

**Table 4 Older People and Aged Care Priority Statements for the Adelaide PHN, 2021**

Priority
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care.
Older people requiring community and residential aged care services are supported by a skilled, motivated, and empowered workforce.
Older people living in the community and residential aged care are supported by timely, accessible, coordinated primary care services in and out of hours.
Older people have access and support from palliative care services which address their needs, wishes and health care preferences.



## 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). 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 most appropriately support people 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-serviced 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).

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 collaborated 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 addresses 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 young people with chronic and complex (severe) mental health conditions and improving access to 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. Service issues identified in the consultations are provided throughout this chapter. The full consultation 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 (DHW 2019). 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 2021c).

#### **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 East (77% higher than the Australian rate), 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 2020b).

#### **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.

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).

## **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 2019a)

### ***Suicide ideation***

In 2015, 5% of South Australians aged 18 years and over were estimated to experience suicidal ideation (SA Health 2016). Based on this estimate, approximately 47,000 people aged 18 years and over in the Adelaide PHN region had experienced suicidal ideation in the past year (ABS 2017c). The overall prevalence of suicidal ideation has remained constant at the State level over the past ten years (SA Health 2016).

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

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 2021b) indicates that in the Adelaide PHN region the highest overall rates (per 100,000) for hospitalisations from intentional self-harm in 2019/20 were females aged 0-24 years (228.8), females aged 25-44 years (176.4), and people aged 25-44 years (163.8).

In 2019/20 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 Adelaide City (243.0), Port Adelaide-West (206.5), Onkaparinga (195.0), Marion (173.6), Playford (169.3) and Salisbury (154.5).

The areas with the highest hospitalisation rates from intentional self-harm of people aged 25-44 years were Playford (324.7), Adelaide City (286.2), Onkaparinga (204.0), Marion (182.1), Salisbury (177.2) and Port Adelaide-West (154.8).

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

In 2020, there were 155 deaths from suicide in the Adelaide PHN region (AIHW 2021b).

From 2016-2020 the SA3s with the highest suicide rates (per 100,000) were Holdfast Bay (16.2), Playford (15.2), Adelaide City (15.1), Norwood-Payneham-St Peters (14.7), Port Adelaide-West (14.7) and Salisbury (14.6).

Areas with the highest number of deaths by suicide from 2016-2020 were Onkaparinga (106), Salisbury (102), Playford (67), Charles Sturt (67), Marion (66) (AIHW 2021b).

In the five years from 2016-2020, death rates from suicide in the Adelaide PHN region were significantly higher in males compared to females, ranging from 2.5 times higher in Adelaide-South SA4 to 3.6 times higher in Adelaide -West SA4 (AIHW 2021b).

### ***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.

## **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 2021f).

## 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.

### Medicare subsidised mental health services

In the five years from 2015/16 to 2019/20, the overall crude rate of Medicare-subsidised mental health-specific services in the Adelaide PHN region increased by 9%. General practitioner (GP) provided services increased by 14% in this period, clinical psychologist services increased by 12%, while Medicare-subsidised psychiatrist services decreased by 7% (AIHW 2021f).

In 2019/20, 208,795 people in the Adelaide PHN received a Medicare-subsidised mental health service, with 632,248 services provided in total. GPs provided 186,324 of the total services, clinical psychologists 177,973 services, and psychiatrists 130,858 services (AIHW 2021f).

#### By age

In Adelaide PHN in 2018-19, 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 2020h).

#### By sub-region

In 2018/19, the SA3s region with the highest rates of Medicare-subsidised mental health-specific services (per 100 people) by provider type were:

- Playford (20.8), Salisbury (16.8), Onkaparinga (16.2), Port Adelaide - West (15.2) and Adelaide City (14.5) for GP provided services;
- Unley (31.9), Mitcham (29.5), Onkaparinga (27.9), Marion (26.3), and Prospect – Walkerville (26.0) for allied health mental health care services; and
- Adelaide City (18.1), Unley (17.7), Norwood - Payneham - St Peters (15.8), Burnside (14.9) and Prospect - Walkerville (14.7) for psychiatry services (AIHW 2020h).

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 2020h). Service mapping undertaken by Adelaide PHN still identifies a concentration of providers of psychological and psychiatry services in the centre of the Adelaide PHN region (APHN 2017d; APHN et al. 2020). Previous service mapping identified that approximately two-thirds of providers of psychological services, and two-thirds of mental health services are located in the centre of the Adelaide PHN region (NHSD 2015).

### Mental health-related prescriptions dispensing

In the six years from 2014–15 to 2019–20 the SA3s of Playford, Onkaparinga, Tea Tree Gully, Port Adelaide – West, Holdfast Bay and Adelaide City had the highest rate of dispensing for mental health-related prescriptions (subsidised and under co-payment) (AIHW 2021f). 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).

## Acute mental health services

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

From 2014–15 to 2019–20 mental health-related emergency department presentations in Adelaide PHN region increased by 10%, notably higher than growth in total emergency department presentations of 2% (AIHW 2021f). In the Adelaide PHN region in 2019-20 there were almost 19,000 emergency department presentations for mental health, equivalent to a rate of 152.3 per 10,000 people (AIHW 2021f).

There was significant variation in presentation rates across the Adelaide PHN region, from 62.2 per 10,000 people in the SA3 of Burnside, to 212.5 per 10,000 in Adelaide City. The SA3s of Adelaide City (212.5 per 10,000), Playford (206.8), Onkaparinga (202.7), and Marion (201.6) consistently had the highest rates of mental health-related emergency department presentations from 2014–15 to 2019–20 (AIHW 2021f).

### *Mental health-related hospital admissions*

In 2017/18 in the Adelaide PHN region there were 15,053 admissions for mental health-related conditions, equivalent to a rate of 1,210.9 per 100,000 population (PHIDU 2020b).

There was significant variation in admission rates within LGAs across the Adelaide PHN region, from 849.8 per 100,000 people in Burnside, to 1,789.2 per 100,000 in Adelaide. Rates also were also high in Holdfast Bay (1,706.9), Marion (1,628.2), Prospect (1,475.2), and Walkerville (1,416.0).

In 2018-19 there were 13,212 overnight mental health-related admissions, resulting in over 160,000 patient bed days (AIHW 2020h). There was a large regional variance in rates for overnight admissions, with seven SA3s above the Adelaide PHN rate of 107.0 per 10,000 population. The highest rates occurred in Adelaide City (162.5 per 10,000 population), Marion (137.3), Port Adelaide – West (131.3), Onkaparinga (126.3) and Holdfast Bay (123.0) (AIHW 2020h).

Nationally in 2018-19 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 (20% of total); dementia (10%); mental and behavioural disorders due to other psychoactive substance use (8%); and depressive episode (6%) (AIHW 2020h). For overnight admissions with specialised psychiatric care, the top five primary diagnoses were: depressive episode (16% of total); schizophrenia (14%); 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 2020h). 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 2017c).

## 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 2019b).

Adelaide PHN commissions a range of low intensity service options and pathways such as face-to-face low intensity psychological services delivered on 1:1 or group basis, and telephone or on-line low intensity psychological services. 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.

Feedback from stakeholders demonstrated that there is a perception among some consumers and GPs that low intensity programs are less effective or less valuable compared with psychological therapies. Stakeholders also emphasised that there is a low awareness among GPs about the available programs. Other concerns raised included: that group-based therapies are often fully booked, leading to protracted wait times; and the lack of clarity concerning eligibility and categorisation for referrals. Several



stakeholders noted that certain modalities were not suited to the needs of some consumers (specifically group-based therapies and programs not offered face-to-face) (APHN 2021d).

### **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 2019c).

Adelaide PHN commissions psychological services to complement fee-for-service MBS mental health services in the region; they account for the majority of the primary mental health services that Adelaide PHN commissions. Psychological therapy services in the Adelaide PHN region are provided by psychologists, mental health nurses, mental health competent occupational therapists, mental health competent social workers; and Aboriginal and Torres Strait Islander health workers.

Stakeholder consultations raised a number of issues relating to current psychological service provision in the region. Protracted wait times to accessing psychological therapies for consumers experiencing moderate mental health conditions was raised across multiple stakeholder groups. Additional concerns raised were lack of psychologists; the additional support needs of consumers seeking to access NDIS; and the increasing complexity and severity of presentations in primary mental health (APHN 2021d).

### **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 2019d). 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 (NMHSPF, UOQ 2016).

However, there are currently few formalised pathways to care between Adelaide PHN and LHNs when delivering services to people with chronic and complex (severe) mental health conditions in the Adelaide metropolitan area. This can also be extended to people with mental health concerns who are experiencing physical health problems.

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. 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).

### **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 (TWP 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).

## **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, 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.

### **Aboriginal and Torres Strait Islander people**

Mental and substance use disorders (19%) are the leading cause of total disease burden experienced by Aboriginal and Torres Strait Islander people (AIHW 2016d). 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 2019b).

## ***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 36% 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 2019b).

## ***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 2019/20, the rate of community mental health care service contacts was 3.6 times the rate for non-Aboriginal and Torres Strait Islander South Australians (AIHW 2021f).

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. 2017b)
- 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. 2017c), 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. 2017d).

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 annual average 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. 2017a).

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

In 2020, suicide was the 5<sup>th</sup> leading cause of death for Aboriginal and Torres Strait Islander people in Australia, compared to 13<sup>th</sup> for non-Aboriginal and Torres Strait Islander people (ABS 2021).

From 2016-2020, suicide was the leading cause of death for Aboriginal and Torres Strait Islander children in Australia. Almost one-third (32%) of deaths of Aboriginal and Torres Strait Islander children were due to suicide (ABS 2021). Over 73% of Aboriginal and Torres Strait Islander children who died by suicide were aged between 15 and 17 years.

From 2016–2020, the age-standardised death rate from intentional self-harm for Aboriginal and Torres Strait Islander South Australians was 65% higher than the rates for non- Aboriginal and Torres Strait Islander South Australians, 20.9 deaths per 100,000 population compared to 12.7 deaths per 100,000 population respectively (AIHW 2021b).



The highest rate of intentional self-harm deaths in Aboriginal and Torres Strait Islander people was in young people aged 35–44 years (54.1 per 100,000 population), with the second highest rate in the 25–34 age group (23.8 per 100,000 population). For non-Aboriginal and Torres Strait Islander people, the same age groups had the highest rates, however the rates were lower, 18.2 per 100,000 population for 35–44 year olds and 17.3 per 100,000 population for people aged 25–34 years (AIHW 2021b).

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. 2017b);
- 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. 2017c); 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. 2017d).

## **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 2021c).

AIHW data (2019a) 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 2019a).

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 and Wodak 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 2017–18, South Australia had the highest proportion of ED presentations (all ages) in public hospitals for 'behavioural and emotional disorders with onset usually occurring in childhood and adolescence (ICD-

10-AM-code F90–F98), at 7.2% of all mental health presentations. This was over triple the rate of other states, with a national rate of 2.6% (AIHW 2019a). More than one-quarter (26.3%) of all mental health-related ED presentations in 2017-18 were for people aged under 25 years (AIHW 2019a).

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

### ***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 highest rates and number of prescriptions dispensed correlated with areas of lower socioeconomic status (ACSQHC 2015).

### ***Autism***

The proportion of the population with Autism Spectrum Disorder (ASD) in South Australia (all ages) is estimated to be 0.7% (ABS 2015a), 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). According to the ABS Survey of Disability, Ageing and Carers (SDAC), an estimated 164,000 Australians had autism in 2015 and the number of people with autism in Australia has increased considerably in recent years, from an estimated 64,400 people in 2009 (ABS 2015a). Of those who were estimated to have autism in 2015, 143,900 were identified as also having disability (88%) (ABS 2015a).

Analysis of Adelaide PHN General Practice data for FY 2018-19 indicates there were 2,174 patients aged 0 to 18 years who visited a general practice and have a coded diagnosis of ASD. This is equivalent to 1.3% of all patients aged 0 to 18 years (APHN 2019a). Most of these ASD coded diagnoses in this age group are patients visiting practices in the NALHN region (45% of the APHN). SALHN and CALHN had 31% and 24% of the Adelaide PHN diagnoses coded for ASD respectively.

### ***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) 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***

Commonwealth PHN guidance identifies children, 0-11 years, as an underserved group when attempting to access preventative, and mild to moderate intensity psychological therapies (DOH 2019e). 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.

### **People from CALD backgrounds**

South Australia is home to people from more than 200 CALD backgrounds. In the Adelaide PHN region, 323,544 people were born outside of Australia, including 215,431 people who were born in a predominantly non-English speaking country (ABS 2017e). Approximately 44,600 people residing in the Adelaide PHN region in who speak a language other than English at home reported poor proficiency in spoken English (ABS 2017e).

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 2018g)

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 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 2018g).

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 2021c).

## 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 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 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 2018c);
- 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 SA and SARAA 2018).

To gain a better understanding of the health and service needs of our local LGBTIQA+ communities Adelaide PHN consulted our memberships groups and interviewed several LGBTIQA+ service providers in the region. Mental health and suicide were identified by all as an urgent and serious problem (APHN 2020a). LGBTIQA+ 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. Difficulties have been experienced with workforce recruitment and the service has a long wait list (4-6 months) (APHN 2021c).

### **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 2017b).

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 et al. 2017a).

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 2017b). 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 2017b).

### **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 (TWP 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 2015c).

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 2015c).

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 2015c). 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 2015c).

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 2015c).

### **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 2021c). 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 2018a).

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.

### **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. Within the Adelaide PHN region, higher levels of homelessness are experienced in Adelaide City (644), Port Adelaide Enfield (751), Salisbury (627),

Onkaparinga (485) and Playford (401) (Adelaide Zero Project 2018). 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.

### ***Clinical psychologists***

The number of clinical psychologists working in the region has grown by 18% from 2016 to 2020 (DOH 2021a). In 2020, 1,240 clinical psychologists worked in the region, 264 in SALHN (21%), 804 in CALHN (65%) and 172 in NALHN (14%) (DOH 2021a).

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 2021a).

### ***Psychiatrists***

The number of psychiatrists working in the region has grown by 9% from 2016 to 2020 (DOH 2021a). In 2020, 1,240 clinical psychologists worked in the region, 48 in SALHN (18%), 168 in CALHN (64%) and 46 in NALHN (18%) (DOH 2021a).

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 2021a).

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

The number of mental health nurses working in the region has grown by 11% from 2016 to 2020 (DOH 2021a). 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 2021a).

## **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, Thomas and Boyle 2020). Job satisfaction, turnover intention and burnout are major issues for the mental health workforce (Cleary, Thomas and Boyle 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, Thomas and Boyle 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 2021c).

In recent stakeholder consultations, 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.

## **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, 2016c, 2016d, 2020c, 2021a, 2021d).

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).

## 6.9 Opportunities and priorities – Mental Health and Suicide Prevention

Table 5 summarises the priorities arising from the analysis of mental health and suicide prevention needs identified in the Adelaide PHN region. Twelve new priorities were identified for Mental Health and Suicide Prevention, replacing the previous priorities from 2020.

**Table 5 Mental Health and Suicide Prevention Priority Statements for the Adelaide PHN, 2021**

Priority
Aboriginal and Torres Strait Islander people can access timely, culturally safe and appropriate primary mental health care services
Children at risk of, or experiencing mild to moderate mental health conditions and their families/carers have access to appropriate primary mental health services
LGBTIQA+ communities can access safe, inclusive and appropriate primary mental health care services
People from underserved and hard to reach populations experiencing mental health conditions have access to timely, appropriate and integrated primary mental health services
People at risk of, or experiencing mild to moderate mental health conditions can access primary mental health services through a range of modalities
People experiencing severe mental health conditions have access to appropriate supports, services and coordinated care
Responsive and appropriate psychosocial support services that meets the needs of people with severe mental health conditions
Timely, region specific, cross-sectoral suicide prevention services for people who are at risk of suicide and/ or who have recently attempted suicide
People experiencing mental health conditions are supported by a workforce with the skill mix that meets a diverse range of needs
Enhance service and clinical integration between mental health care providers, and with State services
Integration between primary mental health services and alcohol and other drug treatment services to improve continuity of care and outcomes
Ensure visibility of Adelaide PHN commissioned services and eligibility criteria to GPs, state, community services and to underserved groups to enhance access

## 7 Alcohol and other drugs

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

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

Alcohol and other drug (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 (Commonwealth of Australia 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 (Adelaide PHN 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 (Commonwealth of Australia 2019b). Adelaide PHN expects all commissioned service providers to hold or be actively working toward one of the accreditation standards (Adelaide PHN 2020b).

### 7.1 Redesign of Adelaide PHN-funded Alcohol and Other Drug Treatment Services

Following a review and redesign of the AOD Treatment Services Program, Adelaide PHN developed, in 2020, its Alcohol and other drugs Treatment and Quality Framework. 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 including a series of consultations that were used to inform 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).

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).

Newly commissioned AOD service providers, commencing 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.

## 7.2 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.

### Alcohol

Alcohol consumption has resulted in significant fiscal and health costs in Australia. In 2010, the cost of alcohol-related harm (including harm to others) was reported to be \$36 billion. Nationally, alcohol is also associated with over 5,000 deaths and more than 150,000 hospitalisations every year (DOH 2017b). Alcohol-related harm has a significant impact on Australian society with almost 250,000 Australians estimated to have been the victims of an alcohol-related physical assault in 2015-16. Alcohol also has an impact on frontline police and health workers (DOH 2017b). In addition, 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 2020a).

Rates of alcohol consumption in the Adelaide PHN region are consistent with national rates (AIHW 2020b). 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 2020b).

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

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 2020b).

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 2020b).

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 and DASSA 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).

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

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

## **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

2021 (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).

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

Prevalence of recent methamphetamine 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 ED presentations (463 presentations) and 22% of AOD-related hospitalisations (924 hospitalisations, the 2<sup>nd</sup> highest contributor after alcohol) in the Adelaide PHN region (Roche et al. 2017b).

### **Non-medical use of pharmaceuticals including opioids and benzodiazepines**

The range of pharmaceutical drugs commonly used for non-medical reasons include opioids (such as oxycodone, fentanyl, morphine, methadone, pethidine and codeine), benzodiazepines (such as diazepam, temazepam and alprazolam), and other analgesics (such as paracetamol and ibuprofen in preparations combined with codeine) and performance and image enhancing drugs (such as anabolic steroids, phentermine and human growth hormones). The harms that can arise 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 2017b).

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 2017b). 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 2017b).

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

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

Opioids and benzodiazepines are the main drug groups associated with unintentional drug-induced deaths in Australia. Deaths involving other prescription medications – such as anti-convulsant medications (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 since 2013-14 (ACSQHC 2015), however they are higher in Adelaide PHN compared to the national rate. In 2016-17, there were 893,316 opioid prescriptions dispensed in Adelaide PHN, representing a rate of 63,175 prescriptions per 100,000 population, compared to 58,595 per 100,000 population nationally (ACSQHC and AIHW 2018).

There were large variations in the rate of dispensing of opioid medicine prescriptions across the region. Rate of dispensing in the Statistical Area Level 3 (SA3) with the highest rate (Playford) was 2.9 times higher than the SA3 with the lowest rate, Burnside SA3 (37,749 per 100,000 population) (ACSQHC and AIHW 2018). Playford SA3 had the highest age-standardised rate for dispensed prescribed opioids in South Australia and the second highest rate nationally, with 111,262 prescriptions per 100,000 population (ACSQHC and AIHW 2018). This is also an increase in the rate since 2013/14 of 109,191 per 100,000 population (ACSQHC 2015).

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

### ***Patterns of anxiolytics prescription dispensing***

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

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

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

Like opioid dispensing, a clear social gradient was apparent in the age standardised population rate of dispensed prescribed anxiolytics. As socio-economic status within an SA3 declined, the rate of dispensed prescribed opiates increased (ACSQHC 2015). The difference in 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).

## **Cannabis**

Cannabis is the most widely used of the illegal drugs 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 2017b).

Cannabis was the most common illicit drug used in the Adelaide PHN region and use has remained relatively stable in recent years; in 2016, the prevalence was 11% of the general population (Roche et al 2016; DASSA and SANDAS 2018). Analysis of wastewater suggests that average consumption levels in metropolitan Adelaide have fluctuated over 2019 and 2020, but on average appeared to have remained consistent with 2018 consumption levels. Overall average consumption declined from 2012 to 2017 (DASSA 2020b). Cannabis consumption in the Adelaide PHN region increased substantially in mid-2020, before decreasing in early 2021 and increasing again in mid-2021 (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 2020b).

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 et al. 2017b).

## **Other drugs of concern**

### **Ecstasy**

Analysis of wastewater suggests that within metropolitan Adelaide overall average ecstasy consumption levels have been increasing since February 2019, in contrast to the previous pattern of decline from 2012 to 2018 (DASSA 2020b). Levels of use increased substantially in mid-2020, before declining in late 2020 and early 2021 (DASSA 2021).

At the state level, ecstasy use increased between 2018 and October 2020, before declining in late 2020 (ACIC 2021).

### **Cocaine**

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

Analysis of wastewater suggests that cocaine consumption levels 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 2017b). Nicotine was the most common secondary drug of concern in data collected from local treatment services (SANDAS and DASSA 2018).

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

## **7.3 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 2017b). 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 + (LGBTIQA+) and people in contact with the criminal justice system (DOH 2017b; APHN 2020a, 2020c; Purdie, Dudgeon, & Walker 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.

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

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, Dudgeon, & Walker 2010). A lack of, and lack of access to adequate, and appropriate treatment services and prevention strategies also contribute (DOH 2017b; 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 2017b). Wherever possible, interventions should be based on evidence of what works specifically for Aboriginal and Torres Strait Islander people (DOH 2017b; 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).

## 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 2020). Although this is a reduction since 2012-13 of 23% and 55% respectively (Roche et al. 2017), rates for short-term risk for Aboriginal and Torres Strait people are still substantially higher than total region rates of 27% (AIHW 2020c).

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

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

## **Tobacco**

The proportion of 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 et al. 2017a).

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

In 2014–15, 76% 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; this is higher than the national rate of 69% (AIHW 2017e).

## **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 2020b), compared to 40% of Aboriginal and Torres Strait Islander people living in Adelaide PHN in 2018-19 (ABS 2020b). This was also a substantial increase from the 2012-13 rate of 27% (Roche et al. 2017a).

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

Nationally, cannabis was the most common recently used substance by Aboriginal and Torres Strait Islander people (16%) (as it was for the non-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 2020c). 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 2020d).

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 et al. 2017)

## **Service gaps**

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

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

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

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

## **Children and young people**

Young people (between the ages of 10 and 24 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 2017b).

Nationally, in 2015, 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 for females (AIHW 2019j). While tobacco smoking and the use of alcohol and illicit drugs is declining among young people, the consumption of alcohol at risky levels remained high in 2019 (AIHW 2020b).

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

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

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

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

## Culturally and linguistically diverse communities

There is limited data about substance use in culturally and linguistically diverse (CALD) populations within the Adelaide PHN region which leaves them vulnerable to 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 2017b).

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

## 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 2017b).

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

Compared to the general population, LGBTIQ+ populations are 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 2019c, 2020c). For specific substances, compared to heterosexual Australians rates of use amongst homosexual or bisexual Australians were approximately:

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

There is limited data about substance use in LGBTIQ+ populations within the Adelaide PHN region which leaves them vulnerable to 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 (APHN 2020a).

A lack of access to appropriate, safe, and inclusive AOD treatment services, and the lack of dedicated LGBTIQ+ AOD treatment services in the region were needs identified by stakeholders who were consulted (APHN 2020a). 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 use prevalence and the needs of the LGBTIQ+ communities due to inadequate data collection also needs to be addressed (APHN 2020a).

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.

## Older people

Harmful use of prescription medications, effects of illicit drug use and alcohol 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 2017b). 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 (Pennington 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 2020c). Older people often have unique health circumstances including pain, co-morbidities, and social circumstances such as isolation (DOH 2017b). 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 2020c). A review conducted by Roche et al. (2017a) identified that as well as alcohol, opioids, analgesics, anxiolytics (particularly benzodiazepines) and cannabis were the main drugs of concern for older people residing in the Adelaide PHN region.

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

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

To better understand the emerging 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)

A series of recommendations have been identified to achieve Option 2:

Recommendation 1: Examine and address barriers to older people's services to address AOD problems

Recommendation 2: Undertake workforce development activities to enhance responses among primary, secondary and tertiary health and welfare workers to address the needs of older people with AOD use issues

Recommendation 3: Undertake workforce development activities to enhance responses among AOD workers to older people with AOD use issues

Recommendation 4: Enhance linkages between agencies with a role in responding to AOD problems among older people

Recommendation 5: Enhance responses to older people from: Culturally and linguistically diverse (CALD) backgrounds; Aboriginal and Torres Strait Islander backgrounds; and lesbian, gay, bisexual, transgender, intersex, queer or asexual (LGBTIQA+) people with substance use issues

Recommendation 6: Enhance access to age-specific health promotion programs and resources for older people in the Adelaide PHN Region (Fischer et al. 2021).

## **People in contact with the criminal justice system**

People in contact with the criminal justice system in Australia are one of the most vulnerable groups in the community; they experience a range of complex and chronic health problems (Fazel & Baillargeon 2011), entrenched poverty and social disadvantage (Baldry et al. 2002; 2006) and cycles of imprisonment (AIHW 2016d; 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 2019k).

Compared to the general population, people in prison have higher rates of mental health conditions, chronic disease, communicable disease, acquired brain injury, tobacco smoking, high-risk alcohol consumption, recent illicit drug use, and recent injecting drug use (AIHW 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 2019k).

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 2019k).

In 2015, 13% of South Australian prisoners used illicit drugs in prison and six percent injected drugs while in prison (AIHW 2015, in Roche et al 2017a). Nationally in 2018, 8% of people discharged from prison d 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 2019k).

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).

### **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 2017b).

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

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

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

Co-morbidity, or the co-occurrence of an alcohol, tobacco, and other drug use disorder with one or more mental health condition, 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 2017b). 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 2017b).

Based on literature reviews and secondary analysis of various data sets, Roche et al. (2017a) has 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 et al. 2017a).

### **Alcohol use**

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

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

### **Tobacco use**

Tobacco smoking rates in South Australians who had been diagnosed 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 et al. 2017a).

### **Use of other drugs**

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

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

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

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

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

## **7.4 Priority actions**

The National Drug Strategy (DOH 2017b) 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.

## **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 and DASSA 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 and DASSA 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 and DASSA 2018).

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

### **Choice of services for Aboriginal and Torres Strait Islander people**

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

However, it is also important to minimise the potential for social conflict and disruption within kinship networks in Aboriginal and Torres Strait Islander communities (Gomez 2014). Consultations 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' (Intergovernmental Committee on Drugs 2014). Both community-controlled AOD services and mainstream services that are culturally safe and appropriate, are needed to ensure Aboriginal and Torres Strait Islanders people can choose the service that suits their needs.

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 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 (Intergovernmental Committee on Drugs 2014). It is important that all health services, such as AOD services, understand and respect the diversity of culture that exists for Aboriginal and Torres Strait Islander people. Aboriginal cultures are many and varied but share elements that are important across all 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 2014).

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

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

### ***Person-centred treatment services***

The National Framework for Alcohol, Tobacco and other Drug Treatment 2019-2029 (2019) is clear on the importance of AOD treatment services being person-centred. 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 (Turning Point 2017). For this reason, treatment strategies should be broader than clinical responses, include social support services and focus on long-term provision of services in a seamless manner (NDRI 2014).

Previous consultation with the Adelaide PHN community has identified holistic service delivery approaches focusing on the whole person and their circumstances (such as coexisting physical health needs and social factors) as a priority area (APHN 2016d 2016e 2017e). This is reflected in more recent consultations where stakeholders identified that complexity is often the norm, (APHN 2020c) with complexity being 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 & DASSA 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 2016c).

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, Colquhoun, & Johnson 2006 in Gomez 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).

### ***Measuring performance and outcomes***

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

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

As part of the Alcohol and other Drugs Treatment and Quality Framework, Adelaide PHN 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 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 4 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. It typically takes approximately 10 minutes to complete (APHN 2021e).

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 Maori. 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 (DHHS 2018). In a recent survey, a majority (65%) of AOD workers reported AOD lived experience (personal, family, other), of whom two thirds (63%) declared it to their workplace (Skinner 2020).

Recent Adelaide PHN consultations with key stakeholders from the local AOD treatment sector identified that 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).

Peer workers are undervalued in the current local system, and 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 (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).



## **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 (NDSC GP Working Group 2019) include:

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

## **Consistent prescribing practices**

Primary health care workers, including 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. Adelaide PHN has recently appointed an AOD GP Support Project Officer to support the uptake of the RACGP's online training for GPs.

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

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

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

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

## **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 of whom 5 had 101 or more clients each and a further 12 prescribers who had between 51 and 100 clients each

(AIHW 2021i). 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 stakeholder and membership groups has prioritised a need for health literacy, early intervention and better education for consumers and professionals across the health sector (APHN 2016a, 2016b, 2016c, 2016d). This would be aimed at improving and encouraging the take-up and application of preventative measures. Whilst this issue is generic it is applicable to substance use issues. Stakeholders have previously identified that primary health care workers need to be better equipped to address the needs of people experiencing complex health issues. There is a need to ensure health services and programs are sustainable and focus on both early intervention and recovery programs (APHN 2016c). For example, an earlier consultation identified the quality use of medicines as a priority to be embedded as a principle across all Adelaide PHN programs, specifically around improving health literacy and education with regards to opioid prescribing (APHN 2016a).

The evidence from data and stakeholder consultations in the NDSC GP Working group paper shows that although GPs are engaging with people with substance use issues, it appears to be limited and more could be done. This is despite the fact that respondents described that GPs are well placed to play a central role in the education and prevention of substance use and dependence. In fact, they noted that GPs are in a good position to put early interventions strategies into place, to make appropriate referrals, and to support people throughout their treatment (NDSC GP Working Group 2019)

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

### ***Reducing stigma***

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

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

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 2016c).

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 Reserach 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 (NDSC 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).

## 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 2016b). Consultations also identified that MH and AOD services lacked non-flexible pathways and are confusing systems for the most vulnerable and at-risk consumers (APHN 2016b). Participants from all Adelaide PHN membership groups prioritised the importance of connection of services and care coordination as elements of best practice. Whilst this is a generic statement it 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 2016c).

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 2016b). There are also weak communication pathways between treatment service providers and GP clinics. GPs are not aware of the best way to refer patients, or which treatment services are appropriate. Lack of or changing referral pathways are often an additional limiting factor to address already complex cases (NDSC GP Working Group 2019).

The extent of complexity and comorbidities for people with substance use issues adds to the importance of providing continuous, integrated care. In recent consultations providers, GPs, client, and family representatives, LHNs, police and corrections representatives, 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, 2016c, 2016d) 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).

There is long standing debate regarding the best place for services targeting problematic substance use. 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 as important 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).

## 7.5 Opportunities and priorities – Alcohol and Other Drugs

Table 6 summarises the priorities arising from the analysis of alcohol and other drugs treatment needs identified in the Adelaide PHN region. All five priorities were unchanged from the 2020 Needs Assessment.

**Table 6 Alcohol and Other Drugs Priority Statements for the Adelaide PHN, 2021**

Priority
Priority populations have access to high quality alcohol and other drug treatment services and interventions
Primary health care providers can identify and support people with substance abuse issues and understand the scope of AOD treatment services and PHC services.
People requiring AOD treatment services in Adelaide are supported by a sufficient, safe, skilled and appropriate workforce
Integration and partnership between AOD and Primary Health Care services improves continuity of care and experiences
LGBTIQA+ communities can access safe, inclusive and appropriate alcohol and other drugs treatment options

## 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 2016f).

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 2016f).

### 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 2016f).

A brief snapshot of selected health professions in the Adelaide PHN region is provided below.

#### **General Practice**

In 2020/21 there were 333 General Practices in the region, 83 in SALHN, 152 in CALHN, 98 NALHN (APHN 2021f).

#### **General practitioners**

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).

The number of general practitioners in the region had grown by six percent from 2016 to 2020. In 2020, there were 1,689 general practitioners employed in the region, 470 in SALHN, 739 in CALHN and 480 in NALHN (DOH 2021c).

MBS claims data indicates there were 8.58 million GP attendances and almost 542,600 GP attendances in the after-hours period in Adelaide PHN in 2020–21 (AIHW 2021h).

### **Nurses in general practice.**

The number of nurses working in general practice in the region had grown by nine percent from 2016 to 2020. In 2020, 612 nurses were employed in general practices in the region, 190 in SALHN, 241 in CALHN and 181 in NALHN (DOH 2021c).

Nurses undertake a wide range of tasks within general practice, including immunisation, wound management, health assessments, care planning, chronic disease prevention/management, annual cycles of care, administration/practice management, clinical services, patient education and nurse-led clinics (APHN 2018b).

MBS claims data indicates that nursing and aboriginal health workers provided over 267,200 services in Adelaide PHN in 2020–21 (AIHW 2021h).

### **Pharmacy**

In 2020, there were 382 Pharmacies in the region, 102 in SALHN, 179 in CALHN, 101 NALHN (APHN 2020d).

### **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).

The number of community pharmacists working in the region has grown by 11% from 2016 to 2020 (DOH 2021c). 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 2020–21, 1.46 million allied health attendances in Adelaide PHN were claimed through Medicare (AIHW 2021h).

### **Mental health**

#### **Clinical psychologists**

The number of clinical psychologists working in the region has grown by 18% from 2016 to 2020 (DOH 2021c). In 2020, 1,240 clinical psychologists worked in the region, 264 in SALHN (21%), 804 in CALHN (65%) and 172 in NALHN (14%) (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 2021c). In 2020, 1,240 clinical psychologists worked in the region, 48 in SALHN (18%), 168 in CALHN (64%) and 46 in NALHN (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).

## Aboriginal primary health services

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 (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 (HPC 2017).

In 2020 there were 26 Aboriginal and Torres Strait Islander health practitioners (AHPRA registered) working in the region, 7 in SALHN, 11 in CALHN and 8 in NALHN (DOH 2021c). This is twice the number working in the region in 2016.

## 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. 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 membership 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. Our *General Practice Support Survey* is another key information source, 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.



## 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 2019i).

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 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 (Adelaide PHN 2016d, 2016c, 2021a).

Consultations with Adelaide PHN Membership determined that the health literacy of health professionals was also a barrier to person centred health care (APHN 2016a, 2016b, 2016c, 2016d, 2021a). 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 2018b).

#### 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 2021c).

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 2021c). 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 2021c).

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).

### **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 2021c, 2021g).

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 2021c). 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 (Adelaide PHN 2016a, 2016c, 2016d, 2019d, 2019e, 2021a).

For consumers, poor communication reduces transparency, restricts understanding, and results in consumers being unempowered (Adelaide PHN 2016b APHN, 2016c; 2016d, 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 (Adelaide PHN 2019d, 2021a).

Challenges of providing timely and quality clinical communication between providers included (Adelaide PHN 2019e, 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 2018b, 2019d, 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 2019d, 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 2019d).

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 2019d, 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 2019d, 2019e, 2021a).

### 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*

The lack of respect and sensitivity from service providers and the need to ensure that health services particularly Adelaide PHN commissioned services are culturally safe for Aboriginal people were reoccurring theme across multiple community consultations (APHN 2016c; 2016e; 2017e; 2018d, 2021a).

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 (Adelaide PHN 2016a; 2016d; 2017e, 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 2016c; 2016d; 2016e). They included:

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

National data (AIHW 2017e) 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 community***

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 (Adelaide PHN 2017b, 2017c, 2021a).

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 (APHN 2017c).

### ***LGBTIQA+ community***

Consultations raised 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. 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 (Australian Government Department of Health 2019; Mullens 2017; SARAA 2019; Strauss et al 2017; Waling et al. 2019).

Fear of and experiences of stigma and discrimination as a barrier to accessing primary health services was also a reoccurring issued identified in recent Adelaide PHN membership and stakeholder consultations (APHN 2020a).

The Adelaide PHN consultations also highlighted that some LGBTIQ+ communities, specifically transgender, gender diverse and intersex people, as well as older people and men who have sex with men, have unique health and service needs which require dedicated and specific LGBTIQ+ services and models of care (APHN 2020a).

### **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 2021e). 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 2020-21, 247 general practices in the Adelaide PHN region (74%) participated in the Practice Incentives Program (PIP) Quality Improvement (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. The 2020-21 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 2021j).

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 2018b, 2021c).

### **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 2019f). 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 Membership workshop in June 2021 highlighted specific areas of workforce support and development (Adelaide PHN 2019d, 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.

## Emergency preparedness

The COVID-19 pandemic has had an impact on both patients 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 temporary 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. Temporary 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 commissioning.

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 | ● Home visit coordination                   |
| ● Eligibility criteria                          | ● Roll-out – when practices are on-boarding |
| ● Redistribution of excess doses                | ● Vaccine Clinic Finder amendments          |
| ● RACF in-reach program                         |   |

### PPE

- |   |  |
|---|--|
| ● Requests from GP, Pharmacy, Allied Health | ● Provide PPE to GP Respiratory Clinics and Commonwealth Vaccination Clinics |
| ● Fit testing/fit checking questions        |  |
| ● Questions re guidelines for PPE wearing   |  |

### 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 VideoCall licenses and support

### Communication

- |                         |  |
|-------------------------|--|
| ● Webinars              | ● Attendance at the State COVID Control Centre |
| ● To the point bulletin |  |
| ● Primary Links         |  |



### 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.

Adelaide PHN dispatched over 200,000 surgical masks and 35,700 P2 masks to local providers; delivered regular updates via our dedicated website resources, COVID-19 bulletins and webinars; and supported the COVID-19 vaccine roll-out and the onboarding of over 200 general practices, four Commonwealth Vaccine Clinics, and one Aboriginal Community controlled health service delivering Pfizer and or the AstraZeneca vaccine to the community. Adelaide PHN also supported residential aged care facilities (RACFs) to prepare for the COVID-19 vaccine roll-out and supported in-reach clinic schedules (APHN 2021g).

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 we 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 in the Adelaide PHN region, to ensure providers adequately respond to local needs and utilise all available resources, including digital technologies, multi-layered workforces and local services. We need to maintain and adapt the systems and structures currently in place to continue to support the primary health workforce in preparedness to handle a rapid surge.

## 8.4 Opportunities and priorities – Health Workforce

Table 7 summarises the priorities arising from the analysis of the health workforce needs identified in the Adelaide PHN region. Four new priorities were identified for Health Workforce, replacing all priorities from 2020.

**Table 7 Health Workforce Priority Statements for the Adelaide PHN, 2021**

Priority
Support practitioners to improve communication and build relationships with other health care providers
Support primary health care providers to adopt and implement patient-centred models of care
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in an ever-changing health landscape.

## 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, HealthPathways SA, 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.

#### 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. Over 95% of the general practices in the region are computerised and use clinical information systems, the most common being *Best Practice*, *Medical Director*, and *Zedmed* (APHN 2021f).

Many practices are using clinical auditing tools to analyse their patient data to improve quality and safety, and in 2020/21 Adelaide PHN provided over 240 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 2020/21, 74% of practices in our region participated in the PIP QI (APHN 2021h).

#### 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 uptake of My Health Record in our region remains a digital health priority for Adelaide PHN, and we are working closely with the Australian Digital Health Agency to connect specialist and community

health organisation to My Health Record. In 2020/21, 364 general practices across the region were registered to participate in My Health Record, however only 63% of practices were actively uploading shared health summaries (Collaborate 2021). Rates of use have increased since the previous financial year (2019/20), with a 27% increase in discharge summary uploads, 7% increase in shared health summary uploads, and 12% increase in dispense record uploads from pharmacies (APHN 2021i).

As of October 2021, 345 pharmacies in the region had registered for the My Health Record (APHN 2021i), 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 73 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 2021i).

## **Telehealth**

Telehealth can potentially 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. New telehealth items were funded from March 2020 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).

South Australia has not been facing the same level of challenge with the outbreak of COVID-19 compared to the rest of the nation, particularly the eastern states, and has one of the lowest rates of COVID-19 cases per 100,000 population in Australia (DOH 2021b). This is reflected in the statistics regarding uptake of new telehealth MBS item numbers.

In 2020/21, the rates of telehealth video conferencing in South Australia were notably lower than other states and territories and the national average across a number of GP service types including standard services, mental health services as well as allied health service types including clinical psychologist and social worker attendances (AIHW 2020f).

In late 2021, 320 health care providers including general practice, specialists, allied health, and community health centres, had access to Healthdirect's Video Call Platform, a telehealth service that support safe service delivery, safeguarding the wellbeing of patients throughout the pandemic (HealthDirect 2021).

## **Secure Message Delivery**

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 adopt secure messaging services through a collaborative project with SA Health. The initiative will reduce reliance on traditional forms of communication, (such as fax) and improve the continuity of care received by patients in South Australia.

Use of an Adelaide PHN survey of general practice in 2018 indicated that approximately two-thirds of the practices in the region used secure messaging to send patient information to other health providers, while a third of practices relied on fax and post (APHN 2018b). By mid-2020, 90% of General Practices in the region had access to a secure messaging system (APHN 2020e).

In 2020/21, Adelaide PHN supported over 120 general practices transitioning to secure messaging by providing software licences and helping configure their current software and workflows (APHN 2021f).

## **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).

## **HealthPathways SA**

Working in partnership, Wellbeing SA, Adelaide PHN and Country SA PHN are jointly responsible for implementing HealthPathways across South Australia to support consistent care and management of health conditions, and to improve the health outcomes and journey of patients through our local health system. HealthPathways SA is an online portal that provides general practitioners and other health professionals with easy access to comprehensive, evidence-based assessment, management and localised referral resources for specific health conditions. At the end of September 2021, 261 localised pathways were available (HPSA 2021a).

Since July 2018, an increasing number of users have accessed HealthPathways SA with a peak recorded during March to April 2020. This peak coincides with the COVID-19 pandemic (HPSA 2021a). Until mid-2019, the monthly number of sessions and page views had been stable, but since late 2019 both these have gradually increased over time. Between 2019-20 and 2020-21 there was a 23% increase in number of sessions (HPSA 2021a), however very few users accessed the site regularly (AusHSI & QUT 2021). General practice is the highest user group at 60-65% of total user types (HPSA 2021a).

## **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 membership 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.

### **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.

For example, from 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.

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 October 2021, only eleven percent of general practices had eRequesting for Clinpath and or Australian Clinical Labs enabled (APHN 2021f).

Similarly, the rate of shared health summary uploads to My Health Record could be improved and remains unchanged between the 2019/20 and 2020/21 (APHN 2021h).

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 2019e). 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, 2016c, 2016d, 2019d, 2019e, 2021a).

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 2019d, 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.

## **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 2018b).

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 2018b).

### ***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 2018b, 2021c). 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 2019e).

### ***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 2019e). 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 2020e). 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.

The use of telehealth was lower among health providers in South Australia compared to those in other states (AIHW 202f). In 2020/21 13% of General Practices in our region have used Healthdirects Video Call service. (Healthdirect 2021). As Scott (2021) suggests, a continuing lack of certainty about the permanence of Medicare funding for telehealth could have discouraged general practices and other health providers to invest in this infrastructure during 2020/21.

However, as the state and international borders open and we move towards and begin living with COVID-19 in the region, there may be more impetus for providers in the region to invest in infrastructure to support telehealth, and other digital health technologies that enable, safe, accessible, coordinated care.

### 9.3 Opportunities and priorities – Digital Health

Table 8 summarises the priorities arising from the analysis of digital health needs identified in the Adelaide PHN region. Four new priorities were identified for Digital Health, replacing all priorities from 2020.

**Table 8 Digital Health Priority Statements for the Adelaide PHN, 2021**

Priority
Primary health care providers have access to resources and support to improve digital health literacy
Primary health care providers are supported to adopt and fully implement digital health technologies
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication
Primary care providers are supported to use digital health tools that improve safety and quality of care

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