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 November 2024**.

Adelaide PHN

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We acknowledge the Kaurna peoples who are the traditional Custodians of the Adelaide Plains. 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 and contribute on Kaurna Country.

Marni Naa Pudni - Welcome

Abbreviations

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

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

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

1 Narrative

1.1 Introduction to Our Organisation

The Adelaide PHN is one of 31 Primary Health Networks (PHNs) across Australia established and funded by the Federal Government covering the Adelaide metropolitan area. Our mandate is to work towards streamlining health services, particularly for those at risk of poor health outcomes and to better coordinate care so people receive the right care, in the right place, at the right time.

Our Vision

Shaping the health system to deliver better outcomes for vulnerable people, and a healthier Adelaide.

Our Focus Areas

Health Equity; Partnerships; Co-creating solutions and Data Insights and Stories.

Our Strategy

Our 2023 -2026 Strategic Plan sets the foundation for us to address health inequities and inequalities by working with our partners to shape the health system to deliver better outcomes for vulnerable people.

Details on our strategy can be found via the Adelaide PHN website - Who we are | Adelaide PHN and are summarised in Figure 1 below.

Figure 1 Adelaide PHN Strategic Plan 2023-2026 Summary

1.2 Needs Assessment Methodology

Primary Health Networks (PHNs) are mandated by the Australian Government Department of Health to undertake and maintain an evidence-based health needs assessment (HNA) to identify unique regional and local priorities. This work is guided by national health priorities. The purpose of the HNA is to:

- inform each PHN's understanding of their region by undertaking a detailed and systematic assessment of the regional population's health needs, local healthcare services, gaps and opportunities for improved health outcomes
- provide a basis for subsequent service planning and commissioning of services

Our needs assessment process

The needs assessment 2024/25-2026/27 – 2024 report is underpinned by the Adelaide PHN Needs Assessment Framework incorporating 3 phases:

1. Planning and Exploration - determining the focus and scope of the needs assessment, investigate what is known (or not known) and action planning accordingly, including milestones, outputs timelines and responsibilities.
2. Data Gathering and Analysis – collecting (via consultation and desktop), analysis, synthesis and triangulation of the data (qualitative and quantitative) required to generate justifiable information to make decisions, as set out in Phase 1.
3. Use and Implementation - final stage to bridge the data and plans for action, by prioritising the findings of the previous stages and understanding available opportunity and options. This phase also details how findings and associated actions will be communicated broadly to the organisation and external stakeholders.

The HNA process is led by the Adelaide PHN Strategy, Planning and Performance Portfolio and supported by Subject Matter Experts (SMEs). All needs assessment work is overseen by the Adelaide PHN Needs Assessment Working Group (NAWG) under the Commissioning Lifecyle (CLC) Steering Group.

1.2.1 Planning and Scoping

Adelaide PHN NAWG recommended topics for assessment for the year 2024, were determined after taking into consideration expressions of interest, environmental scanning, emerging priorities, and strategic and/or operational alignment. The range of work undertaken in 2024 is presented in Table 1 below.

Table 1 2024 Adelaide PHN Needs Assessments – Completed Work

2024 Priority Area/Topic	Undertaken by
Mental Health - Eating Disorders	Adelaide PHN
Mental Health - Suicide Prevention	Adelaide PHN
Workforce - Allied Health-Multidisciplinary Team Care	Adelaide PHN
Alcohol and Other Drugs (AOD)	Adelaide PHN based on commissioned work by National Centre for Education and

	Training on Addiction (NCETA), Flinders University
Population Health - Multi-Cultural Health Access to primary health care services	Adelaide PHN based on commissioned work by Research Centre for Public Health, Equity and Human Flourishing (PHEHF), Torrens University
Population Health - Primary care access for people experiencing or at risk of Homelessness	Health Q consulting (Health Q)
Population Health - Family Domestic and Sexual Violence (pilot project)	Adelaide PHN in partnership with Country SA PHN and incorporating commissioned work by The Australian Centre for Social Innovation (TACSI)

1.2.2 Data collection, analysis and prioritisation

Our needs assessment methods included a combination of quantitative and qualitative data analysis, background analysis of policy and strategy environment, and stakeholder consultation. Our data analysis included, but not limited to:

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

Stakeholder consultation included, kitchen table discussions, interviews, focused group discussions, surveys, written feedback from Adelaide PHN clinical, GP and community advisory councils, people from culturally and linguistically diverse (CALD) backgrounds, young people and LGBTQIA+ communities, yarning circles with Aboriginal and Torres Strait Islander communities, public and private sector medical, nursing and allied health service providers, and Adelaide PHN commissioned service providers.

Adelaide PHN set annual priority needs by triangulating health, service and community[1] needs, with input from Adelaide PHN councils[2] and internal Adelaide PHN subject matter experts. Together with our Board, they bring together a diverse range of experience and knowledge informing our evidence-

[1] The definition of community here encompasses consumers, service providers, stakeholders and health professionals (primary and allied health care providers).

[2] Community Advisory Council, Aboriginal Community Advisory Council, Clinical Council and Network Leadership group.

based planning process to determine the local needs and priorities of our catchment area and consider opportunities for action and/or partnership.

Identified priorities align with the Adelaide PHN 2023-26 Strategic Plan, National and South Australian Metropolitan priorities and that of our partner organisations.

1.2.3 Consultation activities

Adelaide PHN continues to seek advice and feedback via surveys, consultations and workshops from our Advisory Councils and stakeholder groups, primary health care providers, and clinicians from acute and specialist health services about health and service needs in the region. In 2024, a total of 700 voices contributed as part the HNA process. An overview of number of voices who participated in these activities are presented in **Table 2** below**.**

Table 2 Summary of Consultation Activities in 2024

Priority Area	Number of Voices
Mental Health – Eating Disorders	91
Mental Health – Suicide Prevention	126
Workforce Health – Allied Health – Multidisciplinary Team Care (MDTC)	123
Alcohol and Other Drugs (AOD)	66*
Population Health – Multi-cultural Health Access	79
Population Health – Homelessness	63
Population Health – Family Domestic and Sexual Violence	152
Total	***700***

** Inclusive of NCETA consultation*

Note - participation in the combined councils and other prioritising sessions is in addition to this.

Additional consultation activities

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

1.2.4 Needs Assessment Evaluation and Review

The Adelaide PHN NAWG as part of the governance in overseeing the NA monitors and reviews the process and outputs. Recommendations from the 2022 process were applied to the 2023 process and further refinements occurred in 2024 as continuing quality improvement. This included documentation improvement and adjustments to the Framework as needed and appropriate.

Gaps and Limitations

Data issues

The Adelaide PHN data collection period is open for a fixed period to finalise our analysis and produce this deliverable.

- This means that some reports or data released outside of the data collection phase have not been included in the analysis for this update.
- Although there is a large amount of relevant PHN level data available through the AIHW, ABS, and PHIDU, it must be noted that there are still significant limitations and gaps to the findings presented in this report.
- Additionally, some available data cannot be shared outside of the Adelaide PHN and its providers due to the confidential nature and sensitivity of the data.
- Limitations in administrative data collections restricts our ability to quantify the health and service inequity faced by specific to population groups such as people living with a disability, people from CALD backgrounds, and LGBTIQA+ communities.

Further ongoing and targeted data collection will be required to provide additional insight into the needs of these communities in the Adelaide PHN region.

Key considerations and limitations are also built into topic summary reports produced for publication.

1.2.5 Additional comments or feedback

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

- Timing of new Commonwealth funding announcements does not always allow for in depth investigations inside the submission timeframe. This can mean priorities or needs are out of sync with funding models and commissioning cycles.
- Timing of Needs Assessment submission to Commonwealth is similar and overlaps with 12-Month Reporting, putting pressure on resourcing in the Adelaide PHN.
- Needs assessments to inform commissioning of activities in the following financial year must be completed much earlier than the submission date to inform the program/project design, commissioning approach and market development. The Adelaide PHN continue to align the timing of our activities, but this remains an ongoing challenge.

1.3 Topics for 2025

In line with our strategic direction, the 2025 needs assessment updates will focus on:

- A place-based needs assessment approach (access and equity)
- Older People and Aged Care (care access and coordinated care)

Other supplemental needs assessments will be undertaken in 2025 as necessary and appropriate.

1.4 Summary of changes

The 2024 NA process, all chapters have been fully reviewed and updated by Adelaide PHN staff (Subject Matter Experts, data analyst leads and Managers) with Executive Management approval prior to submission.

Chapter review has been undertaken for the following:

- Chapter 1 – Narrative
- Chapter 2 – Adelaide PHN Region
- Chapter 4 – Aboriginal and Torres Strait Islander Health
- Chapter 5 – Older People and Aged Care
- Chapter 9 – Digital Health

This has included the provision of the most recent data available as at October 2024 (and associated editing of commentary, corrections, and removal of 'old' data/references ≥6 years as appropriate).

All chapters have been revised to be more succinct, with associated formatting improvements.

Chapters that underwent a comprehensive update in 2024 with new content added, including community and stakeholder consultations, are:

- Chapter 3 - Population Health
- Chapter 6 - Mental Health
- Chapter 7 - AOD
- Chapter 8 – Health Workforce

This included the identification of:

- 5 new priority statements in the areas of Mental Health (3) and AOD (2)
- 13 existing priority statements requiring modified /updated wording across:
  - Population Health – Care Continuum/MDTC (1)
  - Aboriginal Health – Mental Health (1)
  - Mental Health (7)
  - AOD (2)
  - Health Workforce (2)
- 2 existing priority statements in the areas of Mental Health and AOD agreed as obsolete given revisions (refer to 2023 Priority Statements ID 6-9 and 7-2)

These are presented in:

Table 7 Population Health Priority Statements for the Adelaide PHN, 2024

Table 8 Aboriginal Health Priority Statements for the Adelaide PHN, 2023

Table 13 Mental Health and Suicide Prevention Priority Statements for the Adelaide PHN, 2024

Table 14 Alcohol and Other Drugs Priority Statements for the Adelaide PHN, 2024

Table 16 Health Workforce Priority Statements for the Adelaide PHN, 2024

2 Adelaide PHN region

2.1 Our region and people

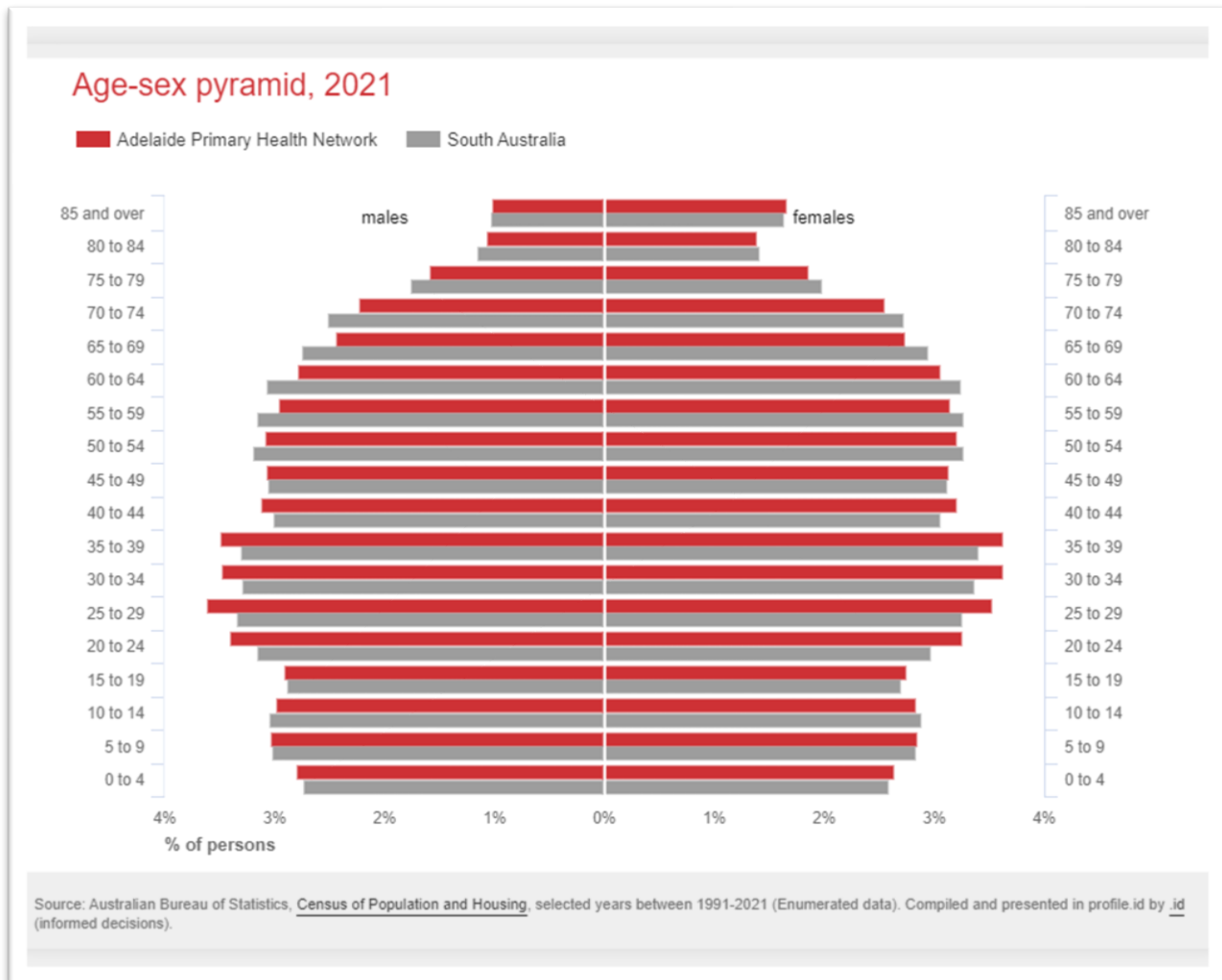
The Adelaide Primary Health Network is one of two Primary Health Networks (PHNs) in South Australia. The Adelaide PHN region covers 1,553 square kilometres and stretches from Sellicks Hill in the south to Angle Vale in the north, and from the beaches in the west to the foothills in the east.

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

2.1.1 Population

The Adelaide PHN has a diverse population with varying levels of health, and socioeconomic advantage and disadvantage in terms of household income, education, employment, occupation, and housing, with approximately 27% more people in the most disadvantaged decile compared to the national rate, and 80% fewer people in the least disadvantaged decile compared to the national rate (ABS 2023a).

In 2023, an estimated 1.32 million people resided in the region, which is 71% of the population of South Australia, and 5% of the total Australian population (26.65 million people) (2024a).



Source: Australian Bureau of Statistics, Census of Population and Housing, selected years between 1991-2021 (Enumerated data). Compiled and presented in profile.id by .id (informed decisions).

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

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

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

Average life expectancy in the Greater Adelaide between 2020-2022 was 83.3 years, for males 81.3 years and females 85.4 years, consistent with 2018-2020 where the life expectancy at birth was 83.4 years (for males – 81.4 and for females – 85.6). This is consistent with Australian Life expectancy at

birth which was 81.3 years for males and 85.4 years for females in 2019-21 (Australian Bureau of Statistics (ABS) 2023b).

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

2.1.2 Demographics

Children and Young People

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

In our region this included 68,243 (5.4% of total region population) babies and pre-schoolers (0 to 4 years), 103,431 (8.1%) primary schoolers (5 to 11 years) and 86,046 (6.8%) secondary schoolers (12 to 17 years) (Australian Statistics Bureau (ABS) 2022)The three Local Government Areas with the highest number and proportion of young people were Onkaparinga (37,254, 21.3%), Salisbury (33,586, 23.0%) and Playford (26,429, 26.6%) (profile.id 2022).

Population projections for the region indicate that by 2030 there will be 228,764 (15.9%) people aged 0-14 years, slightly below the projection for Australia (16.8%) (Australian Institute of Health and Welfare (AIHW) 2024a).

Older populations

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

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

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

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

Population projections for the region indicate that by 2030 there will be 295,417 (20.6%) people aged 65 years and over, slightly above the projection for Australia (19.5%), and 44,300 people aged 85 years and over (3.1%), significantly greater than the projection for Australia (2.6%) (2024a).

Aboriginal and Torres Strait Islander population

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

There was an estimated 26,929, Aboriginal and Torres Strait Islander people residing in the Adelaide PHN region in 2021, comprising 2.1 per cent of the region's total population. In comparison there were 983,700 Aboriginal and Torres Strait Islander people in Australia which is 3.8% of total of Australia's population (ABS 2023c).

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

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

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

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

Culturally and linguistically diverse (CALD) communities

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

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

Birthplace

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

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

The top five countries of birth of residents that were born in non-English speaking countries and arrived in Australia in the five years before the 2021 Census were India (29%), China (excludes SARs and Taiwan) (13%), Nepal (6%), Vietnam (4%) and the Philippines (4%) (profile.id 2022).

The Local Government Areas of Campbelltown (24.4% of the population), Port Adelaide Enfield (23.1%), Salisbury (21.9%), Burnside (19.9%), and West Torrens (18.6%) had the highest proportion of people born in NESC and resident for longer than five years (Public Health Information Development Unit (PHIDU) 2022a).

Languages spoken

In 2021, there were 290,108 people (22.9%) who spoke a language other than English at home. This is slightly higher than the national rate of 22.3%. The top 10 languages other than English spoken at

home for people living in the Adelaide PHN region were: Mandarin, Italian, Vietnamese, Greek, Punjabi, Arabic, Cantonese, Hindi, Nepali, and Gujarati (profile.id 2022).

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

English proficiency

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

3 Population Health

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

3.1 Policy and Planning Context

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

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

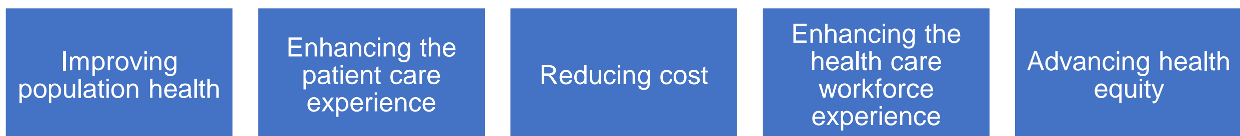
The key contextual considerations for development of the new population health framework include:

Health System Dimensions

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

Quintuple Aim

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



Australia's Primary Health Care 10 Year Plan

The focus of Australia's Primary Health Care 10 Year Plan 2022-2023 (Australian Government Department of Health 2022) (the Plan) is on Australia's primary health care services provided through general practices, Aboriginal Community Controlled Health Services (ACCHS), community pharmacies, allied health services, mental health services, community health and community nursing services and dental and oral health services. The plan also focuses on the integration of primary health care with hospitals and other parts of the health system, aged care, disability care and social care systems.

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

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

- Living with COVID-19 - Support for PHNs to Coordinate COVID Care
- Strategic, collaborative commissioning approaches between PHNs and Local Hospital Networks (LHNs) under the National Health Reform Agreement (NHRA) show significant promise in delivering more integrated, value-based care pathways at local and regional level.

Adelaide PHN Role

PHNs have been established with the key objectives of increasing the efficiency and effectiveness of primary health care services for individuals, particularly those at risk of poor health outcomes. They also aim to improve coordination of care to ensure people receive the right care, in the right place, at the right time.

Adelaide PHN prepares a comprehensive needs assessment to identify the key population health and service needs of people in our region. We use this information as the basis for our consultation with our Advisory Councils to inform the commissioning of programs and services to deliver better health outcomes.

Adelaide PHN commissions services to meet population health needs and reduce barriers to access for communities with the highest needs by:

- identifying and addressing health service gaps based on careful planning and analysis
- providing support services so health care providers are better placed to care for patients
- supporting workforce development through training and education
- assisting health care services to implement and use digital health systems
- working with others to commission health services for priority populations.

Our 2023-2026 Strategic Plan sets the foundation for us to address health inequities and inequalities by working with our partners to shape the health system to deliver better outcomes for vulnerable people.

3.2 Recommissioning of Adelaide PHN-funded activities

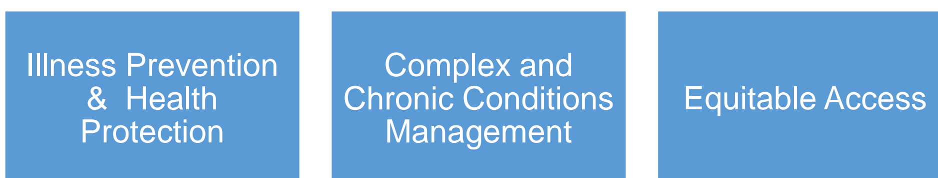
Since 2015, the Adelaide PHN has commissioned and delivered a range of activities under the banner of Population Health. Population Health was identified as a focus area for the 2022 Needs Assessment. To support the Population Health Needs Assessment and the re-design of activities, a refreshed definition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

Population Health Definition

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

Focus Areas

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



Data within the 2024 Needs Assessment has been organised under these focus areas.

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

3.3.1 Summary of identified needs for Population Health

Table 3 below summarises the health and service needs identified through the needs assessment process for the Population Health priority area undertaken in 2022 and are still relevant in 2024. The evidence against each of these statements is provided within this chapter.

Table 3 Summary of health and service needs identified for Population Health, 2022

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

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

Outcomes of the health and service needs analysis – Population Health		
Immunisation	Rates of childhood immunization in the Adelaide City region are below overall Adelaide PHN rates and national target in the 60-<63 month age group. Residents of the Adelaide PHN face multiple barriers to accessing vaccination. There is substantial regional variation in COVID-19 vaccine uptake among regions in the Adelaide PHN, with lower coverage in the western areas of the region.	Immunisation Factors impacting access to primary health care services Health and service needs of specific populations groups and communities

3.4 Complex and Chronic Condition Management

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

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

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

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

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

3.4.1 Risk Factors

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

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 (Public Health Information Development Unit (PHIDU) 2021a).

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

Smoking / E-cigarettes

The modelled estimates for 2017-18 indicate 134,118 people in Adelaide PHN region or 14.5 per 100 people were current smokers, which is consistent with the Australian rate of 15.1 per 100 people. Rates varied substantially across the region, ranging from 6.2 per 100 in Burnside LGA to 21.6 per 100 in Playford LGA. Consistent with the national pattern, rates of smoking were substantially higher

for males (17.6 per 100) compared to females (11.2 per 100) (Public Health Information Development Unit (PHIDU) 2022a).

In early 2023, the Australian population aged 14+ years had over 3.5 million smokers and/or vapers, with current smokers (11.8% of the population) outnumbering current vapers (8.9%). However, there were more current vapers than current smokers among those aged under 35 years. Among older people, the prevalence of smoking was higher than vaping, especially for those aged 50+ years (Department of Health and Aged Care (DOHAC) 2023)

Examining annual prevalence estimates further, while overall smoking prevalence was relatively stable over time, the annual prevalence of exclusive smoking appeared to trend downwards, while the prevalence of exclusive vaping and dual use of tobacco and e-cigarettes both showed large increases from 2020 to early 2023. The increase in exclusive vaping and dual use from 2020 to 2023 was most observable among those aged under 35 years (Department of Health and Aged Care (DOHAC) 2023).

Alcohol consumption

The modelled estimates for 2017-18 indicate 128,931 people in Adelaide PHN region or 13.8 per 100 people consumed alcohol at a level considered to be a high risk to health, marginally lower than the Australian rate of 16.0 per 100 people. Rates varied substantially across the region, ranging from 10.4 per 100 in Salisbury LGA to 18.5 per 100 in Holdfast Bay LGA. (Public Health Information Development Unit (PHIDU) 2022a). Consistent with the national pattern, risky alcohol consumption rates were significantly higher for males (20.8 per 100) compared to females (10.1 per 100) (Public Health Information Development Unit (PHIDU) 2022a).

Physical inactivity

In 2017-18, 638,171 people in Adelaide PHN region, approximately half of the region's residents, undertook low, very low or no exercises in previous week (68.0 per 100 population). This is marginally higher than the Australian rate of 66.1 per 100 population. Rates varied substantially across the region, ranging from 53.7 per 100 in Burnside LGA to 78.1 per 100 in Playford. At the PHA level, the five areas with the highest rates of physical inactivity were in outer northern Adelaide (Public Health Information Development Unit (PHIDU) 2022a).

Unhealthy weight

In the Adelaide PHN region in 2017-18, 637,087 adult residents were overweight or obese. This is a rate of 67.9 per 100 adults, which is slightly above the Australian rate of 66.9 per 100. Rates varied substantially across the region, ranging from 59.1 per 100 in the Adelaide LGA to 80.0 per 100 in the Playford LGA. Four of the five PHAs with the highest rates were in outer northern Adelaide, with the remaining PHA in outer southern Adelaide (Public Health Information Development Unit (PHIDU) 2022a).

High blood pressure

One in five adult residents in Adelaide PHN region (209,499 people, 21.8 per 100 population) had high blood pressure in 2017-18. This is slightly below the Australian rate of 22.84 per 100 population. Rates varied marginally across the region, ranging from 18.9 per 100 in Walkerville LGA to 23.6 per 100 people in Playford LGA. Four of the five PHAs with the highest rates were in outer northern Adelaide (Public Health Information Development Unit (PHIDU) 2022a).

3.4.2 Chronic Conditions

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

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

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

Long term health conditions

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

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

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

Within the general practice (GP) data that was shared with the Adelaide PHN, within the month of September 2024, there was a total population of 1,317,042 people who were considered active patients. These are defined as patients who have visited a general practice 3 times in the previous 2 years (RACGP), and this is the population referred to throughout this report. The top five chronic conditions for these patients were Hypertension (15.5%), Hyperlipidaemia (15.1%), Anxiety (11.4%), Asthma (10.0%) and Osteoarthritis (7.6%) (APHN 2024a).

Mental health conditions

Prevalence

The burden of mental health conditions within the Adelaide PHN is consistent with national estimates. In 2017-18, one in every five people (243,632 people, 20.4 per 100) in Adelaide PHN region had a mental and behavioural problem (Public Health Information Development Unit (PHIDU) 2022a). Rates varied substantially across the region, ranging from 14.0 per 100 in Burnside LGA to 28.0 per 100 people in Playford LGA. Three of the five PHAs with the highest rates were in outer northern Adelaide, with the remaining two PHAs in outer southern Adelaide. (Public Health Information Development Unit (PHIDU) 2022a).

Within the GP data, the percentage of the active population with mental health conditions in September 2024 anxiety (11.4%) and depression (6.6%) were the most prevalent mental health conditions, followed by Attention Deficit Hyperactivity Disorder (1.8%), autism (1.1%), bipolar (0.7%), Schizophrenia (0.6%), Dementia (0.6%) and postnatal depression (0.2%) (APHN 2024a).

Emergency department presentations and hospitalisations

In 2020-21 there were 19,543 emergency department presentations due to mental and behavioural disorders, equivalent to a rate of 1,558.1 per 100,000 people. This is 19% higher than the national rate of 1,304.8 per 100,000. The rates in the LGAs of Adelaide, Marion, and Onkaparinga are more than twice as high as the national rate (PHIDU 2023).

Public hospital admissions for mental health related conditions in Adelaide PHN were 12% higher the national rate in 2020-21, with 15,019 admissions (PHIDU 2023).

Compared to the national rate, rates of hospitalisation are significantly higher in the LGAs of Adelaide (249% higher), Holdfast Bay (85% higher), and Marion (75% higher) (PHIDU 2023).

Mortality

Between 2017 to 2021, 709 people aged 0 to 74 years who resided in the Adelaide PHN region died from suicide and self-inflicted injuries. The regions with the highest rates of deaths from suicide and self-inflicted injuries were not necessarily those with the highest prevalence of mental health conditions. Holdfast Bay, Adelaide, Norwood Payneham St Peters, and Prospect were the LGAs with the highest mortality rates from suicide and self-inflicted injury, and were between 51-66% above the national rate (PHIDU 2023). Premature mortality from suicide and self-inflicted injuries in this time period equated to 22,664 potential years of life lost (PHIDU 2023).

Diabetes Mellitus

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

Prevalence

In 2017-18, 63,741 people (5.1 per 100 population) aged 18 years and over in Adelaide PHN region had diabetes, consistent with the Australian Greater Capital City Areas average of 4.4 per 100 population. Rates varied across the region, ranged from 3.2 per 100 in the LGAs of Burnside and Holdfast Bay to 8.1 per 100 people in Playford LGA. The five PHAs with the highest rates in Adelaide region were all in northern Adelaide (Public Health Information Development Unit (PHIDU) 2022a).

Within the GP data submitted to the Adelaide PHN in September 2024, the percentage of active patients with either Type I or Type II diabetes was 6.0% (APHN 2024a).

Hospital admissions

There were 2,222 potentially preventable hospitalisations due to diabetes complications in 2020-21 in public hospitals in the Adelaide PHN region, equivalent to a rate of 172.9 per 100,000 population, slightly lower than the national rate of195.0 per 100,000. Significant and substantial variation in diabetes hospitalisation rates was evident at the LGA-level across the region, ranging from 62% below to 70% above the national rate. Rates in the LGAs of Port Adelaide Enfield (70% higher), Playford (66% higher), Charles Sturt (35% higher), and Salisbury (35% higher) were significantly above national rates (PHIDU 2023).

Mortality

Between 2017-2021, 360 people aged 0 to 74 years who resided in the Adelaide PHN region died from diabetes. The LGAs of Playford, Port Adelaide Enfield, and Salisbury had the highest rates, between 23% and 39% above the national rate (PHIDU 2023). Premature mortality from diabetes in this time period equated to 4,268 potential years of life lost (PHIDU 2023).

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

Cardiovascular conditions

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

Prevalence

In 2017-18, 59,620 people (4.7 per 100 population) in Adelaide PHN region had a cardiovascular disease, the same as the Australian Greater Capital City Areas average rate. Prevalence rates varied marginally across the region, ranging from 3.4 per 100 in the LGA of Walkerville to 5.7 per 100 people in Playford LGA. Four of the five PHAs with the highest rates in the Adelaide region were in northern Adelaide(Public Health Information Development Unit (PHIDU) 2022a).

Within the GP data submitted data to the Adelaide PHN in September 2024, the percentage of the active population that had a cardiovascular related condition were: 15.5% hypertension, 15.1% hyperlipidaemia, 3.1% coronary heart disease, 2.1% atrial fibrillation, 1.3% stroke and 0.8% heart failure. Based on MBS item count data within the GP data submitted to the Adelaide PHN, 2.5% of the total population had a recorded heart health check (APHN 2024a)

Emergency department presentations and hospitalisations

In 2020-21 there were 14,789 emergency department presentations due to circulatory system disease, equivalent to a rate of 1,130.0 per 100,000. This is 21% lower than the national average rate of 1,429.4 per 100,000. Compared to the national rate, rates are significantly higher in the LGAs of Onkaparinga (46% higher) and Playford (16% higher) (PHIDU 2023).

Similarly, public hospital admissions for cardiovascular conditions in Adelaide PHN were lower (by 15%) compared to the national rate in 2020-21, with 18,641 admissions in Adelaide PHN region, equivalent to a rate of 1,413.2 per 100,000 population. One fifth (20%) of circulatory system-related public hospital admissions in 2020-21 were due to ischaemic heart disease, 16% due to stroke and 14% due to heart failure (PHIDU 2023).

The highest rates of hospitalisation were in the LGAs of Playford (41% higher than the national rate), Onkaparinga (34% higher), and Salisbury (30% higher) (PHIDU 2023).

Potential preventable hospitalisations: chronic angina

In 2020-21, there were 960 potentially preventable public hospital admissions in Adelaide PHN due to chronic angina. Equivalent to 73.3 per 100,000 population, the rate for Adelaide PHN is 11% lower than the national rate. Significant and substantial variation in admission rates was evident across the APHN region with rates ranging from 51% below the national rate in the LGAs of Burnside and Prospect, to 84% above the national rate in Salisbury and over double the national rate in Playford. (PHIDU 2023).

Potential preventable hospitalisations: chronic congestive cardiac failure

In 2020-21, there were 2,652 potentially preventable public hospital admissions in Adelaide PHN due to chronic congestive cardiac failure. Equivalent to 194.6 per 100,000 population, the rate for Adelaide PHN is 7% lower than the national rate. Rates ranged from 45% below the national rate the Adelaide LGA to 73% above the national rate in the West Torrens LGA (Public Health Information Development Unit (PHIDU) 2022a).

Mortality

Between 2017 to 2021, 2,398 people in Adelaide PHN region died prematurely from circulatory system diseases, an annual average rate of 39.7 per 100,000 population, that was 6% below the national rate. Ischaemic heart disease was the cause in the majority (50%) of these deaths. The regional variation in premature mortality rates was substantial, ranging from 51% below the national rate in Burnside LGA, to 49% above the national rate in Playford LGA (PHIDU 2023). Premature mortality from circulatory system diseases in this time period equated to 29,859 potential years of life lost, 47% of which was due to ischaemic heart disease (PHIDU 2023).

Coronary heart disease and cerebrovascular disease were respectively the 2nd and 3rd ranked leading cause death in 2016-2020 in the Adelaide PHN region, contributing to 17% of all-cause mortality and 7,923 deaths (Australian Institute of Health and Welfare (AIHW) 2022b).

Respiratory conditions

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

Prevalence

Within the GP data submitted to Adelaide PHN, the percentage of the active population with Asthma was 10.0% and COPD was 1.9%.(APHN 2024a)

Asthma

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

Chronic obstructive pulmonary disease

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

Burnside to 3.0 per 100 people in Playford LGA (Public Health Information Development Unit (PHIDU) 2022a).

Emergency department presentations and hospitalisations

In 2020-32 there were 24,560 emergency department presentations due to respiratory system disease, equivalent to a rate of 1987.9 per 100,000. This is 9% lower than the Australian rate. Substantial variation in rates was evident at the LGA-level, being 39% lower in Burnside compared to the national rate, and 71% higher in Onkaparinga and 54% higher in Playford (PHIDU 2023).

Public hospital admissions for respiratory system conditions in Adelaide PHN were 4% higher than the Australian rate in 2020-32, with 15,938 admissions in Adelaide PHN region, equivalent to a rate of 1,250.7 per 100,000 population. 17.1% of respiratory system-related hospital admissions in 2020-21 were due to chronic obstructive pulmonary disease, and 8.4% due to asthma (PHIDU 2023).

The rate of hospitalisation in the LGA of Playford was 95% higher than the national rate (PHIDU 2023).

Potential preventable hospitalisations: chronic asthma

In 2020-21, there were 1,060 potentially preventable public hospital admissions in the Adelaide PHN region for chronic asthma. Equivalent to 86.4 per 100,000 population, the rate for Adelaide PHN was consistent with the Australian Greater Capital City Areas rate. Significant and substantial variation in admission rates was evident at the LGA level, ranging from 25% below the national rate in Unley to 85% above the national rate in Playford (PHIDU 2023).

Potential preventable hospitalisations: chronic obstructive pulmonary disease

In 2020-21, there were 2,763 potentially preventable public hospital admissions for chronic obstructive pulmonary disease in Adelaide PHN. Equivalent to 172.9 per 100,000 population, the rate for Adelaide PHN is 11% lower than the national rate. Significant and substantial variation in admission rates was evident at the LGA level, ranging from 68% below the national rate in Burnside to 70% above the national rate in Port Adelaide Enfield. (Public Health Information Development Unit (PHIDU) 2022a).

Mortality

Between 2017 to 2021, 902 people in Adelaide PHN region died prematurely from respiratory system diseases, an annual average rate of 14.8 per 100,000 population, slightly lower than the Australian rate of 15.5 per 100,000 population. Chronic obstructive pulmonary disease was the cause in the majority (56%) of these deaths. Premature mortality from respiratory system diseases in this time period equated to 9,334 potential years of life lost, 48% of which was due to chronic obstructive pulmonary disease (PHIDU 2023). The regional variation in premature mortality rates was significant and substantial, ranging from 51% below the national rate in Burnside LGA, to 116% above the national rate in Playford LGA (PHIDU 2023).

Chronic obstructive pulmonary disease was the 5th ranked leading cause death in 2016-2020 in the Adelaide PHN region, contributing to 4% of all-cause mortality and 1,969 deaths (Australian Institute of Health and Welfare (AIHW) 2022b).

Musculoskeletal system and connective tissue conditions

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

Prevalence

Within the GP practice data submitted to the Adelaide PHN, the percentage of patients with the following musculoskeletal conditions were osteoarthritis 7.6%; osteoporosis 5.0%; other musculoskeletal 2.9% and inflammatory arthritis 2.0% (APHN 2024a).

Arthritis

Modelled estimates indicated that 192,747 people (15.3 per 100) in Adelaide PHN region had arthritis in 2017-18. This is marginally higher than the Australian Greater Capital City Areas average of 14.2 per 100 population (Public Health Information Development Unit (PHIDU) 2022a). Prevalence rates varied across the region, ranging from 26% lower than the national rate in the LGA of Walkerville (11.1 per 100) to 26% higher in Playford LGA (18.9 per 100) (Public Health Information Development Unit (PHIDU) 2022a).

Osteoporosis

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

Emergency department presentations and hospitalisations

In 2020-21 there were 18,400 emergency department presentations due to musculoskeletal system and connective tissue diseases, equivalent to a rate of 1,458.1 per 100,000. This is significantly lower than the Australian rate of 1,892.0 per 100,000 population. Substantial and significant variation in rates was evident at the LGA-level, being 48% lower in Burnside compared to the national rate, and 71% higher in Onkaparinga (PHIDU 2023).

The public hospital admission rate for musculoskeletal system and connective tissue diseases in Adelaide PHN was 24% below the Australian rate in 2020-21, with 10,730 admissions in Adelaide PHN region, equivalent to a rate of 830.7 per 100,000 population (PHIDU 2023). Rates of hospitalisations varied across the PHN region, from 54% lower than the national rate in Burnside to 60% above the national rate in Onkaparinga (PHIDU 2023).

Chronic kidney disease

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

Prevalence

Estimates suggest that the prevalence of chronic kidney disease increases with age, affecting 4.1% of people aged 18-54 years, 9.6% of people aged 55-74 years and 34.6% of people aged 75 years and over (Australian Institute of Health and Welfare (AIHW) 2021b).

Within the GP data submitted to the Adelaide PHN in September 2024, the percentage of active patients with chronic kidney disease was 1.7% (APHN 2024a)

Hospital admissions

The public hospital admission rate for chronic kidney disease in Adelaide PHN was 6% higher than the Australian rate in 2020-21, with 2,199 admissions equivalent to a rate of 173.3 per 100,000

population (PHIDU 2023). Rates of hospitalisations varied across the PHN region, with the Unley LGA having a rate 36% below the national rate and Campbelltown having a rate 2.5 times as high as the national rate. (PHIDU 2023). Rates of same-day public hospital admissions for renal dialysis in 2020-21 within the Adelaide PHN were 6% lower than the national rate. Rates varied between LGA regions of the PHN and ranged from 44% below the national rate in Burnside, to 72% above the national rate in Salisbury. (PHIDU 2023).

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

Mortality

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

Kidney disease was the 18th ranked leading cause death in 2017-2021 in the Adelaide PHN region, contributing to 1.3% of all-cause mortality and 609 deaths (AIHW 2024b).

Comorbidities

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

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

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

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

Of the 561,963 people with chronic conditions (at least one of the following: diabetes, respiratory, cardiovascular, renal impairment or mental health) who attended a GP that submitted data to the Adelaide PHN in September 2024, 58.2% had one comorbidity category, 26.7% had two categories, 11.0% had three categories, 3.5% had four categories and 0.8% had 4+ categories (APHN 2024a).

Chronic pain

Chronic pain has recently been defined as pain that persists or reoccurs for more than three months and has been added to the International Classification of Diseases (Treede et al. 2019). It has been estimated that 1.6 million, or 1 in 5 Australians aged 45 years and over are living with persistent,

ongoing pain. In 2018, chronic pain was estimated to cost $139 billion, primarily attributed to reduced quality of life and productivity losses (Australian Institute of Health and Welfare (AIHW) 2020a).

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

Within the Adelaide PHN, a joint Adelaide PHN and Country SA PHN HealthPathways Consumer survey (N=110) targeting consumers was conducted in 2018 (Adelaide Primary Health Network (APHN) 2018a).Key challenges for those with chronic pain included experiences of long waiting lists (3+ years) for LHN pain services, frustration at not being believed or taken seriously by health professionals and maintaining active lifestyles despite being in pain. Participants found peer support (face-to-face and online), physiotherapy and mental health services such as CBT, mindfulness, and group therapy most beneficial for managing their condition (Adelaide Primary Health Network (APHN) 2018a).

Cancer

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

Prevalence

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

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

Cancer Incidence

Overall, the Adelaide PHN has a 64% lower incidence rate for all cancers when compared to Australia based on 2014-2018 data. Within the Adelaide PHN, there is geographical variation for all cancers ranging from 5% above the national rate in Playford to 19% below the national rate in Prospect (PHIDU 2023).

Rates of breast cancer in females within the Adelaide PHN in 2014-18 were 1% higher than the national rate. Again, there is significant variation within regions across the Adelaide PHN. In the Adelaide LGA, the rate was 18% below the national rate, while the rate in Mitcham is 24% above the national rate (PHIDU 2023).

Colorectal cancer incidence within the Adelaide PHN in 2014-2018 was 5% below national rates. Variation within the Adelaide PHN ranges from Walkerville (27% lower than the national rate) to Playford (9% higher) (PHIDU 2023). Incidence rates of cervical cancer within the Adelaide PHN are consistent with National rates (Australian Institute of Health and Welfare (AIHW) 2019a).

Potential years of life lost from cancer

Between 2017 and 2021, there were 73,282 (12.4 per 1,000) potential years of life lost due to cancer in the Adelaide PHN. This was 6% higher than the national rate, with significant variation between regions of the Adelaide PHN ranging from 34% below the national rate in the Adelaide LGA to 58% above the national rate in Playford (PHIDU 2023).

Cancer Mortality

When compared to national standardised death rate (SDR), the premature mortality due to cancer (aged 0 to 74 years) was 3% higher in the Adelaide PHN from 2017 to 2021. The variation between LGAs within the PHN were substantial with Burnside 29% below the national rate and Playford 55% above (PHIDU 2023).

Of note, while Playford had the highest mortality rates within the Adelaide PHN for cancer, it also had the lowest screening rates for all three of the national screening programs – Breast, Bowel and Cervical. This may suggest a correlation between lack of uptake of screening and higher rates of mortality, further highlighting the importance of early intervention and prevention (PHIDU 2023).

3.4.3 Barriers to chronic and long-term conditions management

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

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

These barriers continued to be highlighted by participants in the 2023 early intervention kitchen table discussions (Adelaide Primary Health Network (APHN) 2023a).

3.4.4 New and Emerging Areas of Interest

Oral Health

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

Comments made during the Population Health Needs Assessment Consultation (PHNAC), reiterated the importance of oral health and its importance as an indicator of overall health. For example, it was stated that neglecting oral health is a barrier to chronic disease management and that an enabler to improve health outcomes would be to engage with oral health practitioners (Adelaide Primary Health Network (APHN) 2022a).

Results from the Larter After Hours consultation identified that urgent, non-emergent oral health is a priority for the Adelaide PHN population in relation to after hours. First Nations peoples in the Onkaparinga area highlighted dental care as a concern, particularly in relation to the discontinued school dental program and cost (Larter 2023).

3.5 Illness Prevention & Health Protection

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

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

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

3.5.1 Cancer screening

Participation in national screening programs

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

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

[3] Australian Government, Department of Health and Aged Care, Immunization

Bowel cancer screening

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

Within the GP data submitted to the Adelaide PHN, 28% of the eligible population (aged 50-74 years) have had a FOBT recorded in the last 2 years (APHN 2024a).

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

Breast cancer screening

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

Within the GP data submitted to the Adelaide PHN 16% of eligible active patients between 50-74 years, had a mammogram recorded (APHN 2024a).

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

Cervical cancer screening

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

Within the GP data submitted to the Adelaide PHN in September, 40% of the active patients, female and aged 25-74 years had a cervical screening result recorded (APHN 2024a).

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

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

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

Barriers to Screening

Kitchen table discussions highlighted barriers to access for health screening being experienced by community members (Health Consumers Queensland 2022). These included:

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

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

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

3.5.2 Immunisation

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

Certain chronic medical conditions, such as Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Asthma increase the risk of complications of certain vaccine preventable diseases, especially zoster, pneumonia and influenza (Patel et al. 2022).

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

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

Participation in national immunisation programs

The national immunisation program schedule is a series of immunisations given at specific times throughout a person's life. The immunisations range from birth through adulthood. All vaccines that

are included in the national immunisation program are provided free by the federal government (Hull et al. 2021). Where possible, Adelaide PHN rates are reported below and compared to national or South Australian rates.

Children

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

Childhood immunisation

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

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

Influenza

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

Adolescent immunisation

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

HPV coverage

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

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

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

Meningococcal ACWY vaccine coverage

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

Influenza

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

Adult immunisation

Zoster vaccine coverage

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

Influenza

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

Emerging vaccine-preventable conditions

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

Monkey Pox

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

Japanese Encephalitis

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

Barriers to vaccination

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

Barriers identified include:

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

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

- Fear/misinformation about vaccination
- Lack of trust of vaccine benefits
- Uncertainty around the costs
- Difficulties in accessing a GP

- The politicised nature of the vaccine program
- Vaccine hesitancy and misinformation
- Future cost barriers (free COVID-19 vaccinations likely to be repealed)

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

Hospitalisations due to vaccine preventable conditions

In 2020-21, there were 1,025 potentially preventable public hospital admissions for vaccine-preventable conditions in Adelaide PHN. Equivalent to 80.7 per 100,000 population, the rate for Adelaide PHN is 20% lower than the Australian rate. Rates range from less than half the national rate in the LGA of Tea Tree Gully, to over 2.5 times the national rate in the LGA of Adelaide. (PHIDU 2022a).

3.5.3 Sexual Health and Blood Borne Viruses

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

Analysis of Adelaide PHN GP data, indicates that a total of 44,201 active patients had a Chlamydia screen, 16,518 had a Gonorrhoea screen, 25,839 had a Syphilis screen, had a 21,126 HIV screen and 36,985 had a Hepatitis B screen within the last 12 months of data submitted in September 2023.

Chlamydia

Of the 6,430 chlamydia notifications in 2019, most were in people aged 15 to 29 years (4,803/6,430; 75%), with GPs located in metropolitan Adelaide the most frequent notifiers (30%; 1,934), followed by the specialist sexual health service Adelaide Sexual Health Centre (ASHC) (15%; 957) and country GPs (6%; 379) (Shukla et al 2021). The top three countries of birth of cases were 56% born in Oceania and Antarctica, 2% born in sub-Saharan Africa, and 2% born in south-east Asia (Shukla et al 2021).

Gonorrhoea

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

Antarctica (80%) followed by 3.4% born in south-east Asia and 2.3% in sub-Saharan Africa (Shukla et al 2021).

Syphilis

Infectious syphilis

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

Syphilis (unspecified)

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

Human immunodeficiency virus (HIV)

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

Hepatitis B

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

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

Hepatitis B – newly acquired

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

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

Hepatitis B – unspecified

In 2019, there were 281 notifications of hepatitis B (HBV) infections of unspecified duration in SA, compared to 278 in 2018 and 47% were reported in females, 53% reported in males (Shukla et al 2021). The most frequently reported major region for the country of birth of cases notified in 2019

were North East Asia (85/281; 30%) followed by South East Asia (81/281; 29%), with 34 (12%) cases born in the major region Oceania and Antarctica and 20 cases were born in Australia. (Shukla et al 2021).

Hepatitis C

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

Hepatitis C – newly acquired

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

Hepatitis C (unspecified)

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

3.6 Equitable Access to primary health care

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

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

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

- Culturally and Linguistically Diverse (CALD) communities
- Parents and babies
- Children and young people
- LGBTIQA+ communities
- People living with a disability
- Low Socio-Economic-Status communities

3.6.1 Primary health care services

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

practices, other private practices, community health, local government, and non-government service settings (Price Waterhouse Cooper (PWC) 2018).

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

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

Snapshot of primary care services

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

General practice (GP) services

According to Adelaide PHN CRM in 2023/2024 there were 341 General Practices in the region (APHN 2024b).

GP attendances

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

In 2022-23, 8,102,081 GP services were provided to 1,102,723 people living in the Adelaide PHN region (85% of total population), which is below the national rate (91%). In line with the pattern nationally, older people used GP services more than younger people. In 2022-23, the data suggests that 100% of people aged 65–79 and aged 80 and over living in the region, received an GP service compared to only 79% of 0-14 year old’s and 70% of 15-24 year old’s (AIHW 2024c).

By SA3, there were moderate variations in rates of service per 100 people across the region, with regions of lower socioeconomic status generally having higher rates of services than areas of higher socioeconomic status. (AIHW 2024c).

Enhanced Primary Care services

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

In 2022-23, a total of 762,199 enhanced primary care services (EPCS) were provided to 301,111 people living in the region which is an increase in both services and people from 2021-22, equivalent to 9.4% of total GP attendances. In 2022-23, 530,220 GP Chronic Disease Management Plans were provided to 201,771 people (70% of total EPCS), 163,415 GP Mental Health services to 102,999

people (21% of total EPCS) and 58,720 GP Health Assessments to 58,180 people (8% of total). The proportion of people receiving GP services for Chronic Disease Management Plans and GP Health Assessments increased with increasing age, whereas the majority of GP Mental Health services were provided to people aged between 15-44 years (AIHW 2024c).

Consumer experiences of GP services

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

Allied health services

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

In 2022-23, 1,455,244 services were provided to 524,913 people (41%) living in the Adelaide PHN region, which is consistent with the national rate (39%). In line with the pattern nationally, older people use allied health services more than younger people. In 2022-23, 71% of people aged 65–79 and 80% of people aged 80 and over living in the region, received an allied health service compared to only 19% of 0-14 year olds and 26% of 15-24 year olds (AIHW 2024c).

By SA3, there were moderate variations in rates of service per 100 people across the region, with a general trend of fewer services per 100 people in lower SES areas than higher SES areas. (Australian Institute of Health and Welfare (AIHW) 2022f).

In 2022, the National PHN Collaborative developed the Allied Health in Primary Care Engagement Framework which outlines encourage a consistent approach to support efficient and effective primary healthcare Allied Health service delivery to communities, define roles and approaches for engaging with the Allied Health sector, and drive change to increase collaboration between the Allied Health sector and PHNs.

Mental health services

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

In 2022-23, in total 614,873 Medicare-subsidised mental health related services were provided in the Adelaide PHN region (AIHW 2024c). Psychologists provided approximately half (48%) of the Medicare-subsidised mental health-related services received in 2022-23, with GPs providing a 27%, and psychiatrists providing 19% of these services (AIHW 2024c). Across all service types, the majority of services were provided to people in the 15-24 and 25-44 age groups, who had the highest rate of services per 100 population (AIHW 2024c).

By SA3, there were clear variations in rates of service per 100 people across the region by service type in line with socioeconomic status (SES); regions of higher SES had higher rates of both clinical psychologist and psychiatry services. There was less variation in rates of GP mental health services, and in contrast the rates were higher in SA3s of lower SES (Australian Institute of Health and Welfare (AIHW) 2022f).

3.6.2 After Hours

Summary of identified needs for After Hours

Table 4 below summarises the health and service need identified through the needs assessment process for the Population Health priority area. The evidence against each of these statements is provided within this chapter. The full report will be made available on the Adelaide PHN website once it has been received.

Table 4 Summary of needs identified for After Hours, 2023

Outcomes of the health and service needs analysis – After Hours		
Identified Need	**Key issues identified**	**Evidence**
Enhance all communities' understanding of what is available, and how to use, AH services	• Videos for new migrants and rural visiting Aboriginal people are needed. • Urgent vs emergency is confusing. • Community knowledge about AH services is very limited. • There is poor understanding of the healthcare system, especially, new migrants, refugees and other CALD community members. • Poor health literacy is an issue, including nonunderstanding of urgency.	Larter Report Results of after hours health and service needs Results of after hours consultations
Low or no cost dental care – urgent, but not emergency	• Cost is a prohibitive factor, for First Nations – particularly children 0-15 • Lack of access for nonemergency dental care. • One key reason for nonemergency ED presentations in Adelaide.	Larter Report Results of after hours health and service needs Results of after hours consultations
Cost to access care an issue, particularly for those without ambulance subscription	• Bulk billing difficult to access. • Cost of transport is a factor. • Consider subsidising after-hours telehealth.	Larter Report Results of after hours health and service needs Results of after hours consultations
Enhance GP and pharmacy access for disadvantaged communities	• Few GPs are seeing homeless in the Adelaide central business district (CBD). • There is a lack of public transport or it's impractical. • Grants + access to pathology and radiology is necessary. • There is poor understanding of the healthcare system and poor health literacy. • There is a lack of cultural inclusiveness for First nations.	Later Report Results of after hours health and service needs Results of after hours consultations

Outcomes of the health and service needs analysis – After Hours		
Enhance efficiency and GP + RACF knowledge of SA Health virtual care services	• Recently, seeking patient access has taken more time.	Larter Repot Results of after hours health and service needs Results of after hours consultations
More timely and reliable access to GPs for residential aged care facilities	• It is difficult for patients to access GP when needed. • There is a lack of consistency of access to care. • Cultural, language and sexuality are barriers to person centred care.	Larter Report Results of after hours health and service needs Results of after hours consultations

Results of After Hours health and service needs analysis

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

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

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

In 2023, Adelaide PHN engaged Larter Consulting to conduct an in depth and comprehensive needs assessment. This was in response to:

- Changes in the service landscape, state funded services, private services in recent years with the pandemic resulting in changes in both provider and community preferences
- The need to further build on the broader PHN Needs Assessment work
- The Commonwealth's 2023-24 budget announcement of $77.9 million nationally to extend the PHN After Hours Program.

Results of the 2023 After Hours Needs Assessment builds onto the work undertaken previously and adds value through stakeholder engagement, planning, and prioritisation of both needs and pragmatic options for action.

Results of After Hours Consultations

In 2023, Larter Consulting conducted a range of community consultations to provide community members and health care providers to provide input in to understanding after hours health care needs and service provision.

Engagement with community and stakeholders included:

- 49 consumer survey responses
- 31 provider survey responses
- 23 phone interviews
- 15 face-to-face interviews

- 8 focus group attendees

Findings from community engagement undertaken by Larter Consulting included:

Cost of services

Scarcity of bulk billing medical practitioners, reliance on “free” hospital services, delaying GP visits until they can be afforded. People living with a disability avoid seeking emergency care due to ambulance fees and the lack of transportation to reach ED.

Lack of after-hours services

Both GPs and pharmacies. For individuals facing homelessness, few GP clinics are available in the city centre where rough sleepers often reside. First Nations peoples highlighted dental care as a concern, particularly re discontinued school dental program. People with disabilities and caregivers noted limited services, especially for children.

Lack of transportation

Limited public transport after-hours. The cost of taxis or Uber rides is often prohibitive. Many refugees, recent arrivals, and people facing homelessness do not have vehicles. Refugees and recent arrivals rely on others for transportation. In the northern regions, after-hours bus services are limited. Lack of ambulance coverage further limits emergency options. In central Adelaide, some benefit from the free bus and tram services. For Aboriginals and Torres Strait Islanders, buses can be impractical, especially when dealing with illness late at night and when having to travel with children. Safety concerns also deter many from using public transport during after-hours periods.

Low health literacy

Refugees and recent arrivals lack knowledge about after-hours options. This is compounded by illiteracy in English and in their own languages, making it difficult to access information. Preference for video. People experiencing homelessness and many in the Aboriginal and Torres Strait Islander communities are uninformed about service options. There is confusion between the terms 'urgent' and 'emergency'.

Long wait times

Prolonged waiting times, especially at hospitals, can be distressing. For example, young homeless individuals seeking help for suicide ideation waiting hours can be highly traumatic. Language is a challenge for refugees, recent arrivals, and Aboriginal and Torres Strait Islander people (particularly those travelling from rural) seeking after hours healthcare. Interpreting services are known to be available at EDs. Limited proficiency in English can hinder phone-based and telehealth services.

Need for gender / language specific doctors

Refugees and recent arrivals need to consult a doctor of the same gender or who speaks their language. It is difficult to locate a doctor nearby who meets both criteria, and some may avoid local doctors due to privacy.

Lack of culturally inclusive services

Aboriginal and Torres Strait Islander people want clinics with Aboriginal doctors that can provide after-hours care, employ Aboriginal staff, and integrate traditional and western medicine. Similarly, people facing homelessness encounter barriers due to a lack of culturally inclusive services. Many young people have had poor experiences with health care service.

Difficulty accessing home visiting services

Home visiting doctor services are not accessible to rough sleepers. Refugees and recent arrivals tend to avoid using home visiting services due to language barriers. If a doctor were to visit, communication difficulties arise because of their limited English proficiency.

Lack of accommodation

Some Aboriginal people in remote and regional areas travel to Adelaide for health care. This can be challenging for families, as finding culturally appropriate and affordable accommodation becomes an issue when they need to stay in Adelaide overnight or for extended periods.

Loss of ID

People experiencing homelessness frequently lose or have their identification stolen, including healthcare and Medicare cards. Hospitals may provide medical treatment without these documents, while other services may only serve individuals who are already a client/patient of the service.

After-hours service awareness

The following is a summary of the findings from previous consultations.

In 2019, improving awareness of after-hours services among the community and providers was an issue in the Adelaide PHN region. The CC identified the need for greater promotion of after-hours services in primary health care to ensure community uptake, particularly in culturally and linguistically diverse communities, and suggested that GPs are referring patients to ED rather than after-hours services, so greater awareness is needed among GPs in order to avoid this (Adelaide Primary Health Network (APHN) 2019a). The CAC raised the need for GPs to improve the promotion of after-hours services to their patients (Adelaide Primary Health Network (APHN) 2019a).

CAC and CC members also considered there to be a lack of after-hours mental health services to address the needs of children and youth, people with AOD issues, Aboriginal and Torres Strait Islander populations, and the LGBTIQA+ community, and for other population groups including people experiencing homelessness, those with low incomes, and the elderly (Adelaide Primary Health Network (APHN) 2019a).

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

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

Use of HealthDirect helpline

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

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

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

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

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

Medicare-subsidised after-hours services

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

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

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

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

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

Use of acute services in the after-hours period

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

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

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

Lower urgency ED presentations

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

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

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

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

Urgent Care Centres, Priority Care Centres and Virtual Care Services

Changes in the service landscape, state funded services, private services in recent years with the pandemic resulting in changes in both provider and community preferences. These services include the emergence and establishment of the following services which impact on after hours service availability for urgent care needs:

- Urgent Care Centres are Commonwealth funded services providing free, immediate, treatment and care for patients with or are experiencing non-life-threatening injuries or illnesses.
- Priority Care Centres provide community-based healthcare and treatment for eligible patients with urgent but non-life threatening conditions who would otherwise be seeking treatment at a public hospital emergency department.
- SA Virtual Care Service (SAVCS) is improving access to healthcare across the state and responding to the needs of frontline workers by bringing emergency care to patients, that

would normally only be available in an ED. The statewide service provides an individualised assessment service via video link for urgent patients on-scene with SA Ambulance crews, regional clinicians or aged care staff.

- Child and Adolescent Virtual Urgent Care Service connects parents with a virtual team of highly skilled emergency doctors and nurses who can assess and provide medical advice for your children, aged between 6 months and up to 18 years.

Findings from the Larter 2023 Needs Assessment Draft Report indicated community satisfaction of these services when utilised was high, however, awareness and understanding of these services across community groups and service providers was low. (Larter 2023)

COVID-19 Impacts on After Hours

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

3.6.3 Factors impacting access to primary health care services: Health literacy

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

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

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

Nationally, 67% of people born overseas in a mainly non-English speaking country have less than adequate levels of literacy and health literacy, meaning that they may not be able to effectively

exercise their choice or voice when making healthcare decisions (Australian Statistics Bureau (ABS) 2013).

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

Key points identified by participants included:

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

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

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

3.6.4 Barriers to Equitable Access

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

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

Effectiveness

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

Safety

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

Appropriateness

- There is still stigma associated with LGBTIQA+ patients
- There are limited services for CALD and LGBTIQA+ populations
- There is a shortage of GPs who will see LGBTQIA+ patients
- There is a lack of interpreters available for CALD populations
- Women of ethnic background do not feel comfortable speaking to male doctors
- Gender appropriate services are required

Continuity of Care

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

Accessibility

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

Efficiency and Sustainability

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

3.7 Health and service needs of priority population groups and communities

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

3.7.1 Multicultural health access

Needs Assessment Purpose

In 2024 a Needs Assessment (NA) was conducted to identify the needs for improved primary care for multicultural communities in the Adelaide PHN region. The Culturally and Linguistically Diverse (CALD) populations in Australia exhibit significant diversity in terms of cultures, languages and migration experiences and are recognised as a priority group in several key Government strategies. The following is from the Multicultural Health Access Needs Assessment Summary Report (APHN 2024c).

Methodology

A mixed methods approach was used to conduct this NA including consultations with community and service providers. The PHN Multicultural Health Framework was also used to inform this NA.

Key Findings on Demographics and Health Service Needs

(a) Demographics:

- CALD populations live predominantly in the Northern (22%), Central (22%) and Western (24%) Adelaide PHN regions
- Slightly more CALD females (52%) than males (48%)
- CALD populations who do not any speak English originate mostly from China (excluding Special Administrative Regions and Taiwan), Vietnam, Afghanistan, Bhutan and India
- Newly arrived migrants and those with a refugee background have intersecting health and social disadvantage and encounter significant challenges navigating social and health systems.

(b) Health service needs:

- Critical issues impacting access to care include affordability, service availability and workforce shortages
- Individual barriers impacting health service access include low health literacy, low English proficiency, transportation difficulties and psychosocial factors (e.g. cultural and differences, social stigma, discrimination)
- A lack of culturally sensitive practices, particularly for management of chronic conditions
- These populations have multiple intersecting health and social disadvantage and encounter significant challenges in navigating social and healthcare systems. Factors such as migration patterns, low educational attainment, limited income, and low English proficiency negatively impact their health. System factors that contribute to these challenges include:
- Limited structured partnerships and referral systems, particularly within the migrant health sectors.
- Limited capacity of current services (e.g. Alcohol and Other Drug (AOD) services) to cater to diverse CALD groups.

Need Statements

1. Enhance chronic health conditions management especially mental health issues for the humanitarian entrants.
2. Enhance screening participation for cancer and other preventative health services including sexual health.
3. Embed a holistic view to health to recognize, social determinants of health including psychosocial factors.
4. Enhance primary care access for multicultural communities.

Prioritised Need Opportunities

The following are prioritised need opportunities that were identified through the needs assessment process:

1. There is a significant gap in culturally appropriate and timely health care services for the CALD population.
2. There is a lack of integrated and coordinated care, continuity of care and suitable referrals services for CALD communities.
3. There is a lack of person-centred comprehensive support and holistic care to address the Social Determinants of Health for CALD population.
4. There is insufficient proactive community engagement among health service providers.
5. There is a lack of support for vulnerable populations, particularly newcomer women and older individuals with co-morbidities from humanitarian background.

3.7.2 Parents and Babies

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

Smoking in pregnancy

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

Infant mortality and low birthweight

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

from 5.0% in Burnside to 7.6% in Salisbury (Public Health Information Development Unit (PHIDU) 2022a).

Antenatal care

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

3.7.3 Children and young people

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

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

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

Risk Factors

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

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

Developmental vulnerability

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

Long-term health conditions

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

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

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

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

Respiratory system conditions

Emergency department presentations and hospitalisations

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

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

Asthma

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

Potential preventable hospitalisations: chronic asthma

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

Emergency department presentations and hospitalisations: chronic asthma

In 2018-19, there were 594 admissions to public hospitals in children aged 0 to 14 years due to potentially preventable chronic asthma, an ASR per 100,000 of 273.1 which is higher than the Australia's rate of 230.7. There were 115 public hospital admissions for persons aged 15 to 24 years because of potentially preventable asthma. This equates to the ASR per 100,000 of 71.4 which is

lower than the Australian rate of 93.5. (PHIDU 2021) The lowest ASR per 100,000 in the PHN for children aged 0 -14 years was Unley (142.9), the highest was Playford (393.4) (Public Health Information Development Unit (PHIDU) 2022b).

Mental health conditions

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

Emergency department presentations and hospitalisations: mental health conditions

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

Disability

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

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

Autism

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

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

Analysis of Adelaide PHN GP data as of September 2024 (audit month, filtered by active patients, 0-18 years) indicates there have been 8,357 patients aged 0 to 18 years who have a coded diagnosis of ASD. This is equivalent to 3.5% of active patients aged 0 to 18 years.(APHN 2024a)

Early intervention services for children

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

3.7.4 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 (Adelaide Primary Health Network (APHN) 2019d). To better understand the health and service needs of this population and build upon the evidence presented in previous Needs Assessment submissions, in 2020 the Adelaide PHN undertook an environmental scan of recent relevant literature, conducted consultations with the Adelaide PHN councils and stakeholder groups and interviews with several LGBTIQA+ service providers in the region. This section summarises the general primary health care and service needs and issues that were identified from this process; health and service needs relating to mental health and alcohol and other drugs treatment for LGBTIQA+ communities are reported in those respective chapters.

It is important to note that the majority of data quantifying local prevalence and service utilisation are generalisations based on national and international data and research; this lack of consistent, rigorous or reliable data regarding the size and demographics of South Australia's LGBTIQA+ communities, and their utilisation of health services is acknowledged as a distinct issue (Fay Fuller Foundation (FFF) 2018; Commissioner for Children and Young People SA (CCYP SA) 2019; Adelaide Primary Health Network (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; Adelaide Primary Health Network (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 (Adelaide Primary Health Network (APHN) 2020a; Commissioner for Children and Young People SA (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 Health 2019), have higher rates of substance use (Fay Fuller Foundation (FFF) 2018; Australian Institute of Health and Welfare (AIHW) 2019c), and poorer outcomes compared to general population (Karen et al. 2017). LGBTIQA+ people also have a higher incidence of life-limiting illness and tend to present to health care services later and with more advanced disease than the general population (Bristowe 2018; Australian Government Department Health 2019). A recent Australian study of the health and wellbeing of LGBTIQA+ young people (Hill et al. 2021a) 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.

In the "LGBTIQ+ Health Australia Roadshow: Meeting with senior public sector leaders presentation" held on September 27, 2023, Professor Adam Bourne presented slides summarising a number of survey results. (Bourne 27 September 2023) Titled "The health and wellbeing of LGBTQ communities in Australia: findings from large-scale population surveys", key findings included:

- 41.7% of LGBTIQA+ people reported intimate partner violence, and 38.5% reported family of origin violence.
- LGBTIQA+ people experience higher rates of homelessness than non-LGBTIQA+ people. 32 to 41% of trans and gender diverse people experienced homelessness.

- 14% of LGBTIQA+ people reported struggling to manage drug use or it negatively impacts their daily life (higher among trans/gender diverse people).

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; Fay Fuller Foundation (FFF) 2018; Mooney-Somers 2018; Leonard et al. 2015; Strauss et al. 2017). In line with the above, fear of and experiences of stigma and discrimination as a barrier to accessing primary health services was a reoccurring issued identified in consultations with Adelaide PHN councils and stakeholders (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (APHN) 2020a). These issues are reflective of national and international research (Australian Government Department Health 2019; Mullens et al. 2017; South Australian Rainbow Advocacy Alliance (SARAA) 2019; Strauss et al. 2017; Waling et al. 2019).

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

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

3.7.5 People with a disability or limitation

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

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

The *National Roadmap for Improving the Health of People with Intellectual Disability* (Department of Health and Aged Care (DOHAC) 2021) highlights that people with intellectual disability experience:

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

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

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

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

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

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

Assistance needed and received

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

Disability group

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

Main conditions of people with disability

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

Mental or behavioural disorders were reported as their main condition by 23% of people with a disability. The most common mental or behavioural disorders were psychoses and mood disorders

(8%), intellectual and development disorders (7%) and neurotic, stress related and somatoform disorders (6%) (Australian Bureau of Statistics (ABS) 2020).

Older people living with a disability

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

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

Over 29,200 older people living in the region had a profound or severe limitation, equivalent to 14% of all people aged 65 years and over. Playford LGA had the highest proportion of people with a profound or severe limitation (20%, 2,181 people), while Onkaparinga (4,084, 14%) and Charles Sturt (3,285, 16%) had the highest numbers. Similarly, Onkaparinga and Charles Sturt LGAs had the highest number of people with mild or moderate limitation, 9,128 and 5,975 people respectively. Playford LGA also had the highest proportion of with 36% of people aged 65+ years living with a mild or moderate limitation (Australian Bureau of Statistics (ABS) 2020).

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

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

People with intellectual disability

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

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

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

3.7.6 Low socio-economic status communities

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

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

In South Australia, the correlation between higher levels of disadvantage leading to poorer health outcomes are demonstrated through data collected in the South Australian Population Health Survey (Wellbeing SA 2020). For example, SEIFA areas of low and lowest scores, correlate to higher proportions of children with diagnosed heart disease and/or stroke, reported asthma and reported mental health conditions. In adults, low income ($40,000 and below) is correlated with higher reported use of mental health services, reported mental health conditions, high or very high psychological distress, higher rates of food insecurity in the last 12 months and reported rates of chronic disease (diabetes, asthma, COPD, CVD, arthritis and cancer) (Wellbeing SA 2020).

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

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

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

3.7.7 People at risk of/or experiencing homelessness access

Needs assessment purpose

This Needs Assessment was conducted by Health Q consulting to support the Adelaide PHN to assess need and identify opportunities and priorities to improve primary care access for people who are experiencing or at risk of homelessness by undertaking a detailed and systematic assessment of the population's health needs across the Adelaide PHN catchment areas.

The Needs Assessment comprises:

- Population health planning and assesses the service needs of the region
- Review and identification of the market factors and drivers relevant to the provision of Primary Health Care services for the target population
- Analysis of relevant and current local and national health data
- Stakeholder and community consultation and market analysis
- Priorities and strategies to be implemented to better align funding to needs of people experiencing or at risk of homelessness.

Methodology

A Needs Assessment Framework was developed to guide the data collection (inclusive of the consultation strategy) and analysis activities. The Framework included the assessment domains, overarching lines of enquiry and potential points of data collection. A suite of assessment tools, designed to facilitate the answering of questions were identified in the Needs Assessment Framework. Consultation with a broad representation of stakeholders was a core component of the Needs Assessment. Our consultation strategy included the use of face to face and telephone/Teams interviews as well as online and paper-based surveys.

Key Findings

According to 2021 census data, approximately one in every 200 people experience homelessness in Australia. The South Australian rate of homelessness was slightly less, with one in every 240 people experiencing homelessness (ABS, 2023). Utilising combined homeless and socioeconomic disadvantage this Needs Assessment has identified the following locations as highest priority (in order):

1. North Adelaide
2. Adelaide City
3. West Adelaide
4. South Adelaide
5. Central Adelaide and Adelaide Hills (excludes Adelaide City)

In respect to priority populations:

- Younger people are overrepresented in the homeless population in the Adelaide PHN region, with a quarter of those experiencing homelessness in the region aged 15-24, and almost a third (30.4%) aged 25-44.
- For people receiving support from Specialist Homelessness Services (SHS) across South Australia, 27% (5,188) were identified as experiencing family and domestic violence.
- Although only 2% of the Adelaide PHN's population are Aboriginal or Torres Strait Islander, 9% of homeless people identified as Aboriginal and/or Torres Strait Islander and are most likely to be living in supported accommodation or severely crowded dwellings.

Other priority populations include older Australians, and Culturally and Linguistically Diverse (CALD) populations.

People experiencing homelessness in Adelaide exhibit a high prevalence of poor health outcomes, aligning with global trends reporting elevated rates of physical and mental health conditions, including depression, anxiety, and dental problems (Flavel et al. 2022).

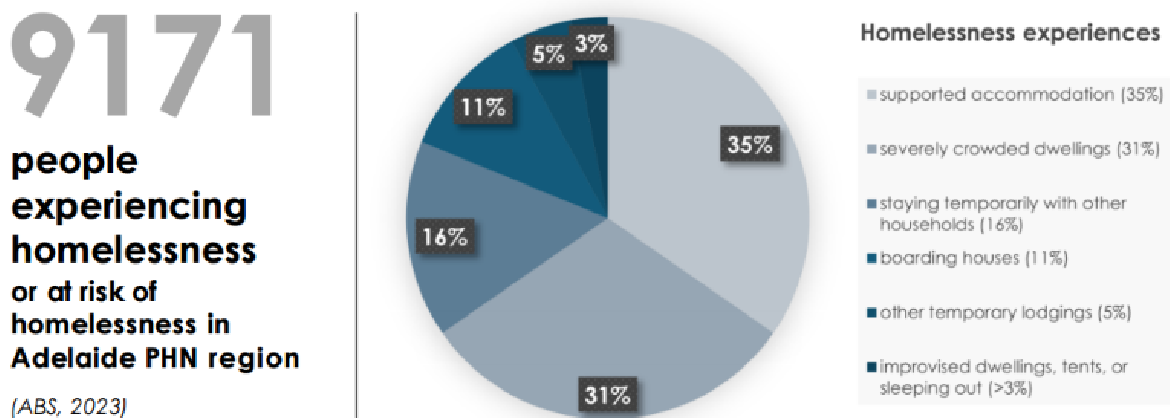
When people are experiencing homelessness or at risk of homelessness access to stable and safe housing is the biggest crisis in their life at that time, therefore addressing or managing their health issues and/or conditions is not a priority. When ready to access services, the services are not

available or if available people experience multiple significant barriers to accessing services across the Adelaide PHN catchment area.

Mainstream primary health care services are not affordable and are often not welcoming environments for people who are homeless, they can often feel judged with services not underpinned by cultural respect, social justice, and equality. Whilst there are some specialist homelessness health care services in the Adelaide CBD, these are limited in availability with no specialist homelessness health care services outside of this region. Other barriers for this population to accessing primary health care include lack and cost of transport, rigid appointment systems and times, limited access to technology, wait lists and costs for services, few outreach services and costs of medications.

People experiencing homelessness or at risk of homelessness are not accessing primary health care services, contributing to the poor health outcomes for this population.

Figure 2 Homelessness in the Adelaide PHN region



Source: (ABS 2023d)

Summary of Needs

The following section provides more details about the identified needs and issues as part of this needs assessment.

Geographic Areas of Priority

The health needs analysis in Chapter three presented an analysis of the homelessness population across the Adelaide PHN region. Combining homeless and socioeconomic disadvantage the needs assessment has identified the locations in order of priority as shown.

Order of Priority	Region	Rationale
1	Northern Adelaide	Accounted for the majority of those who reported experiencing homelessness or living in marginal housing at the 2021 census (39%).
2	Adelaide City	While it accounted for only 3.3% of those experiencing homelessness or at risk of homelessness in Greater Adelaide, this small region represents the highest density of people experiencing homelessness or at risk of homelessness.
3	Western Adelaide	Western and Southern regions of Adelaide reported similar proportions of the total number of people experiencing homelessness or at risk of homelessness in Greater Adelaide (approximately 13-14% each). West Adelaide has a smaller total population than South Adelaide (estimated at 250,140 people compared to 381,357 people in South Adelaide). This suggests a higher density of people experiencing homelessness or at risk of homelessness in West Adelaide compared to South Adelaide.
4	South Adelaide	See Westen Adelaide above.
5	Central Adelaide and Adelaide Hills (excludes Adelaide City)	When excluding Adelaide City, this region accounted for only 6% of those experiencing homelessness or at risk of homelessness in Greater Adelaide. Most of this region is also out of scope to the Adelaide PHN needs assessment, leaving only a few remaining suburbs of interest.

Figure 3 Priority locations

Identified Priority locations based on homeless and socio economic disadvantage ranked as shown.

Source: (APHN 2024d)

Priority Population Groups

The following table presents sub-populations in order of priority, per the findings of this Needs Assessment. However, it is important to recognise that many people will be counted across multiple categories and eligible for support across a number of these areas reflecting the multifactorial issues experienced and the socioeconomic disadvantage that is seen in this population.

Order of Priority	Population	Rationale
1.	Youth	Almost half (49%) of people experiencing homelessness in the Adelaide PHN are under 25 years old with a quarter under 15. Eighty percent of respondents to the alliance care worker survey identified Youth as a population presenting with specific health needs.
2.	People experiencing family and domestic violence	This group has the highest percentage of people receiving support from SHS across South Australia, with numbers increasing across Australia with 50% of new SHS clients in 2022-2023 under 18 years old. This population was ranked in the top 3 subpopulations in both the care worker and primary care provider surveys as presenting with specific health needs.
3.	Aboriginal and Torres Strait Islander peoples	More than 9% of people experiencing homelessness identified as Aboriginal and/or Torres Strait Islander across the Adelaide PHN region with 22% of people accessing SHS in SA identifying as Indigenous. in the Adelaide CBD, 56% of survey respondents identified as Aboriginal or Torres Strait Islander.
4.	CALD	43% of persons experiencing homelessness are speakers of non-English primary languages in the Adelaide PHN region with the majority in the North West regions of Adelaide.
5.	Older Adults	There is a growing homelessness problem among this population, with service providers identifying this as a key group experiencing homelessness and having specific health needs, however the numbers for this population are the lowest across the Adelaide PHN.

3.7.8 Family, Domestic and Sexual Violence

Introduction

In response to the Fourth Action Plan of the National Plan to Reduce Violence against Women and their Children (2010–2022), the Commonwealth funded the Improving Health System Responses to Family and Domestic Violence measure in 2019. Part of this measure was a pilot to develop a model to strengthen the capacity of primary care to respond to Family and Domestic Violence (FDV). This pilot included 6 PHNs from Queensland, Victoria, and New South Wales. The first tranche PHNs were expected to trial locally integrated models adapting the Recognise, Respond, Refer (RRR) pilot model which was implemented by Brisbane South PHN from 2017.

Following the success of this model's implementation in these regions, the Commonwealth Government announced additional funding in the 2022-2023 budget for the Supporting the Primary

Care sector response to Family, Domestic and Sexual Violence (FDSV) pilot. Adelaide PHN, in partnership with Country SA PHN (CSAPHN), was successful in its grant application and received funding as a second stage pilot site, to take a statewide approach to the FDSV pilot. The Adelaide PHN is the lead in this project. The Needs Assessment (NA) completed in October 2024 supports Adelaide PHN and Country SA PHN to assess need and identify opportunities and priorities to improve primary care for those affected by FDSV by undertaking a detailed and systematic assessment of the population's health needs across the two regions.

An overview of the relevant details of the FDSV Pilot Project NA is presented below.

Please refer to the Adelaide PHN website for the more detailed summary report (APHN 2024e).

Please also note further insights specifically regarding FDSV and Alcohol and Other Drugs (AOD) are presented in Chapter 8.

Definitions

- **FDSV** includes family violence, domestic or intimate partner violence, sexual violence, and child sexual abuse.
- **Family violence** (FV) describes violence used by any family member against another family member or in family-like settings. It includes violence used against intimate partners, children (by caregivers or other family), against parents or elders (by children, young people, or others in the family).
- **Domestic violence** (DV) describes any behaviour within an intimate relationship (including current or past marriages, domestic partnerships or dates) that causes physical, sexual or psychological harm.
- **Sexual violence** (SV) describes any sexual activity that happens where consent is not freely given or obtained, is withdrawn or the person is unable to consent due to their age or other factors. It occurs any time a person is forced, coerced, manipulated, or deceived into sexual activity. It can include contact and noncontact activity, including sexual harassment or unwelcome attention.
- **Child sexual abuse** (CSA) describes the involvement of a child in sexual activity by an adult or older child that they are unable to give consent to due to their age, developmental stage, or unequal power and dependence.
- **Person / people experiencing violence / victim** is a person at the time they are experiencing a pattern of violence and abuse. Includes people at risk of experiencing violence.
- **Person / people with lived experience / victim-survivor** is a person that has experienced violence. Some definitions include people who are still living with violence or that use their experience in some way.
- **PUV / person / people using violence / perpetrator** is a person who uses or has used violence or harmful behaviours. PUV is preferred as focus on behaviour over identity reflects the capacity to change and/or the reduced responsibility when it is a minor using the behaviour.

Methodology

- A mixed methods approach was used to conduct this FDSV NA including a Desktop Research Report completed by The Australian Centre for Social Innovation (TACSI), and consultations through interviews, focus groups and survey; with people who had lived experience of FDSV and Professionals with experience in either the FDSV or primary care

sector in both regions. A total of 152 voices participated in the consultations (69 from Metropolitan Adelaide and 83 across Country SA)

- Emerging themes generated multiple need statements, and a prioritisation session was conducted on 28 August 2024. A total of 39 attendees from Adelaide PHN & CSAPHN combined councils, board members and executive team, FDSV Project specialist facilitators, co-design group, project GP and Lived Experience Advisory Panels participated. The attendees were also asked to prioritise geographic indictors to inform service locations in both PHN regions.

Key Findings from Data and Consultation Insights

- FDSV, including child sexual abuse (CSA) is extremely common in South Australia and Australia.
- FDSV (including CSA) has a range of short- medium- and long-term physical and psychological health problems that would benefit from earlier intervention.
- Abusive dynamics make it difficult for people experiencing FDSV to disclose, seek help for, or end their experiences of violence.
- A person using violence (PUV) make it unsafe for people experiencing FDSV to disclose their experiences of violence.
- Inappropriate responses from others compound the abusive dynamics and prevent people experiencing violence from receiving support.
- Sub-groups identified across the two regions include:
- Aboriginal and Torres Strait Islander women experience higher rates of violence and poorer health outcomes compared to non-Indigenous women. They are also more likely to experience sexual violence and sustain injury.
- Culturally and linguistically diverse women (CALD) women may have different experiences, risk factors and needs relative to family and domestic violence, than other Australian women.
- Women living outside major cities report experiencing partner violence (23%), compared with of women living in major cities (15%).
- Women and children living with disability are more likely to experience violence than those without disability. Women and children living with disability may have different experiences, risk factors and needs relative to FDSV (including CSA), than those without disability.
- The majority of LGBTIQA+ people have experienced some form of FDSV in their lives.

  Health Service and Systemic Needs (South Australia):

- Services responding to FDV available for the general population in SA are focused mainly on crisis response and are more readily available in metropolitan Adelaide areas.
- There are large gaps in service availability and options in areas of SA for people experiencing SV and CSA, especially in rural areas.
- Service options across all types of violence and regions of SA demonstrates a lack of service specific options for priority groups Aboriginal and Torres Strait Islander, disability, LGBTIQA+ and multicultural communities.
- There is a lack of coordination between FDSV providers leading to a lack of coordinated care and support for people to access the right care at the right time.

Table 5 Summary of identified needs, key issues, and priority statements from the FDSV Pilot Project need assessment (October 2024)

Identified place or community group	Identified need (current state – reflective of a range of issues)	Key issues (the various issues creating the need)	Priority statements (the desired outcome)
Community members experiencing family, domestic and sexual violence (including child sexual abuse)	There is an over reliance on individuals experiencing family, domestic and sexual violence (including child sexual abuse) to disclose their abuse to access intervention and support services, despite many barriers to doing so.	The dynamics of abuse create a number of emotional and practical barriers to disclosure, including very real and severe safety concerns. The conditions of primary health care settings also create a number of barriers to disclosure, including: Unsafe past experiences with GPs / primary care staff Issues with access to primary care create a lack of time, space, and trust needed to make a disclosure The presence of children during appointments Fear of statutory consequences / issues (e.g., child protection, immigration) Concerns about privacy and confidentiality, especially in rural areas	Individuals experiencing family, domestic and sexual violence (including child sexual abuse) can access timely and appropriate intervention and support services.
Primary Health Care Providers	There are limited primary health care providers with sufficient readiness to recognise, respond to, and refer patients experiencing family, domestic and sexual violence (including child sexual abuse)	Readiness to identify, respond, and refer to patients experiencing family, domestic and sexual violence (including child sexual abuse) requires primary health care providers to have: Sufficient awareness and understanding across a range of topics. Appropriate attitudes towards victim-survivors of Family, domestic and sexual violence (including child sexual abuse) and the role of primary care in responding to family, domestic and sexual violence (including child sexual abuse). Confidence in recognising indicators of family, domestic and sexual violence (including child sexual abuse) and approaching conversations about Family, domestic and sexual violence (including child sexual abuse).	Primary health care providers have the readiness to recognise, respond to, and refer patients experiencing family, domestic and sexual violence (including child sexual abuse).

		Awareness of and trust in the family, domestic, and sexual violence service system.	
System	A lack of resources, infrastructure, and system readiness limits the capacity of primary health care providers to recognise, respond to and refer patients experiencing family, domestic and sexual violence (including child sexual abuse)	Workforce capacity issues and funding models within the primary health care sector have created a range of barriers for primary health care providers to support patients experiencing family, domestic and sexual violence (including child sexual abuse). There are a lack of appropriate guidelines, resources, and tools to support primary health care providers to support patients experiencing Family, domestic and sexual violence (including child sexual abuse).	Primary health care providers have the capacity to recognise, respond to, and refer patients experiencing family, domestic and sexual violence (including child sexual abuse)
	A lack of integration between social and health service systems limits the capacity of health and social systems to provide coordinated, person-centred care to patients experiencing family, domestic and sexual violence (including child sexual abuse)	There are a lack of processes and policies in place to support communication and collaboration between primary health care providers and other services. There is a lack of funding for integration and coordination between various services. There is a lack of referral pathways for primary health care providers due to the disconnected and limited services available to respond to family, domestic and sexual violence (including child sexual abuse).	People experiencing family, domestic and sexual violence (including child sexual abuse) can access coordinated, person-centred care from integrated social and health services
	Disconnected services force an over reliance on individuals experiencing family, domestic and sexual violence (including child sexual abuse) to navigate and coordinate care from a range of disconnected social and health services.	The social service systems available to support people experiencing family, domestic and sexual violence (including child sexual abuse) are highly fragmented with large gaps in available services. There is a lack of support for people experiencing family, domestic and sexual violence (including child sexual abuse) to identify their needs and then find the right services to meet those needs. There is a lack of coordination between services leading to inadequate and sometimes harmful care.	Individuals experiencing family, domestic and sexual violence (including child sexual abuse) can access coordinated and integrated social and health services that meet their needs during and after their experiences of abuse.

Table 6 Adelaide PHN FDSV considerations/opportunities

Program	Activities
RRR Model	The NA was conducted as part of a national pilot adapting the Recognise, Respond, Refer model to the local context. The needs identified in this NA align closely to the needs that informed the original model. Although there are additional local challenges, a place-based approach to adapting the model should support a strong adaptation of the model that addresses community need. The locality integration and system influence components of the model will support the development of locally based opportunities through the co-design process.
HealthPathways SA	Primary health care stakeholders regularly raised the need for a centralised database or resource that could provide readily accessible information about service options and referral pathways. However, many stakeholders consulted were unaware of HealthPathways or had not yet fully integrated this resource into their workflow. HealthPathways SA has a range of relevant, up-to-date FDSV focused pathways and so would be an appropriate resource to leverage to meet this need. Integration opportunities will be explored through collaborative design and ongoing implementation.
HaRTSS	HaRTSS is a department within WCHN where Yarrow Place and other important services are situated. HaRTSS has been delivering training to a variety of health professionals across the state on domestic violence and forensic medical evaluations. In addition, Yarrow Place is the main public, free provider of sexual violence services in the state and is well connected in the LHN system. HaRTSS and Yarrow Place could potentially be a provider that could deliver relevant workplace capacity building activities that would have locality integration benefits.

Conclusion

The Family Domestic Sexual Violence Needs Assessment was conducted to assess need and identify opportunities and priorities to improve primary care for those affected by FDSV. This NA identifies the high prevalence of FDSV across South Australia and the many barriers experienced by women and children when experiencing FDSV, particularly amongst subgroups such as Aboriginal and Torres Strait Islander women, women from multicultural backgrounds and women in rural areas.

The assessment revealed several barriers such as a lack of accessible, appropriate and available services for those experiencing FDSV in South Australia, especially for women in rural areas. A lack of integration between FDSV services limits the capacity of services to provide person-centred coordinated care to people experiencing FDSV. The coercive nature of PUV relationships adds another layer of complexity that limits people's capacity to seek help when needed.

Addressing these issues and barriers requires targeted interventions, such as improving accessibility and availability of appropriate, inclusive and quality FDSV services that are coordinated and person-centred.

3.8 Opportunities and priorities – Population Health

Table 7 summarises the priorities arising from the analysis of population health needs identified in the Adelaide PHN region in 2022 and the opportunities for how they will be addressed. No changes to priorities were made in 2023 or 2024.

Table 7 Population Health Priority Statements for the Adelaide PHN, 2024

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Families, children and young people can access timely early intervention, prevention and support services	*Population Health*	*Other – Children and families*	Improved health outcomes for people in the Adelaide PHN	• Adelaide PHN • Primary Care Providers incl General practice, Allied Health, NDIS • Local Health Networks • Women's and Children's Health Network • Commissioned Service Providers
People at risk of developing or living with chronic or complex conditions can receive timely and appropriate interventions, care, support and management	*Population Health*	*Chronic conditions*	Reduced preventable hospitalisations for people with chronic and complex conditions living in the Adelaide PHN region**	• Adelaide PHN • Primary Care Providers • NGOs • Wellbeing SA • SA Health • Local Health Networks • Commissioned Service Providers • General Practices • Allied Health
Culturally and linguistically diverse communities (including newly arrived and refugee communities) can access timely, culturally safe and appropriate primary health care services	*Population Health*	*Appropriate care (including cultural safety)*	People in the Adelaide PHN region can receive timely, coordinated, culturally appropriate services from local health providers	• Adelaide PHN • NGOs in CALD and refugee sector • Commissioned Service Providers • General Practices • SA Health • Refugee Health
Integration, coordination and partnerships between primary and acute care, supports continuity of care and improved health outcomes	*Population Health*	*Continuity of care*	Improved health outcomes for people in the Adelaide PHN region	• Adelaide PHN • SA Health • Local Health Networks • Wellbeing SA • Primary Care Providers

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
				• General Practices • Commissioned Service Providers • Universities • HealthPathways SA • Mental Health service providers • Residential Aged Care Homes (RACH)
LGBTIQA+ communities can access timely, culturally safe and appropriate primary health care services	*Population Health*	*Appropriate care (including cultural safety)*	People in the Adelaide PHN region can receive coordinated, culturally appropriate services from local health providers	• Adelaide PHN • Primary Care Providers • Commissioned Service Providers • Education Services • General Practices • Allied Health • Universities
People in the Adelaide PHN region can understand how to access a variety of primary care services when and where they need them	*Population Health*	*Access*	People in the Adelaide PHN region can access general practices and other services as appropriate	• Adelaide PHN, Health Direct • Commissioned Service Providers • LHNs • Wellbeing SA • General Practices • NGOs in the CALD and refugee sector • Priority Care Centres • Urgent Care Centres
People in the Adelaide PHN region have awareness of, and timely access to person centred models of comprehensive care across the care continuum**	*Population Health*	*Early intervention and prevention*	Improved health outcomes for people in the Adelaide PHN region	• Adelaide PHN • NGOs • Commissioned Service Providers • Wellbeing SA • Primary Care • SA Health • Local Health Networks • General Practices • Pharmacies • Local Councils

Priority	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
People living with a disability can access safe, inclusive and appropriate health care services	*Population Health*	*Appropriate care (including cultural safety)*	People in the Adelaide PHN region can access general practices and other services as appropriate	• Adelaide PHN • Primary Care Providers • General Practices • Commissioned Service Providers

*** 2024 small update to wording*

4 Aboriginal and Torres Strait Islander Health

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

The full report is available on our website: Needs Assessment - Adelaide PHN

4.1 Summary

4.1.1 Population

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

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

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

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

4.1.2 Multiple Dimensions of Life

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

Physical Dimension

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

approximately 55% of South Australian respondents are able to visit their homelands or traditional lands, which is greater than the national average for Aboriginal and Torres Strait Islander peoples. However, we find that less Aboriginal and Torres Strait Islander people in South Australia live on their homelands or traditional lands, which is reflective of ongoing colonisation impacts in South Australia on Aboriginal and Torres Strait Islander peoples.

Psychological Dimension

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

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

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

Social Dimension

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

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

Cultural Dimension

Culture includes connection and identity, in the 2021 census ancestry data was collected, the most common self-report Ancestry by Aboriginal and Torres Strait Islander. This information contains pertinent information on how Aboriginal and Torres Strait Islander respondents classify their Ancestry and consider their identity. The predominant Ancestry response was Aboriginal across all regions. Torres Strait Islander Ancestry included: South Australia 3.1%, Adelaide West 4.2%, Adelaide South

– not reported (small numbers), Adelaide North 3.4%, Adelaide Central and Hills 5.4% (Australian Bureau of Statistics (ABS) 2022b).Culture is grounded in country, where connection, identity and healing come from (Milroy 2006). The ability to engage and practice culture is central to health and wellbeing of the whole community. Language use in households is an example of connecting and practicing culture in this dimension, it was reported to be steadily decreasing over 1991-2016. While English is the most reported language used in Aboriginal and Torres Strait Islander households in Adelaide and reflective of colonisation in Australia, 10.1% of households report Indigenous language use at home with 5.2% of households reporting Pitjantjatjara use (Australian Bureau of Statistics (ABS) 2022b).

Spiritual Dimension

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

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

4.1.3 Health needs analysis

Mental health

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

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

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

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

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

Islander communities occur in the age group of 35 to 44 years (Australian Institute of Health and Welfare (AIHW) 2022j).

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

- co-design of community mental health programs targeting holistic health and healing, increases in Aboriginal Liaison Officers or Health Workers with targeted training, access to 24-hour care and walk in services
- peer support programs and structures
- "Shame is the biggest thing holding people back."
- a need for services specifically Aboriginal men
- programs and works for LGBTIQA+ (lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual) in the Aboriginal and Torres Strait Islander community
- patient centred approaches to care across networks
- training and awareness for families
- "There are increases in suicides affecting the community. Need education for family around how to identify early signs or what to look out for, along with education around coping mechanisms."

Indigenous Health Check

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

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

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

Dental

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

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

Cancer

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

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

Diabetes

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

Rheumatic fever and rheumatic heart disease

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

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

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

Transgenerational trauma and grief

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

Pregnancy and antenatal care

A total of 2.6% of SA Aboriginal and Torres Strait Islander women did not receive any antenatal care compared to 0.8% Aboriginal and Torres Strait Islander women nationally and 0.2% non-Indigenous women in SA (Australian Institute of Health and Welfare (AIHW) 2021h).

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

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

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

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

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

4.1.4 Service analysis

Workforce, cultural safety and trauma-informed service provision

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

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

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

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

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

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

4.2 Opportunities and priorities – Aboriginal Health

Table 8 summarises the priorities arising from the analysis of Aboriginal health needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. Six new priorities were identified for Aboriginal Health in 2022. These remain the same for 2023.

Table 8 Aboriginal Health Priority Statements for the Adelaide PHN, 2023

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate workforce and primary health care services	*Aboriginal and Torres Strait Islander Health*	*Safety and quality of care*	Aboriginal and Torres Strait Islander people are able to access primary health care services as required	• Adelaide PHN • Commissioned Service Providers • General Practice • Allied Health
Aboriginal and Torres Strait Island people can access trans-generational trauma and grief counselling services and narrative therapies for suicide prevention and mental health	*Aboriginal and Torres Strait Islander Health*	*Appropriate Care*	Aboriginal and Torres Strait Islander people are able to access counselling support in a culturally safe environment as required	• Adelaide PHN
Aboriginal and Torres Strait Islander people can access timely and appropriate primary health care services that support social and emotional wellbeing and spiritual healing**	*Aboriginal and Torres Strait Islander Health*	*Mental Health*	Aboriginal and Torres Strait Islander people are able to access primary health care services as required	• Adelaide PHN • Commissioned Service Providers
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate services for chronic conditions management and early interventions	*Aboriginal and Torres Strait Islander Health*	*Chronic conditions*	Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care	• Adelaide PHN • Commissioned Service Providers • SAHMRI • ACCHO and AMS • Asthma Australia • DSA • General Practice

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Aboriginal and Torres Strait Islander people can access culturally safe information and access to Breast, Cervix and Bowel cancer screening services	*Aboriginal and Torres Strait Islander Health*	*Early intervention and prevention*	PHNs address needs of Aboriginal and Torres Strait Islander people in their region	• Adelaide PHN • SAHMRI • SA Aboriginal Health Partnership • Breast Screen SA • Cancer Council • National Bowel cancer Screening Program • General Practice
Aboriginal and Torres Strait Islander people can access culturally safe and appropriate AOD treatment services	*Aboriginal and Torres Strait Islander Health*	*Other – Alcohol and other drugs*	Aboriginal and Torres Strait Islander people are able to access primary health care services as required	• Adelaide PHN • Commissioned Service Providers

*** 2024 small update to wording*

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 (Australian Institute of Health and Welfare (AIHW) 2021d)*.*

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

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

5.1 Demographic Profile

In 2023, 244,046 people aged 65 years and over lived in Adelaide PHN, which was 18.5% of the total APHN population (ABS 2024a) . Population projections published in 2024 show that by 2032, this is predicted to increase to 21.0% of the population, with the number of people aged 65 years and over increasing to over 305,000 people, with over 50,000 of these being aged 85 years or older.(AIHW 2024a).

5.1.1 Cultural Diversity

In 2021, there were 1,117 Aboriginal and Torres Strait Islander people aged 65 years and over living in the region, and 3,730 aged 50 years and over.

Almost 57,000 people (24%) aged 65 years and older living in the Adelaide PHN region were born in a predominately non-English speaking country, and of these people over 13,000 report that they have poor proficiency in spoken English. As identified in the 2021 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 (ABS 2022).

5.1.2 Income and living arrangements

Over 60% or 144,850 older people living in the Adelaide PHN region receive the aged pension in June 2023 (PHIDU 2024), 47% of older people in the region are considered to have low income (PHIDU 2020a), and over 24,000 older people (10%) are Seniors Health Card holders in 2023 (PHIDU 2024).

In 2021, 27% of people aged 65 and over lived alone, increasing to 35% of people 85 year and over (ABS 2022).

5.1.3 Disability and caring

ABS Census data from 2021 shows that almost 46,000 people (19%) aged 65 years and over living in the Adelaide PHN region needed assistance with core activities. This increases to 53% for those aged 85 years and over.

Over 31,000 people (13%) aged 65 years and over provide unpaid assistance to a person with a disability, health condition, or due to old age, while over 33,000 people (14%) provide unpaid childcare (Australian Bureau of Statistics (ABS) 2022a).

5.2 Health Profile

5.2.1 Health Status

Nationally, the proportion of adults who reported excellent, very good or good health declined with increasing age, with 78% of people aged 65-74 years to 66% of people aged 85 years and over reporting good to excellent health . The same trend in self-rated health is shown in South Australian in the most recent data from SA Health's South Australian Population Health Survey, where 70% of people aged 70 years and over reported good to excellent health (SA Health 2021a).

In 2021, the South Australian Population Health survey reported on risk factors in older South Australians. Here, 94% of people aged 70 years and older did not smoke at all, while one quarter of this group were at no risk from alcohol consumption and a further half of the group were at low risk to their health from alcohol consumption (SA Health 2021a).

5.2.2 Chronic Conditions

Chronic conditions are the leading cause of illness, disability, and death in Australia. 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 (Australian Health Ministers' Advisory Council (AHMAC) 2017).

Multimorbidities

The likelihood of having one or more chronic conditions increases with age and in APHN's ageing population there is a corresponding increase in multimorbidity. Almost one in three people (30%) aged 65 years and over in APHN reported having multiple long-term health conditions. This is five times the rate of multiple long-term health conditions for people aged less than 65 years in APHN (ABS 2021).

The rates for males and females aged 65 years and over were similar, being 29% and 30% respectively. However, the rate for those less than 65 years was lower in males (5%) compared to females (7%) (ABS 2021).

5.2.3 Dementia

Dementia is a syndrome usually of a chronic or progressive nature in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing (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 (Australian Institute of Health and Welfare (AIHW) 2021i).

Dementia was the leading cause of death in South Australia in 2023, being the leading cause for females and the second leading cause for males (ABS 2024b). From 2018 to 2022, dementia including Alzheimer disease was the leading cause of death in the Adelaide PHN region with 5,651 deaths (AIHW 2024b).

In Australia in 2021:

- 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(Australian Institute of Health and Welfare (AIHW) 2021i).

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 (Australian Institute of Health and Welfare (AIHW) 2021i).

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

5.2.4 Frailty

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health (e.g. infection, new medication, fall, constipation or urine retention) (British Geriatric 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 et al. 2013). Old age alone does not define frailty, and frailty is not an inevitable consequence of ageing (Royal Australian College of General Practitioners (RACGP) 2019).

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

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

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

5.2.5 Loneliness and social isolation

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

5.2.6 Mental health

Good mental health is a key factor associated with healthy ageing, and this is determined by a combination of psychological, biological and/or social and cultural factors (Slade et al. 2009). While the prevalence of mental health disorders tends to decrease with age, there are certain sub-groups of the older population that are at higher risk. These groups include people in hospital, supported accommodation, people with dementia, and older carers (Royal Australian & New Zealand College of Psychiatrists (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 (Department of Health (DoH) 2021a).

Prevalence

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

5.2.7 Falls

Falls are a common health concern facing older people (Royal Australian College of General Practitioners (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 2018/19 (Public Health Information Development Unit (PHIDU) 2020a). More than one in three people aged 65 or over fall at least once a year and many fall more often, which can impact on people's wellbeing and lifestyle (Thain et al. 2012). Falls are even more common among residents of aged care facilities, and in people with dementia the number of falls-related incidents in hospital are high. Injuries from falls are high due to the prevalence of underlying disease and reduced physiological reserve in older people (Royal Australian College of General Practitioners (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 (Public Health Information Development Unit (PHIDU) 2020a). In 2017/18 328 people living in metropolitan Adelaide died as a result of a fall (Australian Institute of Health and Welfare (AIHW) 2021j). 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 (Australian Institute of Health and Welfare (AIHW) 2021j).

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

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

5.3 Early Intervention

5.3.1 Summary of identified needs for Early Intervention

To complement commissioning of early intervention services, Adelaide PHN undertook consultation activities to supplement existing older people and aged care needs assessments. The needs identified through this process undertaken in 2023 are summarised in Table 9 below.

Table 9 Summary of needs identified for Early Intervention, 2023

Outcomes of the health and service needs analysis – Early Intervention		
Identified Need	**Key issues**	**Evidence**
Chronic condition management	Coordinated, timely, integrated care and treatment to manage chronic ill health and life limiting illness associated with ageing is inconsistent and varies in quality.	Results of early intervention community consultation
	The health and aged care systems are difficult to access and navigate for health care providers, carers and patients	Results of early intervention community consultation
Community-based care services	There is poor translation of evidence into practice to reduce older people's physical, social, and emotional risk factors that contribute to loneliness and social isolation.	Results of early intervention community consultation
	There are barriers to uptake and access to the use of on-site telehealth care for residents in residential aged care.	Results of early intervention community consultation
	There are variations in RACH after hours care plans and arrangements to prevent avoidable hospitalisations.	Results of early intervention community consultation
	There is varied understanding of models of care including referral pathways across community, primary health, tertiary and aged care.	Results of early intervention community consultation
	There is a lack of current, understandable, accessible, available, relevant health information to support informed health decisions regarding personal health issue management for patients and carers	Results of early intervention community consultation
Healthy aging	There is a need to better manage frailty and reduce early deterioration.	Results of early intervention community consultation
	There is a lack of access to coordinated palliative care services for older people living at home	Results of early intervention community consultation
	There is a lack of easily accessible information, training, and facilitation to support older people to complete an Advance Care Directive / Plan	Results of early intervention community consultation

5.3.2 Results of early intervention community consultation

Adelaide PHN conducted a "Community Conversations" campaign to provide community members and health care professionals an opportunity to influence Adelaide PHN's Needs Assessment. In 2023, community conversations were facilitated by Adelaide PHN Community Advisory Council members.

In May 2023 six early intervention Kitchen Table sessions were undertaken. These sessions sought to gain insight into people's knowledge and experiences of accessing early intervention services for chronic condition management, healthy ageing and community based care services.

A diverse group of 49 community members attended including:

- People from culturally and linguistically diverse backgrounds.
- Elderly individuals residing in residential aged care and living independently.
- People living with a disability or a life limiting condition.
- Veterans.
- Carers.

Session participants ranged in age from under 24 years to 81 years or older and resided across the Adelaide PHN, with the majority from the central and southern regions.

The responses to the community conversation questions were transcribed by the hosts, and then summarized by Adelaide PHN staff. Broad findings (**Figure 4**) from the consultation included:

Figure 4 Broad consultation findings

People from culturally and linguistically diverse backgrounds reported

- Poorer experiences of care
- Greater difficulties in accessing primary care services
- Limited primary care services that were culturally safe and appropriate
- Mixed outcomes and experiences due to unreliable interpreter services
- Stigma associated with accessing home assistance and residential care
- Lack of culturally appropriate residential aged care homes

Vulnerable groups identified by participants

- People living with a disability
- People living with dementia
- People identifying as Aboriginal and/or Torres Strait Islander
- People from culturally and linguistically diverse backgrounds
- People identifying as LGBTIQA+

Residential aged care

- Navigating the aged care system is confusing
- There is a lack of trust and confidence in services
- More support is required for individuals transitioning to RAC and their families

Access to GPs and specialists

- Participants generally reported positive experiences
- Cost, wait times and length of appointments were identified as barriers to care
- Support for alternative models of care, with non-GP workforce (pharmacy, nurses, allied health)
- Participants highlighted the importance of appropriate, timely referrals to specialists and other health care and supports services

Responses from the community conversations were grouped into three overarching focus areas, with the key issues identified (Table 10). The responses were themed and grouped under the focus areas of Chronic disease management, healthy aging and community-based care services. Six statements under each area were then voted on a prioritisation session that was held with Adelaide PHN council members in June 2023.

Table 10 Focus Areas and Key Issues: Early Intervention

Focus Area	Key Issues Identified
Chronic Disease Management	• Long wait times for appointments • Variability in the management of complex health needs • Lack of care continuity between services providers • Lack of culturally safe and appropriate services for CALD populations • Inconsistent consumer awareness about chronic disease management plans • Poor health literacy
Healthy Aging	• Unclear pathways to access preventative activities • Increasing living costs impacts ability to pay for health support and medical services • Focus on physical health care not holistic (limited support for mental, emotional and spiritual wellbeing) • Impact of social isolation and loneliness on health outcomes • Variation in knowledge of resources and services available • Access to supportive environments and networks
Community-based care services	• Navigating aged care supports is confusing and challenging • Variability and inconsistency in quality of community-based support and care received • Variation in skills and cultural competence of home care support workers • Limited support for family members to become carers • Cultural stigma prevents family members seeking help with home services and residential aged care • Language barriers impact awareness of and access to available services

5.4 Use of health services

5.4.1 Primary health care

Primary health care is the basis of health care within Australia, as it provides the first point of contact with the health system. It includes a broad range of activities and services that are delivered outside the hospital setting, from health promotion and prevention to treatment and management of acute and chronic conditions. It can be provided in the home or in community-based settings such as in general practices, other private practices, community health, local government, and non-government service settings. While primary health care occurs in a number of settings, the ongoing relationship between the General Practitioner (GP) and patient ensures that the patient encounter is core to Primary Health Care with the GP providing a continuum of patient care throughout their life course (Price Waterhouse Cooper (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 (Australian Statistics Bureau (ABS) 2020).

Within the Adelaide PHN region in 2022-23, there were over 2.92 million GP attendances for people aged 65 and over, equivalent to 36% of the total 8.10 million GP attendances in the region (AIHW 2024c).

In 2022-23, 18,930 people in residential aged care received at least one GP attendance in the facility. In total, GPs provided 301,309 aged care attendances, equivalent to 15.9 GP attendances per residential aged care patient (AIHW 2024c).

Enhanced Primary Care services

The proportion of older people receiving GP services for Chronic Disease Management Plans and Health Assessments increased with age. In 2022/23, 41% percent of people aged 65-79 years living in the Adelaide PHN region received a GP Chronic Disease Management Plan service, compared to 63% 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 more than one-third of people aged over 80 years (AIHW 2024c).

After Hours

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

Use of After-hours GP services in 2022-23 was highest amongst older adults aged 80 years and over for non-urgent, urgent, and total service types (AIHW 2024c). Over one-quarter (28%) of people aged 80 years and over received an after-hours GP service, 26% non-urgent attendances and 8% urgent. The rate of non-urgent GP after-hour services provided to people aged 80 years and over was over 60% higher than the rate for Adelaide PHN residents, and for urgent services the rate for people aged 80 years and over was three times the region rate (AIHIW 2024c).

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 (Australian Institute of Health and Welfare (AIHW) 2021d).

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

Mental health services

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

In 2022/23 over 66,000 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 732,411 mental health-related services subsidised by Medicare in that year. Psychologists provided one third of these services, with GPs and psychiatrists each providing approximately one quarter of the mental health-related services received by people aged 65 and over (AIHW 2024c).

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 (Australian Commission on Safety and Quality in Health Care and National Health Performance Authority 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) (Australian Commission on Safety and Quality in Health Care and National Health Performance Authority 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 (Australian Commission on Safety and Quality in Health Care and National Health Performance Authority 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) (Australian Commission on Safety and Quality in Health Care and National Health Performance Authority 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) (Australian Commission on Safety and Quality in Health Care and National Health Performance Authority 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 (Australian Commission on Safety and Quality in Health Care and National Health Performance Authority 2015).

While there is a correlation between areas of lower socioeconomic status particularly in the north of the Adelaide PHN region, and higher rates of mental health-related PBS prescriptions dispensing to people aged 65 years, the patterns may also reflect the distribution of older residents and the density of aged care facilities across the Adelaide PHN region. The Adelaide PHN also notes that based on the available data, it is not possible to determine the extent to which antidepressant and antipsychotic medicines were prescribed for conditions other than mental health.

5.4.2 Use of acute health care services

Emergency Department Presentations

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

Hospitalisations

In APHN in 2018-19, there were almost 100,000 admissions in public hospitals of people aged 65 years and over. This was approximately 40% of the total public hospital admissions for the region. The rate of admission amongst those aged 65 years and over is almost 2.5 times as it is for the total population (Public Health Information Development Unit (PHIDU) 2021a).

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 2018).

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 (Public Health Information Development Unit (PHIDU) 2021a).

5.5 Palliative Care

Palliative care is described by the World Health Organisation as an approach that improves the quality of life of patients and their families who are facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual (World Health Organization (WHO) 2020a). The benefits of palliative care are well documented and aim to wrap care around the person, informed by their wishes, choices, and health care preferences in the place of their choice (World Health Organization (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 (World Health Organization (WHO) 2014).

In the APHN region in 2022-23 there were 6,048 palliative care hospitalisations at a rate of 46.7 per 100,000 people, which was significantly greater than the Australian rate of 38.6 hospitalisations per 100,000 people. This is also a significant increase in palliative care hospitalisations in the APHN region from 2020-21 where there were 4,527 hospitalisations (AIHW 2024d).

Several studies have attempted to quantify the need for palliative care in Australia; estimates range from 50%– 90% of total deaths. Sleeman et al.(2019) conducted a study into ‘serious health related suffering’ in the top 20 conditions associated with palliative care. Using this as a proxy for palliative care need, the authors suggested that in 2016 around 51% of deaths required palliative care. Adopting this value in today’s context suggests there are 82,000 deaths in Australia which would benefit directly from palliative care each year. Using the same value in the South Australian context over 7,000 people would directly benefit from palliative care each year. Similarly, estimations based just on mortality data (14,426 SA deaths in 2017) indicate that about 41% to 72% of people in South Australia who die from a life-limiting condition each year, currently between 5,800 and 10,400 would benefit from some form of palliative care services (SA Health 2019b). With expectations that 8.2 million individuals aged 65 and over will be added to the 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) (Australian Healthcare Associates Health (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 (Australian Healthcare Associates Health (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 (Australian Healthcare Associates Health (AHA) 2019a). Barriers for providers include lack of awareness, skills and competencies, lack of available services and support, referral issues and insufficient funding (Australian Healthcare Associates Health (AHA) 2019a). Language and communication barriers, and cultural understanding and preferences were barriers for both consumers and providers (Australian Healthcare Associates Health (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 (Australian Healthcare Associates Health (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 (Australian Healthcare Associates Health (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 (Australian Healthcare Associates Health (AHA) 2019a).

People in aged care

Older Australians entering Residential Aged Care Homes (RACHs) 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 (Australian Institute of Health and Welfare (AIHW) 2020f).

Very few residents enter residential aged care with a well-documented advance care plan, and older persons entering aged care present with co-morbid conditions including dementia affecting their capacity to complete an advance care directive (Adelaide Primary Health Network (APHN) 2020b). Many residents will be unable to communicate their wishes for palliative care at the time care is provided. Consequently, to have a real choice in the care they receive RACH’s need to understand 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 (Adelaide Primary Health Network (APHN) 2020b).

Evidence from RACHs 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 (Adelaide Primary Health Network (APHN) 2020b).

A number of recommendations from the *Royal Commission into Aged Care Quality and Safety* (Commonwealth of Australia 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 residential 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 (Commonwealth of Australia 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 (Commonwealth of Australia 2021).

Region snapshot

As reported by the AIHW in Adelaide PHN region as at 30 June 2023 or for the 2022-23 financial year (AIHW 2024e):

- There were 147 residential aged care homes. 95 home care services, and 245 home support services.
- Over 46,500 older people in the Adelaide PHN region used home support services, over 17,000 used home care services and 11,796 accessed permanent residential aged care.
- The occupancy rate for residential care in the Adelaide PHN region at 30 June 2023 was 94%.

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 (Commonwealth of Australia 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 (Commonwealth of Australia 2021).

In the Adelaide PHN, as at December 31, 2022, there were 2,466 people waiting on a Home Care Package at their approved level, with over 73% of these people approved to receive Home Care Packages at level 3 or 4. Of these 2,466 people, 84% of these were yet to be offered an interim level Home Care Package (Department of Health and Aged Care (DOHAC) 2023a).

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 (Commonwealth of Australia 2021).

Addressing needs of people receiving aged care

People entering aged care services typically have increasing health care needs. One factor is older people at risk of frailty cannot often travel to access health care services. Furthermore, health care providers, particularly specialists, are reluctant to provide their services in a person's place of residence (Commonwealth of Australia 2021) leading to unmet healthcare needs.

People in aged care also have limited funded 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.

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 (Australian Institute of Health and Welfare (AIHW) 2020g). 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 (Commonwealth of Australia 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 (Department of Health (DoH) 2021b). The aged care workforce commonly includes many people from non-English-speaking backgrounds, but from different backgrounds to those common among aged care users (Australian Institute of Health and Welfare (AIHW) 2021d). The Royal Commission into Aged Care Quality and Safety states that 'cultural safety must be embedded throughout aged care'. It proposes an Aboriginal and Torres Strait Islander aged care pathway that brings culturally safe and flexible aged care that meets the needs of Aboriginal and Torres Strait Islander people wherever they live (Commonwealth of Australia 2021).

Adoption of digital health technology and infrastructure

Telehealth improves access to high-quality general practice care in RACHs and keeps residents safe (Commonwealth of Australia 2021). Clear variations in the digital health literacy of aged care providers and workforce are evident in the Adelaide PHN region (Adelaide Primary Health Network (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 (Commonwealth of Australia 2021).

5.6.1 Aged Care Workforce

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

The *2020 Aged Care Workforce Census* (Department of Health (DoH) 2021b) also identified potential gaps in workforce training. While 90% of the residential aged care workforce nationally receive regular professional development on Infection Prevention and Control, only 64% receive training on Palliative Care or Falls Risk, and only 62% receive Diversity Training. The proportion of the Home Care Package Program and Home Support Program workforces receiving ongoing professional development is lower: 24% and 20% respectively for Palliative Care, 38% and 34% respectively for Falls Risk and 43% and 40% respectively for Diversity Awareness.

Residential Aged Care Homes are experiencing workforce stress This affects aspects of care requiring a specific skill set with the sector is struggling to adequately recruit to meet the increased care needs of an ageing population. 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 (Department of Health (DoH) 2021b) and there are emerging strategies to address this issue.

5.7 Care Finder

5.7.1 Summary of identified needs

Prior to the initial commissioning of care finder services, all PHNs undertook additional activities to supplement existing Needs Assessments, to identify local needs in relation to care finder support. The needs identified through the supplementary needs assessment process undertaken in 2022 are summarised in Table 11 below.

Table 11 Summary of local needs identified in relation to Care Finder support program in 2022

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

Identified need	Key issue
There is a need to raise awareness of and inform the general population of consumers about MAC and increase awareness of services available to older South Australians, particularly those in more vulnerable groups	There is still a lack of knowledge in the region about MAC, and services available to older South Australians. Feedback from providers indicated it was important for consumers to know about MAC before they need it, or before it becomes a crisis, and suggested that this should be considered as the entry level support activity for Care Finder. The lack of knowledge about MAC and compounds the stress for clients and their family when aged care services are needed due to an unexpected change of circumstances such as the death of a spouse, a decline in health, hospitalisation or other sudden life event
There is a need for stakeholders and providers to stay informed about client and sector needs to ensure delivery of appropriate services	To maintain the appropriateness of services, providers highlighted that they need to understand what current and emerging issues people in the region are facing, and what trends the sector is experiencing. This is often dependent on the maintenance of strong relationships with support partners, and a high-level of understanding of all aspects of the sector including advocacy requirements.
There is a need for flexibility in service delivery models, including opportunities for outreach, group activities, etc., to ensure services are accessible and appropriately meet the needs of all clients requiring support	Flexibility to address unmet need and enhance current service models to meet the requirements of the care finder program was highlighted in stakeholder consultations. Outreach models were suggested to support follow-up with provider and clients to ensure ongoing service provision is accepted and taking place, particularly for more complex cases and those in denial of need. The experience of current navigation support providers in the region suggested that group activities and/or services based on social connection were an important way to provide access to information and supports for more vulnerable groups, such as people identifying as LGBTIQA+
There is a need to maintain strong relationships with support partners and to undertake ongoing community development work to ensure the delivery of culturally appropriate support and assistance to the diverse populations of our culturally and linguistically diverse (CALD) communities	A number of barriers to accessing services were identified for people identifying as CALD, including language barriers, the lack of culturally appropriate services, and family culture. Stakeholder consultations indicated that the barriers that impede their engagement with people for those from CALD backgrounds include cultural, language, literacy, or digital literacy skills, as well as a lack of knowledge about the aged care system and rights and entitlements in Australia. Relationships and networking between and with organisations and individuals representing organisations that provide support to CALD people was identified as being essential to develop trust, continuity and understanding of service needs. As was a range of culturally appropriate complementary programs, and a diverse multicultural and multilingual workforce (Board, staff and volunteers).

Identified need	Key issue
Homeless clients, or clients at risk of homelessness are particularly vulnerable and often have complex needs	Data from specialist homelessness services indicate that in March 2022 between 400-500 people aged 55 years and over were homeless in South Australia. Stakeholder consultations highlighted the complexity and vulnerability of many homeless clients or those clients at risk of homelessness, and the additional resources that may be required from navigation services to support these clients compared to other aged care clients. Specific issues identified by stakeholders included the need to provide coordination and support to access to housing, need for appropriate case management, and to increase availability and better response times of home care services. Stakeholders also raised the need for referral patterns to lead to housing options without having to provide or fund transitional housing options via care finder program.

5.8 Opportunities and priorities – Older People and Aged Care

Table 12 summarises the priorities arising from the analysis of the needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. One new priority was added in 2023.

Table 12 Older People and Aged Care Priority Statements for the Adelaide PHN, 2023

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Older people with chronic and life limiting illness have access to information, advice, and consistent support through coordinated and integrated models of care.	*Aged Care*	*Chronic conditions*	Older people in the PHN region are supported to enjoy a greater quality of life.	• Adelaide PHN • SA Health / Local Health Networks • Primary Care • Aged Care Providers • COTA • LASA
Older people requiring community and residential aged care services are supported by a skilled, motivated, and empowered workforce.	*Aged Care*	*Workforce*	Local health and other care providers are supported to deliver coordinated, effective and appropriate care to older people in the PHN region.	• Adelaide PHN • Aged Care Providers • Aged Care Training Providers • Accredited Training Providers • Workforce Advisory Services
Older people living in the community and residential aged care are supported by timely, accessible, coordinated primary care services in and out of hours.	*Aged Care*	*Continuity of care*	Local health care system provides coordinated, quality care to older people.	• Adelaide PHN • Primary Care Providers • Residential Aged Care
People at high risk of entering residential aged care homes early due to chronic conditions have access to early	*Aged Care*	*Access*	People in the PHN region are supported to access primary health care services that meet their needs.	• Adelaide PHN • Primary Care Providers • Residential Aged Care

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
intervention initiatives that promote healthy aging in the community*				
Older people have access and support from palliative care services which address their needs, wishes and health care preferences.	*Aged Care*	*Access*	Older people in the PHN region are supported to access primary health care services that meet their needs.	• Adelaide PHN • Residential Aged Care • SA Health Palliative Care • Primary Care Providers

**New priority added in 2023*

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.' (South Australian Mental Health Commission (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).

Adelaide PHN responds to mental health and suicide in the region as guided by the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) (COAG 2017) and the 2022 National Mental Health and Suicide Prevention Agreement (the National Agreement) (Commonwealth of Australia 2022).

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

1. Low intensity mental health services to improve targeting of psychological interventions to support people most appropriately with mild mental health conditions.
2. Early intervention for children and young people with, or at risk of, mental health conditions, including those with severe mental conditions who are being managed in primary care.
3. Psychological therapies for people in under-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).

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

In response to the Fifth Plan, and recognition of the critical importance of integrated services, the Adelaide PHN, Local Health Networks (LHNs) and stakeholders in the Adelaide metropolitan region partnered to develop the *Towards Wellness Plan* (TWP). The TWP is a five-year plan that highlights actions to be implemented between 2020-2025. In November 2023, the TWP was reviewed and updated and now named Towards Wellness Plan: Review and Enhancements 2023-2025(Adelaide Primary Health Network (APHN) 2023c). The TWP focuses on improving coordination of care for consumers and carers through the collective advancement of integration along a stepped care continuum. The TWP emphasises service delivery across the lifespan, taking into account the diverse health and social needs across the life course (APHN et al. 2020). The TWP aims to address the needs of people across the mental health stepped care continuum from prevention, early intervention, to supporting chronic and complex (severe) mental health conditions.

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

1. Integrated regional planning and service delivery.
2. Suicide prevention.

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

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

In 2021, Adelaide PHN undertook stakeholder consultations to inform the recommissioning of primary mental health care services scheduled for commissioning and implementation from 2022/23 to 2024/25. The consultations engaged over 100 stakeholders from diverse groups, including people with lived experience of mental conditions, GPs, mental health clinicians, and representatives from Adelaide PHN commissioned primary mental health services, mental health peak body organisations, LHNs, and the SA Government. Stakeholders provided feedback in relation to existing Adelaide PHN commissioned primary mental health care services, with a focus on identifying key strengths, concerns, and solutions to concerns, and identifying vulnerable populations within the community.

Adelaide PHN went to the open market for redesigned PMHC services, including two hubs and specialist services for culturally and linguistically diverse populations, LGBTIQA+ communities, and children in the north of the region. These services commenced on 1 July 2023 through to June 30, 2025. Service issues identified in the consultations are provided throughout this chapter. The full consultation report is available on the Adelaide PHN website.

In 2022, Adelaide PHN undertook stakeholder consultations to inform the evaluation and recommissioning of complex youth services scheduled for commissioning and implementation from 2023/24 to 2024/25. The consultations engaged over 70 stakeholders from diverse groups, including young people who had accessed complex youth services, staff working in complex youth services, and external stakeholders. Stakeholders provided feedback in relation to existing Adelaide PHN commissioned complex youth services, with a focus on identifying key successes and challenges of these services, as well as opportunities for the future. Adelaide PHN re-designed the complex youth service and went to the open market for this service in November 2022. The new complex youth service, Youth Enhance Service (YES) commenced on 1 July 2023 and service streams include psychological therapies, clinical care coordination, peer work interventions, group programs and access to medical care such as psychiatry and GPs. The YES service has now completed 16 months of service delivery.

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 (South Australian Mental Health Commission (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 (South Australian Mental Health Commission (SAMHC) 2017). In 2021/22, one in five people (approximately 210,000 people) living in the Adelaide metropolitan area were estimated to be affected by a clinically significant mental health concern (Department of Health (DoH) 2021a).

6.4.1 Mental health disorders

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

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

6.4.2 Psychological distress

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

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

6.4.3 Eating disorders

Eating disorders are serious, complex mental illnesses accompanied by physical and psychiatric complications which may be severe and life threatening. They are characterised by disturbances in behaviours, thoughts and feelings towards body weight/shape and/or food and eating (National Eating Disorders Collaboration (NEDC) 2021). The elements that contribute to the development of an eating disorder are complex, and involve a range of biological, psychological, and sociocultural factors. (NEDC 2021b).

Prevalence

In Australia, the most common eating disorder is binge eating disorder (47%), followed by other specified feeding and eating disorders (OSFED) (38%), bulimia nervosa (12%), and anorexia nervosa (3%)

(Deloitte Access Economics 2012). Total prevalence of eating disorders is estimated to be 3.95% (over 50,000 people) of the Adelaide PHN population which is similar to the national average of 3.97%. Rates of different types of eating disorders for the Adelaide PHN region are: Anorexia Nervosa 0.11%, Bulimia Nervosa 0.46%, Binge Eating Disorder 1.86%, Other Specified Feeding or eating disorder 1.52% (Deloitte Access Economics (DAE) 2019)

Higher eating disorders prevalence by local government areas, in descending order, are Onkaparinga, Salisbury, Port Adelaide Enfield, Charles Sturt and Playford (University of Queensland, Brisbane. 2016).

Population groups at risk eating disorders

Women are almost 4 times (8.4%) as likely as men (2.2%) to have an eating disorder over their lifetime (Australian Government Department of Health and Aged Care 2024a)). Non-binary and Transgender people are 2 to 4 times more likely to experience an eating disorder than people who are not non-binary and transgender (Deloitte Access Economics (DAE) 2019) Young people have a greater prevalence of eating disorder with approximately a third (31.6%) of Australian adolescents engaging in disordered eating behaviours within any given year (Australian Government Department of Health and Aged Care 2024a). Eating disorders are the 3rd most common disease Young people have a greater prevalence of eating disorder with approximately a third (31.6%) of Australian adolescents engaging in disordered eating behaviours within any given year (DOHAC 2024a). Eating Disorders is the 3rd most common disease experienced among people aged 14-24 years at 6.8% (AIHW 2023a).

Risk factors contributing to eating disorders

Genetics as well as environmental factors influence the likelihood of developing an eating disorder. Genetically, female relatives of individuals with Anorexia Nervosa are 11 times more likely to develop Anorexia Nervosa than relatives of individuals without Anorexia Nervosa (Bulik, C.M, et al. 2019) People with autism are 30% more likely to experience an eating disorder (Embrace Autism 2023). A lack of early life trusting and reliable relationships has been linked to all types of eating disorders and unhealthy eating behaviours in the general population (Faber, A, et al. 2017). Suicide is higher amongst people with eating disorders with suicide up to 31 times more likely to occur for someone with Anorexia Nervosa and 7.5 times higher for someone with Bulimia Nervosa than the general population (Butterfly Foundation 2024)

Access to eating disorder services

In the Adelaie PHN region, less than a quarter (23%) of people with an eating disorder access treatment (NEDC 2024a) People who have accessed eating disorder services include:

- 751 people receiving MBS funded eating disorder plans from their GPs in 2020-2021 in the region (Adelaide Primary Health Network (Adelaide PHN) 2023).
- 464 received eating disorders psychological treatment by a clinical psychologist and 154 people received eating disorders psychological treatment by another psychologist (Australian Institute of Health and Welfare (AIHW) 2022r)

Adelaide PHN funded services provided treatment to 76 people with an eating disorder through their psychological therapy services in 2022-23 (Adelaide Primary Health Network (Adelaide PHN) 2023).

In May 2024, Adelaide PHN consulted and heard from 126 voices from the community (including LGBTIQA+, Aboriginal and Torres Strait Islander people) and eating disorder service providers and health professionals (state, GPs and Adelaide PHN funded providers) all identified a need for more accessible, timely and available services, especially psychological therapies and specialist services. Below are examples of excerpts from some of the conversations.

“A lack of specialist eating disorder services in the north…. And more services for mild and moderate eating disorders, especially for bulimia”

“Geographical location and family finances a major barrier to access.” (APHN 2024f).

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National Eating Disorder Strategy (2023-2033) the Department of Health and Aged Care (DoHAC) have funded the Right Care Right Place (RCRP) - Eating Disorder Care in my Community Project July 2023-June 2026.The Adelaide PHN together with Northwestern Melbourne, Northern Territory and Western Queensland PHNs will develop an Eating Disorder Coordinators (EDC) model which is flexible and scalable aligned with the National Eating Disorders Collaboration's (NEDC) eating disorder system of care framework that makes meaningful change to the experience and outcomes of Australians experiencing eating disorders, and their families. (National Eating Disorder Collaboration (NEDC) 2023) The aim of the project is to address barriers and strengthen enablers for access to effective evidenced based treatment through Primary Care providers (National Eating Disorder Collaboration (NEDC) 2023).

6.4.4 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 (World Health Organization (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 (National Mental Health Commission (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 (Australian Institute of Health and Welfare (AIHW) 2022s).

6.5 Suicide and self-harm

Causes of suicidal behaviour are complex and often linked to many risk 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 (Department of Health (DoH) 2019a).

Prevalence of Suicide

Suicide is a community wide issue with high rates amongst disadvantaged groups within areas of both low and high socio-economic status in the Adelaide PHN. In the Adelaide PHN region 785 people died from suicide, during 2018-2022 (AIHW 2024a). In 2022, there were 152 deaths from suicide in the Adelaide PHN region (AIHW 2024a). Deaths by suicide per 100,000 by Local Government Areas (LGA) in the Adelaide PHN over the same period were highest in Norwood Payneham St Peters, Playford, Holdfast Bay, Marion, and Salisbury (AIHW 2024a).

Suicide ideation

Overall prevalence of suicidal thoughts has remained stable at the State level over the past ten years (Adelaide PHN 2023). In 2016-18, 6.9% of people living in the Adelaide Metro region aged 18 years and over were estimated to experience suicidal ideation (AIHW 2024). Approximately 69,810 people aged 18+ in the Adelaide PHN region experienced suicidal thoughts in 2021 (Adelaide PHN 2023).

Hospitalisations from intentional self-harm

Data from the (AIHW 2024a) indicates that in the Adelaide PHN region the highest overall rates (per 100,000) for hospitalisations from intentional self-harm in 2022/23 were females aged 0-24 years (281.7), people aged 0-24 years (169.8) and females aged 25-44 years (155.8).

In 2022/23 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 Onkaparinga (258.2), Adelaide City (254.9), Playford (214.9), Port Adelaide - West (202.4) and Unley (195.8) (AIHW 2024a)

The areas with the highest hospitalisation rates from intentional self-harm of people aged 25-44 years were Playford SA3 (343.5), Adelaide City SA3 (308.3), Salisbury SA3 (229.6), Marion SA3 (194.5) and Holdfast Bay SA3 (168.4) (AIHW 2024a).

The areas with the highest hospitalisation rates from intentional self-harm of people aged 45 years were Adelaide City SA3 (201.7), Marion (207.7), Playford (163.6), Port Adelaide – West (162.5), and Salisbury (132.8).

Deaths from suicide and intentional self-harm

In 2021, there were 162 deaths from suicide in the Adelaide PHN region (Australian Institute of Health and Welfare (AIHW) 2022t).

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

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

In the five years from 2017-2021, death rates from suicide in the Adelaide PHN region were significantly higher in males compared to females, ranging from 2.6 times higher in Adelaide-South SA4 to 3.6 times higher in Adelaide -West SA4 (Australian Institute of Health and Welfare (AIHW) 2022t). Rates were highest among males in Adelaide-West SA4 (18.9 deaths per 100,000) and Adelaide-South SA4 (18.4 deaths per 100,000), and highest among females in Adelaide-South SA4 (7.0 deaths per 100,000) and Adelaide-North SA4 (6.0 deaths per 100,000).

Risk Factors to Suicide

Mental health, alcohol and other drugs, eating disorders, challenges with emotional regulation, early life adversity, maltreatment and abuse, and a lack of secure and trusting relationships are significant risk factors for suicide.

Approximately 90% of people who die by suicide had a psychiatric disorder in the last six months of life (Turecki, Gustavo 2017) . Between 19% to 63% of people who die by suicide have a personal history of a diagnosed AOD use disorder/s(Fisher A, et al. 2020). Suicide is up to 31 times more likely for people with anorexia nervosa and 7.5 times higher for someone with bulimia nervosa eating disorders than the general population (Butterfly Foundation 2024).

Up to 73% of people who manifest suicidal behaviour have a history of childhood abuse, early life adversity and a lack of secure and trusting relationships (Turecki, Gustavo 2017). Socio-economic risk factors include being widowed, being in a lone person household, unemployment, lower levels of education, and income insecurity or uncertainty (AIHW 2024b). The second and third highest psychosocial risk factors include disruption of family by separation and divorce, and problems in relationship with spouse or partner (AIHW 2024c).

Populations at-risk of suicide

Suicide and self-harm affect people of all ages (except very young children), races, ethnicities, sexual orientations, and occupations. However, people with certain life experiences or identities may experience disproportionately, or in combination, life stressors linked to increased risk of suicide.(Wellbeing SA 2023)

Aboriginal and Torres Strait Islander people are nearly twice as likely to die by suicide than non-indigenous people (AIHW 2024a) . About 90.9% of LGBTIQA+ with a disability or with severe limitations reported having suicidal thoughts in their lifetimes and 50.1% reported attempting suicide in their lifetimes (Hill et al. 2021b). More than half of all deaths by suicide (53%) occurred in people aged 30-59 years (AIHW 2024a). People 65+ with disabilities died by suicide at rate 3 times greater than the general population (AIHW 2024a). Men are 3 to 4 times more likely to die by suicide than women with suicide highest among middle aged and older males (AIHW 2024a).

Trans men are more likely to experience lifetime suicidal thoughts (92.1%) and suicide attempt (46.9%) than trans women (90.7% and 40.0% respectively) (AIHW 2024a) .   . Australian Defence Force veterans had a 26% higher rate of suicide than the general Australian population between 2017-2022 (AIHW 2024a). Humanitarian entrants experienced 1.7 times the rate of suicide compared to 'Other permanent migrants'.

Other population groups who may be at higher risk of experiencing thoughts about suicide or behaviours, include, but are not limited to:

- People who have had contact with the criminal justice system
- People who have been bereaved by suicide
- People who have previously made an attempt on their life
- People whose identity may intersect with more than one of these groups/identities.

Access to Health Services

A high number of people had contact with the health sector 12 months prior to their suicide, however many did not disclose suicidal thoughts or intent.

Approximately 80% of people had contact with primary health care in the 12 months prior to their suicide and 44% at one month before their suicide (Stene-Larson K, and Reneflot, A, 2017). Up to 70% of people who died from suicide did not disclose their suicidal thoughts or intent during their final communications with healthcare providers (Rogers M.L, et al. 2022).

6.6 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 service types where data was available, and a summary of the current issues or challenges that have been identified through needs analysis.

Service utilisation for specific population groups is described in section 6.7 – Priority populations, of this chapter.

6.6.1 Medicare subsidised mental health services

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

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

By age

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

By sub-region

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

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

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 (Australian Institute of Health and Welfare (AIHW) 2022r). 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 (Adelaide Primary Health Network (APHN) 2017a; Adelaide Primary Health Network (APHN) et al. 2020). Previous service mapping identified that approximately two-thirds of providers of psychological services, and two-thirds of mental health services were located in the centre of the Adelaide PHN region (National Health Services Directory (NHSD) 2015).

Mental health-related prescriptions dispensing

In the five years from to 2016–17 to 2020–21 the SA3s of Adelaide City, Playford, Onkaparinga, Port Adelaide – West and Holdfast Bay had the highest rate of dispensing for mental health-related prescriptions (subsidised and under co-payment) (Australian Institute of Health and Welfare (AIHW) 2022u). 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 (Australian Commission on Safety and Quality in Health Care and National Health Performance Authority 2015).

6.6.2 Acute mental health services

Mental health-related emergency department presentations

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

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

Mental health-related hospital admissions

In 2020/21 in the Adelaide PHN region there were 19,543 admissions for mental health-related conditions, equivalent to a rate of 1,558.1 per 100,000 population (Public Health Information Development Unit (PHIDU) 2024)

There was significant variation in admission rates within LGAs across the Adelaide PHN region, from 1,241 per 100,000 people in Burnside, to 3,425.9 per 100,000 in Adelaide. Rates also were also high in Marion (2,808.3), Onkaparinga (2,807.3), Holdfast Bay (2,544.8) and Playford (2,494.4) (Public Health Information Development Unit (PHIDU) 2024).

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

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

6.6.3 Low intensity services

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

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

6.6.4 Psychological therapy services

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

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

The following issues raised in previously mentioned stakeholder consultations persist:

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

6.6.5 Services for people with severe and complex mental health conditions

Primary care, private sector providers, state/territory service providers and the NDIS all play a critical role in providing care for people with severe and complex mental health condition (Department of Health (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 (The University of Queensland 2022).

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

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

6.6.6 Suicide prevention services

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

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 (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (APHN) et al. 2020). In May 2024, Adelaide PHN consultation heard from 126 voices from the community (including LGBTIQA+, Aboriginal and Torres Strait Islander people,

young people) and service providers and health professionals (state, GPs and Adelaide PHN funded providers) all identified a need for more accessible, timely and available services that address whole of person care. Below are excerpts from the consults.

- “Access therapy immediately. Making therapy affordable and accessible… including psychiatry’.
- “More access to peer-based services to deescalate feelings rather than escalate fear by accessing clinical crisis services that are not consumer friendly.” (APHN 2024g).. Additional concerns included lack of follow up care, inclusive, culturally and appropriate suicide prevention services.

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

6.7 Priority populations

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

In consideration of the Fifth Plan, the National Agreement, TWP, PHN Primary Mental Health Care guidance and analysis of mental health research, population data, consultation findings and level of service provision, the following priority groups have been identified as belonging to underserviced 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 LGBTIQA+ 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 underserviced (Adelaide Primary Health Network (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 consequently. 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 underserviced populations.

6.7.1 Aboriginal and Torres Strait Islander people

Mental and substance use disorders (23%) are the leading cause of total disease burden experienced by Aboriginal and Torres Strait Islander people (Australian Institute of Health and Welfare (AIHW) 2021a). Nationally in 2018–19 it was estimated that 24% of Aboriginal and Torres Strait Islander people reported a

mental health condition or behavioural disorder, with anxiety the most commonly reported condition (17%), followed by depression (13%) (Australian Statistics Bureau (ABS) 2019).

Psychological Distress

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

Utilisation of community health and hospital services

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

Mental health was the fourth highest reason for admission behind pregnancy and childbirth, injury, poisoning and other external causes, and respiratory system diseases (Public Health Information Development Unit (PHIDU) 2021b). Age standardised rates of mental health related hospitalisations were over 2.5 times higher for Aboriginal and Torres Strait Islander people living in the Adelaide PHN region compared with the rate for all-persons (Public Health Information Development Unit (PHIDU) 2021a).

Suicide and self-harm

In 2022, suicide was the 2nd leading cause of death for Aboriginal and Torres Strait Islander men and 10th for females in Australia, compared to 15th for non-Aboriginal and Torres Strait Islander people (Australian Bureau of Statistics (ABS) 2023f). Almost one-third (29.7%) of deaths of Aboriginal and Torres Strait Islander children were due to suicide (Australian Bureau of Statistics (ABS) 2023c) being the leading cause of death. For the 10-year period (2013-2022), suicide remains the fifth leading cause of death. The high rates experienced by Indigenous Australians are due to multiple, complex, and interrelated social, cultural, historical influences including colonisation, relocation of people to missions and reserves, transgenerational grief and trauma, racism and continued socioeconomic disadvantage.

6.7.2 Children, young people and their families

Children and young people

Approximately 41,000 children and young people aged 0-17 in the Adelaide PHN are estimated to require treatment for mental health in 2021/22, and this figure is expected to increase to 42,000 by 2024/25. (Department of Health (DoH) 2021a).

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 (Australian Institute of Health and Welfare (AIHW) 2019d).

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

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

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

Emergency department presentations and hospital admissions

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

In 2020-21, South Australia had the highest number of ED presentations (all ages) in public hospitals with a principal diagnosis of 'Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (ICD-10-AM-code F90–F98), at 8% of all mental health presentations. This was over triple the rate of other states, with a national rate of 3% (Australian Institute of Health and Welfare (AIHW) 2022v).

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% (Australian Institute of Health and Welfare (AIHW) 2019c).

Women in the perinatal period

Mental health conditions during the perinatal period are common, affecting an estimated 1 in 5 mothers and can have serious effects on the health and wellbeing of women, their babies and families. In 2019, the two most common perinatal mental health conditions, depression and anxiety, are estimated to have cost Australia $877 million from increased health care costs associated with increased service use, and productivity losses from reduced economic participation (Highet, NJ et al. 2023, (PwC Consulting Australia 2019).

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.

Service needs

The *Primary Health Networks (PHN) mental health care guidance – child and youth mental health services* identifies children, 0-11 years, as an underserviced group when attempting to access preventative, and mild to moderate intensity psychological therapies (Department of Health (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 (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (APHN) 2021d).

Service mapping suggests there is a significant lack of low to moderate level MBS private psychological services for children and their families, especially in the north and south of the Adelaide PHN region.

There is a lack of available high intensity, integrated, multidisciplinary, wrap around services, often referred to as the ‘missing middle’ for young people, 12-25 years, with or at risk of experiencing complex mental health conditions and their families who are not eligible for state services or headspace. This missing middle represents a large, underserviced cohort that cannot be fully serviced by current Adelaide PHN funding or state-based service provision. Not all young people at risk of or experiencing severe mental health conditions eligible for high intensity services will receive a service from Adelaide PHN complex services (Adelaide Primary Health Network (APHN) 2022c).

Suicide and self-harm in young people

Although deaths by suicide occur more often in older age groups, it is the leading cause death in Australian children and adolescents. Death by suicide at any age have profound effects on the families, friends and communities of those that die but, arguably, these effects are even greater when the person is young.

In 2022-23, the rate for young people aged 15–19 years was 308 hospitalisations per 100,000 population, the highest of all age groups. The age-specific rate was highest for females aged 15–19 years (499 hospitalisations per 100,000 population), followed by females aged 20–24 years (289 per 100,000 population). Rates for young males were generally lower compared to females within age groups. The lowest rate was for males under 14 years (8.9 hospitalisations per 100,000 population), followed by males aged 20–24 years (122). Similar to females, those aged 15–19 years had the highest rate among young males (127 hospitalisations per 100,000 population) (AIHW 2024d)

Intentional self-harm hospitalisations in people 24 years and under in Adelaide

In Adelaide, the rate of hospitalisation for intentional self-harm in small geographic areas can provide insight into the incidence of self-harm in local communities. However, variations in hospitalisation rates between geographical areas may be due to a range of factors, and so caution needs to be noted.

In 2022-23 intentional self-harm hospitalisations were highest in young people (24 years and under) in Onkaparinga SA3 (258.2 hospitalisations per 100,000 population), Adelaide City SA3 (254.9 hospitalisations per 100,000 population), Playford SA3 (214.9 hospitalisations per 100,000 population), and Port Adelaide West SA3 (202.4 hospitalisations per 100,000 population) (AIHW 2024e).

6.7.3 People from CALD backgrounds

South Australia is home to people from more than 200 CALD backgrounds. In the Adelaide PHN region, 363,449 people were born outside of Australia, including 255,805 people who were born in a predominantly non-English speaking country (Australian Statistics Bureau (ABS) 2022) Approximately 44,325 people residing in the Adelaide PHN region in who speak a language other than English at home reported poor proficiency in spoken English (Australian Statistics Bureau (ABS) 2022).

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).

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 (Australian Institute of Health and Welfare (AIHW) 2018a).

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 (Australian Institute of Health and Welfare (AIHW) 2018a).

Older culturally and linguistically diverse consumers are at higher risk of mental health issues than their Australian-born peers. They are less likely to use mental health services and are more likely to present at a later stage of their mental illness (NSW 2022).

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 (Adelaide Primary Health Network (APHN) 2021c).

6.7.4 Lesbian, gay, bisexual, transgender, intersex, queer and asexual + (LGBTIQA+) communities

In 2020, an estimated 61% of LGBTQ+ people reported having been diagnosed with depression and 47% reported having been diagnosed with an anxiety disorder. An estimated 57% reported experiencing high or very high levels of psychological distress within the past 4 weeks. An estimated 59% of LGBTQ+ people who accessed a mainstream medical clinic felt that their sexual orientation was very or extremely respected and 38% thought that their gender identity was very or extremely respected (Hill et al. 2021b).

A recent Australian study of the health and wellbeing of LGBTIQA+ young people (Hill et al. 2021a) highlights the burden of mental health faced by young LGBTIQA+ people aged 14 to 21 years in South Australia:

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

Overall levels of psychological distress and mental health wellbeing, experiences and outcomes vary greatly within LGBTIQA+ populations, according to gender identity, sexual identity and age. The following mental health issues have been identified in the Australian LGBTIQA+ community:

- Higher rates of suicidal ideation and depression in this community than any other population in Australia; and, rates were even higher among the transgender population (Morris 2016);
- People with an intersex variation aged 16 years and over were nearly six times more likely to attempt suicide, with 16% having attempted suicide, 60% experiencing suicidal ideation and 26% had self-harmed (Jones et al. 2016);
- LGBTIQA+ young people who experience abuse and harassment are more likely to attempt suicide, have thoughts of suicide, and are more likely to have self-harmed (National LGBTI Health Alliance and NLGBTIHA 2020);
- LGBTIQA+ people are 14 times more likely to die by suicide than heterosexual people (Morris 2016);

- Lesbian women were more likely to engage in self-harm and attempt suicide than gay men, but gay men were more likely to have experienced suicide ideation (Morris 2016);
- Homosexual or bisexual people (28%), as well as people who were not sure/other (23%), were more likely to be experiencing high or very high psychological distress compared with heterosexuals (11%) (Australian Institute of Health and Welfare (AIHW) 2018b);
- The LGBTIQA+ population were twice as likely to be diagnosed with a mental health disorder, with 41.1% aged over 16 years meeting the criteria for a mental health disorder in the last 12 months (Morris 2016);
- A South Australian survey on LGBTIQA+ health identified that 74% of transgender respondents reported seeking psychological or medical help in relation to their transgender status (Department for Communities and Social Inclusion (DCSI) 2017);
- 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 (Council on the Ageing (COTA) SA and South Australian Rainbow Advocacy Alliance (SARAA) 2018);
- Suicide attempts in the past 12 months are 4 x higher among LGBTQA+ young people in SA compared to the general population (Bourne 27 September 2023); and
- Suicide attempts over a lifetime are 5 x higher among LGBTQA+ young people in SA compared to the general population (Bourne 27 September 2023).

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 (Adelaide Primary Health Network (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 LGBTIQA+ communities due to inadequate data collection was also raised as an issue to address (Adelaide Primary Health Network (APHN) 2020a).

Adelaide PHN currently funds mental health care services and supports for young people (ages 12 and over) and adults who are transgender or gender diverse at risk of or experiencing mild to moderate mental health conditions within the Adelaide metropolitan region. High demand has been managed through the provision of brief interventions with a focus on clients with gender-related concerns.

6.7.5 People with alcohol and other drug comorbidity

There is a complex relationship between mental health and alcohol and other drug use. A mental illness may make a person more likely to use drugs to provide short-term relief from their symptoms, while other people have drug problems that may trigger the first symptoms of mental illness (AIHW 2024f). 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 (Department of Health (DoH) 2017a).

In 2022–2023, people who reported high or very high levels of psychological distress were twice as likely to report daily smoking as those who reported low psychological distress (15.3% compared with 6.7%). People with a mental health condition were about 1.2 times as likely to report drinking at risky levels in 2022–2023 as people without these conditions. People who reported high or very high levels of psychological distress were more than twice as likely to report recent illicit drug use as those with low

psychological distress in 2022–2023 (AIHW 2024g).

Use of specific illicit drugs among people with mental health conditions and high psychological distress has varied across time and by drug type. Between 2019 and 2022–2023: there were significant increases in the proportion of people with mental health conditions that reported recent use of hallucinogens (from 2.4% in 2019 to 4.0% in 2022–2023) and ketamine (from 1.9% in 2019 to 3.0% in 2022–2023) (AIHW 2024g). Among people with high or very high levels of psychological distress, recent use of ecstasy decreased from 6.1% to 4.6% among people with high or very high levels of distress (AIHW 2024g).

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. 2017).

Co-morbidity, or the co-occurrence of an alcohol, tobacco, and other drug use disorder with one or more mental health conditions, complicates treatment and services for both conditions. They can also co-occur with physical health conditions (e.g., cirrhosis, hepatitis, heart disease, and diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain (Department of Health (DoH) 2017a). It is important to note that people with substance misuse disorders with dual diagnoses or co-morbidities are at greatest risk of poor outcomes (Adelaide Primary Health Network (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 (Department of Health (DoH) 2017a) supports are made available to the individual (Department of Health (DoH) 2017a). During 2024, APHN consultation, community and stakeholders identified the need for improved holistic, coordinated and integrated care amongst AOD services, and between AOD and related services including mental health (APHN 2024h).

6.7.6 People with physical health comorbidities

People living with mental illness, and in particular severe mental illness (SMI), are more likely to experience comorbidity of physical conditions, more likely to be hospitalised for potentially preventable reasons and tend to die earlier than the general population (Sara G, et al. 2021) . According to the 2020–2022 NSMHW, an estimated 4.3 million Australians aged 16–85 years, or 22% of this population, had experienced a mental disorder in the 12 months prior to the study. Of these, 2 in 5 (39%) also had a long-term physical health condition (ABS 2023). Among the most common long-term conditions reported by those with a mental illness were arthritis (19%), asthma (19%) and diabetes (8.5%) during the 2021 Census (ABS 2023).

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 (Australian Statistics Bureau (ABS) 2017b).

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%) (Public Health Information Development Unit (PHIDU) 2014; Australian Statistics Bureau (ABS) 2014).

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 (Australian Statistics Bureau (ABS) 2015b).

6.7.7 People with severe mental health 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 (Department of Health (DoH) 2021a). The needs of people with severe mental health conditions are not homogenous, with level of severity determined by a range of factors including risk of harm, symptom severity, and functioning levels.

Nationally, the most common disorders of people living with psychotic conditions were schizophrenia (47.0%), bipolar (17.5%), schizo-affective disorder (17.5%) (Department of Health (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 health conditions were also more likely to have thoughts of suicide and have attempted suicide (Department of Health (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 (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (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.

In August 2023, the SA Government released a report prepared by David McGrath Consulting that examined both the population receiving psychosocial support services and the level of services provided in dollar terms, each compared to predicted outputs from the National Mental Health Service Planning Framework (NMHSPF). The report looks at both the population receiving psychosocial support services and the amount of services provided in dollar terms, each compared to predicted outputs from the NMHSPF. The outcome of these analyses initially delivers two contradictory outcomes, with expenditure on psychosocial support services in SA in the 2021/22 year exceeding the funding estimates predicted by the NMHSPF by approximately $34m. However, the population receiving services is well below that predicted by the model with some 19,000 persons not receiving services that the model predicted (David McGrath Consulting 2023).

Nationally, the Department of Health and Aged and the Psychosocial Project Group are overseeing an *Analysis of unmet needs for psychosocial support project* being undertaken by Health Policy Analysis. The project, using similar methodology to the SA examination, aims to estimate the population predicted to need psychosocial supports modelled from the NMHSPF) and comparing this to the populations currently receiving psychosocial support services. Adelaide PHN was involved in a consultation session organised by Health Policy Analysis to finalise the methodology for the project. The findings from this unmet needs analysis will be used to inform the ongoing review of the Commonwealth Psychosocial Support Program (Department of Health and Aged Care (DOHAC) 2023b).

6.7.8 People experiencing homelessness

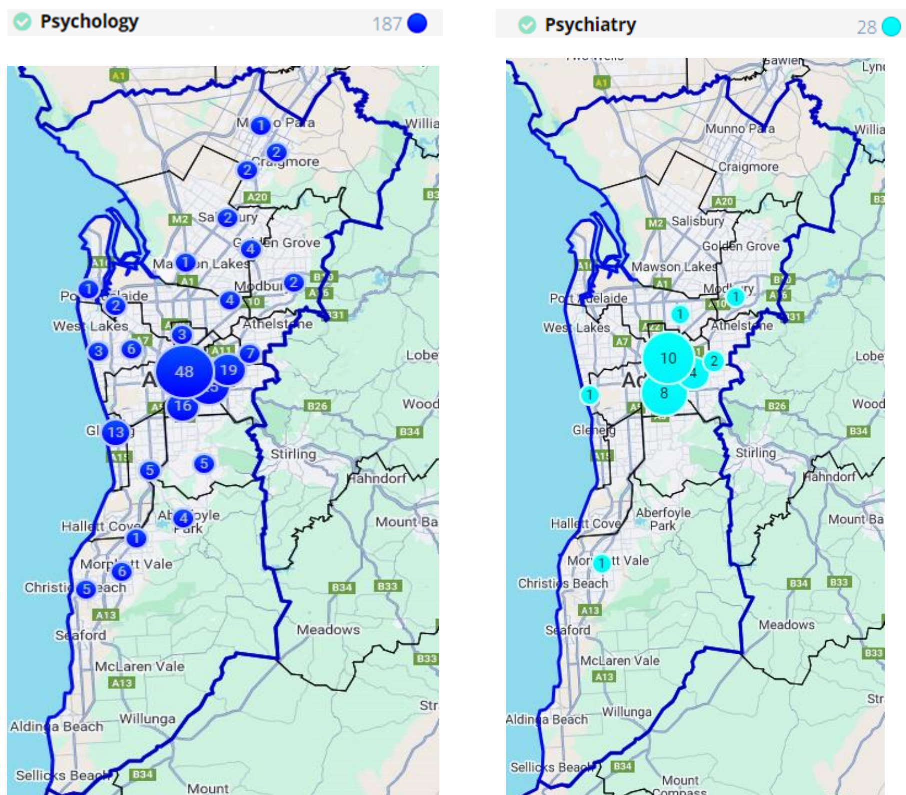
People experiencing homelessness are more likely to have poor mental health compared to the general population, and mental health problems are both a cause and consequence of homelessness (Flavel et al. 2021). Homelessness studies show that 48% of homeless people experience a mental health condition and 73% experience a physical health issue. Based on the *2021 Census of Population and Housing: Estimating Homelessness* report, there were 5,363 homeless persons within the Adelaide PHN region. The Statistical Area 3 level data showed that Playford had the highest number of homeless persons (806,

15%), followed by Salisbury (803, 15%) and Onkaparinga (669, 12%) (Australian Bureau of Statistics (ABS) 2023e).

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.

6.8 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 in 2024 using Healthmap identifies 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. See service maps below.



The workforce shortages mentioned throughout this document apply here.

In the past three years Adelaide PHN has considered 69 requests from commissioned service providers to have a staff member exempted from Adelaide PHN credentialling requirements. These are frequently for people who are in the process of applying for accreditation (e.g. with AHPRA or AASW). Adelaide PHN considers these requests on a case-by-case basis and if approved ensures suitable supervision and workforce development plans are in place and requires undertakings that people only work within their scope of practice.

In 2022, focus groups facilitated by the Office of Chief Psychiatrist explored with GPs and other mental health service providers across South Australia identified the following barriers in relation to mental health shared care (Office of the Chief Psychiatrist 2022):

- Difficulty in identifying and accessing appropriate mental health services, due to constant change in the mental health service landscape

- Appropriate psychosocial support services that meet the needs of people with severe mental illness
- Health workforce capacity to provide appropriate care to people with severe mental health conditions, with no financial incentive to support general practice to manage patients with mental health conditions (i.e. the lack of a Medicare MBS item number)
- Absence of a model of care for shared mental health care
- Absence of a definition of shared mental health care and lack of understanding of any clear/formalised processes/ agreements.

General practitioners

As stated in the *General Practice Health of the Nation 2022* Report, "for the sixth consecutive year, GPs reported that mental health issues were the most common reason for patient appointments. Mental health, particularly youth mental health, was also the patient health issue causing GPs the most concern for the future. GPs are carrying a large share of the mental health workload, with 38% of GP consultations incorporating a mental health component, and patients reporting they are more likely to see a GP for their mental health concerns than any other healthcare professional. The report also presents evidence that the amount of mental health work undertaken by GPs is significantly underestimated in Medicare statistics." (The Royal Australian College of General Practitioners 2022).

In 2020, there were 1,689 general practitioners employed in the region, 470 in the SALHN region, 739 in CALHN region and 480 in NALHN region (Department of Health (DoH) 2021c).

Psychologists

In 2020, 1,240 psychologists worked in the region, 82% of which (1,017, 848.9 FTE) had a role as a clinician in the areas of mental health intervention, counselling, or assessments. The majority of these psychologists worked in the CALHN region (653, 64%), 231 within the SALHN region (23%), and 131 in NALHN region (13%) (Department of Health (DoH) 2021c). The number of psychologists practising psychological therapies working in the region had grown by 18% from 2016 to 2020 (Department of Health (DoH) 2021c).

In 2020, half of the clinical psychologists in the region worked primarily in group private practice (26%) or solo private practice (24%), with 8% in other government department or agency, 7% in a hospital, and 7% in a community mental health service (Department of Health (DoH) 2021c).

Psychiatrists

The number of psychiatrists working in the region has grown by 9% from 2016 to 2020 (Department of Health (DoH) 2021c). In 2020, 262 psychiatrists (242.3 FTE) worked in the region, 48 within the SALHN region (18%), 168 in CALHN region (64%) and 46 in NALHN region (18%) (Department of Health (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 (Department of Health (DoH) 2021c).

Mental health nurses

The number of mental health nurses working in the region has grown by 11% from 2016 to 2020 (Department of Health (DoH) 2021c). In 2020, 1,579 mental health nurses worked in the region, with the majority (67%) working in a hospital setting and 20% working in community health care services (Department of Health (DoH) 2021c).

Social workers

As at November 2022, there were 1,715 members of the Australian Association of Social Workers in South Australia, 1,355 of those members are considered to be working in metropolitan Adelaide (AASW SA 2022). Nationally, 29% of social workers were employed in the mental health field (Australian Association of Social Workers (AASW) 2022), assuming this is consistent within Adelaide, this would be equivalent to almost 400 mental health social workers the region in 2022.

Accredited Mental Health Social Workers (AMHSWs) are highly trained and educated mental health professionals and are one of the few designated allied health professional groups eligible to provide private mental health services to people with diagnosable mental health conditions or people 'at risk' of developing mental health conditions under the Commonwealth Medicare initiative. There are currently more than 2,200 AMHSWs working across Australia, with approximate 60% working in metropolitan areas; no data is currently available to quantify the local AMHSW workforce (Australian Association of Social Workers (AASW) 2019).

Occupational Therapists

The most recent data (01 January 2021 to 31 March 2021) available from the Occupational Therapy Board of Australia, states that of 1,987 occupational therapists are registered in SA, 1,927 are practicing and 5 are undertaking postgraduate or supervised practice (Occupational Therapy Board (OTB) 2021). In 2020, 142 OTs (131.8 FTE), equivalent to 11% of OTs working in the Adelaide PHN region at this time had a scope of practice in mental health (Department of Health (DoH) 2021c).

6.8.1 Primary mental health care workforce challenges

The primary mental health workforce needs significant investment to ensure all staff are appropriately trained and remunerated and that primary mental health care services are adequately resourced and sufficiently staffed (Royal Australian & New Zealand College of Psychiatrists (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 Health Council 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 (Royal Australian & New Zealand College of Psychiatrists (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 (Royal Australian & New Zealand College of Psychiatrists (RANZCP) 2021).

A recent review identified some of the key issues impacting on the quality, supply, distribution and structure of the mental health workforce, including workforce shortages due to challenges associated with attracting and recruiting into mental health careers and retaining existing staff (Cleary et al. 2020). Job satisfaction, turnover intention and burnout are major issues for the mental health workforce (Cleary et al. 2020; Foster et al. 2021). Consequently, the mental health workforce needs to be developed with the right size, distribution and skill mix to meet consumer needs, and investment is required to promote positive workplace cultures and opportunities for professional development and effective supervision (Cleary et al. 2020; Delgado et al. 2021).

There is also a significant need to invest in and support the Lived Experience primary mental health care workforce (COAG Health Council 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 (Adelaide Primary Health Network (APHN) 2021c).

In stakeholder consultations in 2021, commissioned service providers raised concerns that there was a limited pool of clinicians in certain specialisations (i.e., paediatric psychology); difficulties attracting psychologists to work within services due to the workload, renumeration 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 (Adelaide Primary Health Network (APHN) 2021d).

Recent consultations with stakeholders of services for youth with complex mental health needs identified opportunities for improvement related to: providing integrated care for consumers; workforce recruitment challenges, staff stressors and training opportunities (Adelaide Primary Health Network (APHN) 2022d).

6.9 Barriers to service integration

A national review of mental health services identifies that the mental health system in Australia has fundamental structural deficiencies (National Mental Health Commission (NMHC) 2014). Services are fragmented and delivered within a complex system that involves multiple providers often operating in isolation of each other (National Mental Health Commission (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 (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (APHN) 2016a, 2016d, 2016b, 2020c, 2021a, 2021d).

The implementation of the Initial Assessment and Referral Tool nationally and within the Adelaide PHN region will assist somewhat by applying a consistent and evidence-based methodology to ensure people are referred to the right service for them the first time and do not require transfer of care.

Adelaide PHN has also gone back to market for its PMHC services to include a Hub model to address some of the common barriers to integration.

An overarching concern raised in recent stakeholder consultation was that the Stepped Care Model is complex and difficult to navigate when seeking to identify primary mental health care services and program options that are best suited to a consumer's needs. Stakeholders noted that it was challenging to access and filter information about the available services, referral pathways, integrated pathways and eligibility criteria, and expressed a desire for clearer information (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (APHN) 2021d).

In focus groups conducted to support the evaluation of Adelaide PHN's commissioned services for young people with complex mental health, participants acknowledged that achieving integrated care can be challenging because building trust and the partnerships that support integration take time to achieve. Additional barriers to integration identified included different administrative platforms and organisational requirements around consent, which made sharing clinical notes difficult and impacts on a young person's care (Adelaide Primary Health Network (APHN) 2022d).

6.10 Opportunities and priorities – Mental Health and Suicide Prevention

Table 13 summarises the priorities arising from the analysis of mental health and suicide prevention needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. A total of fourteen priorities were agreed upon for 2024 Needs Asses including 3 new priorities, seven modified and one removal. Needs Assessment.

Table 13 Mental Health and Suicide Prevention Priority Statements for the Adelaide PHN, 2024

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Children at risk of, or experiencing mild to moderate mental health conditions and their families/carers have access to appropriate primary mental health services	*Mental Health*	*Other - Children and families*	People in PHN region access mental health services appropriate to their individual needs	• Adelaide PHN
LGBTIQA+ communities can access safe, inclusive and appropriate suicide prevention and primary mental health care services **	*Mental Health*	*Vulnerable population (Non-First Nations specific)*	People in PHN region access mental health services appropriate to their individual needs	• Adelaide PHN
People from underserviced and hard to reach populations experiencing mental health conditions and suicide distress have access to timely, appropriate and integrated primary mental health services **	*Mental Health*	*Vulnerable population (Non-First Nations specific)*	People in PHN region access mental health services appropriate to their individual needs	• Adelaide PHN
People at risk of, or experiencing mild to moderate mental health conditions can access primary mental health services through a range of modalities	*Mental Health*	*Access*	People in PHN region access mental health services appropriate to their individual needs	• Adelaide PHN
People experiencing severe mental health conditions have access to appropriate supports, services and coordinated care	*Mental Health*	*Access*	People in PHN region access mental health services appropriate to their individual needs	• Adelaide PHN

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Responsive and appropriate early intervention psychosocial support services that meets the needs of people with severe mental health conditions **	*Mental Health*	*Care coordination*	People in PHN region access mental health services appropriate to their individual needs	• Adelaide PHN
Timely, region specific, cross-sectoral mental health and suicide prevention services for people who are at risk of suicide and/ or who have recently attempted suicide **	*Mental Health*	*Continuity of care*	Health care providers in PHN region have an integrated approach to mental health care and suicide prevention	• Adelaide PHN
People experiencing mental health concerns and suicide distress receive timely and appropriate crisis care and treatment services delivered by a skilled workforce **	*Mental Health*	*Workforce*	PHN commissioned mental health services improve outcomes for patients	• Adelaide PHN
Integration between primary mental health services and alcohol and other drug treatment services to improve continuity of care and outcomes	*Mental Health*	*System integration*	PHN commissioned mental health services improve outcomes for patients	• Adelaide PHN
Increased visibility of Adelaide PHN commissioned service providers and eligibility criteria to GPs, state, community services and to underserviced groups to enhance access **	*Mental Health*	*Continuity of care*	People in PHN region access mental health services appropriate to their individual needs	• Adelaide PHN
Capacity building and improved community and workforce capability to support people experiencing mental health conditions and suicide distress *	*Mental Health*	*Workforce*	PHN commissioned mental health services improve outcomes for patients	• Adelaide PHN

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
People at risk of, or experiencing eating disorders can access assessment, crisis, treatment, and support services that are affordable and timely *	*Mental Health*	*Access*	People in PHN region access mental health services appropriate to their individual needs	• Adelaide PHN
Families and carers impacted by eating disorders can access timely and appropriate support through improved culturally appropriate and inclusive community awareness *	*Mental Health*	*Other - Children and families*	People in PHN region access mental health services appropriate to their individual needs	• Adelaide PHN

** New priority added in 2024*

*** 2024 modified wording*

7 Alcohol and other drugs

As stated in the South Australian Specialist Alcohol and Other Drug Treatment Service Delivery Framework (South Australian Network of Drug and Alcohol Services (SANDAS) 2018): *"Alcohol and other drug issues impact the health, social, and economic wellbeing of individuals, families and the whole community. Harms from alcohol and other drug use include injury, preventable diseases, mental health issues, risky behaviour, violence and other criminal behaviour. Harms also include social, family and financial problems."*

Alcohol and other drug (AOD) use occurs on a spectrum from occasional use to dependence. The cohort of people who require interventions to prevent or reduce harms differ greatly in their levels of substance use and associated social, economic and health risk factors. Treatment interventions vary accordingly to meet the individual needs of each client.

The *National Framework for Alcohol, Tobacco and other Drug Treatment 2019-2029* aims to ensure that people seeking AOD treatment can access high quality treatment appropriate to their needs, when and where they need it (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 Primary Health Network (APHN) 2020b).

Under the National Quality Framework for Drug and Alcohol Treatment Services, from 29 November 2022, AOD services in South Australia are required to have accreditation with at least one accreditation standard (Commonwealth of Australia 2019b). Adelaide PHN expects all commissioned service providers to hold or be actively working toward one of the accreditation standards (Adelaide Primary Health Network (APHN) 2020b). Adelaide PHN is required by the Department of Health and Aged Care to report on the accreditation status of its commissioned service providers in its 6 monthly commissioning report.

In 2023, Adelaide PHN entered into a Memorandum of Understanding with Drug and Alcohol Services SA (DASSA) and Country SA PHN to develop a high quality, coordinated and accessible AOD service system that works collaboratively to meet the needs of South Australians. Adelaide PHN is working with its partners 1 to:

- prepare for the next SA Alcohol and Other Drug Health Needs Assessment
- develop resources that will enable data sharing across the agencies, including AOD data sets and key performance indicators comparisons
- progress the SA AOD Workforce Action Plan, including mapping the current AOD workforce, AOD workforce census, renumeration and worker wellbeing.

7.1 Stakeholder / Commissioned Service Provider Consultations - 2024

In 2024, The Adelaide PHN commissioned the National Centre for Education and Training on Addiction (NCETA), College of Medicine and Public Health, and Flinders University to complete a market / desktop scan of the Adelaide PHN's existing alcohol and other drug (AOD) commissioned service providers (CPSs). The aim of the scan was to:

- Determine what key stakeholders see as working well / meeting the needs of the population of the Adelaide region.

- Identify if there are any service gaps particularly in relation to priority populations.

The market scan was undertaken in conjunction with reviewing and updating Adelaide PHN's Alcohol and other Drugs Treatment and Quality Framework.

Findings discussed in the NCETA report were used to inform the Adelaide 2024 PHN AOD Needs Assessment. The market scan conducted by NCETA had two components:

1. **Data analysis**: A range of data sources and documents were examined. This included data provided by the Adelaide PHN, the Alcohol and Other Drug Treatment Services National Minimum Data Set and the National Wastewater Drug Monitoring Program.
2. **Stakeholder interviews**: were undertaken with 24 individuals representing CSPs or key stakeholders and Adelaide PHN staff.

Key findings of the **Data analysis** indicate that,

- Alcohol and meth/amphetamine are the key drivers of demand for AOD treatment in the Adelaide PHN region. Alcohol predominated as the principal substance of concern from the Alcohol and Other Drug Treatment Services National Minimum Data Set for all publicly funded AOD services provided in the Adelaide PHN region.
- Meth/amphetamine predominated as the principal substance of concern for treatment episodes in data from the Adelaide PHN's funded CSPs
- Alcohol and cannabis use are the other key drivers of AOD service provision although population levels of use of these drugs are not markedly higher than other capital cities.

Key findings from **stakeholder interviews** indicate,

- There is a strong willingness on the part of AOD service providers to collaborate in workforce development activities, and to some extent service provision.
- There is strong agreement and willingness to collaborate among AOD service providers to enhance the role of peer workers in AOD service provision in Adelaide.
- The funding by the Adelaide PHN of the Thorne Harbour Health LGBTIQA+ AOD Service represents a unique initiative to meet the needs of this community (NCETA 2024).

Identified gaps or issues potentially affecting AOD service provision included but not limited to were.

- People experiencing homelessness
- People experiencing comorbid AOD and mental health conditions
- Older people experiencing AOD-related issues
- People from culturally and linguistically diverse communities (NCETA 2024)

Adelaide PHN 2024 Consultation

Adelaide PHN conducted a series of targeted consultations between August and September 2024 with **42 voices** of key stakeholders including, community, peak bodies, SA Health, DASSA, APHN Advisory councils and APHN CSPs. The consultations were also informed by the NCETA work. Consultation sought to identify new and emerging issues for people with AOD related problems, gaps in service provision, and insights into exploring collective suggestions from the community and healthcare professionals on how to reduce AOD-related harm across the Adelaide PHN region.

Findings from the consultations included:

- Lack of awareness by communities, families and children about AOD related harm, how to access and navigate available AOD services.
- Aboriginal and Torres Strait Islander people, men, people with mental health issues, people in the criminal justice system, young people, LGBTIQA+ and homeless are at greater risk of AOD use.
- People experiencing trauma, abuse, lack of emotional regulation, self-harm, grief and loss, social and emotional disengagement, AOD use by family and peers are at higher risk of AOD use.
- There is a lack of holistic and integrated mental health and AOD treatment services.
- Lack of outreach, home-based, withdrawal and after care AOD services.
- Lack of culturally appropriate AOD services.
- Carers experience a lack of support for themselves and when assisting family and friends' access and navigate AOD services.
- Lack of treatment services for people with opioid addiction.
- Lack of access to AOD services due to fear of stigma and discrimination.
- There is a need for improved coordinated care and integration between AOD services, and between AOD and related services.
- Lack of affordable, accessible and flexible AOD services.
- People with AOD issues are excluded from accessing mental health and other services due to exclusion criterion (APHN 2024i) .

7.2 Contributing to State and National Strategic Policy

In early 2022, Adelaide PHN was invited by the National Centre for Education and Training on Addiction (NCETA), on behalf of the Department of Health and Aged Care to submit a written response to the development of the next iteration of the National AOD Workforce Development Strategy. In its submission, Adelaide PHN identified several workforce challenges within the region including an ageing cohort of AOD workers and a limited peer workforce. Adelaide PHN is using its submission and the findings from its 2022 consultations to inform a peer workforce development initiative.

Throughout 2023, Adelaide PHN partnered with DASSA, Country SA PHN, NCETA and other key stakeholders to develop a South Australian AOD Workforce Development Action Plan. The Plan: *Alcohol and other Drugs Sector Workforce Development Framework 2024-2032* was completed in January 2024.

7.3 Adelaide PHN AOD Treatment and Quality Framework 2024-2026

The updated Framework is designed to inform AOD treatment services in the region, emphasising health equity, partnerships, and data-driven solutions. It outlines strategies for reducing AOD-related harm, enhancing service accessibility, and ensuring culturally competent.

The Framework aims to reduce alcohol and other drug (AOD)-related harm in the community over the long term. The medium-term goals include improving access to AOD services, enhancing the cultural competence of the health workforce, and achieving cohesive service integration. In the short term, the Framework focuses on implementing effective screening and referral pathways, enhancing the attainment of treatment goals, fostering positive treatment experiences, and improving health outcomes, especially for diverse and vulnerable communities.

The Framework aligns with Adelaide PHN and Commonwealth strategic and performance frameworks including the, National Framework for Alcohol, Tobacco and Drug Treatment 2019-2029 and the National Quality Framework for Drug and Alcohol Treatment Services (Adelaide Primary Health Network (APHN) 2020b).

Commissioned service providers are required by Adelaide PHN to use the Framework as a reference when developing and delivering AOD services.

In late 2020, Adelaide PHN participated in a statewide *AOD Health Needs Assessment* (HNA) conducted by Drug and Alcohol Services SA (DASSA). The HNA found that, within the Adelaide Metropolitan region, areas of high need for AOD issues/services were:

- Outer Northern suburbs – Elizabeth, Pooraka, Davoren Park, Smithfield, Salisbury and Paralowie
- North-western suburbs – Enfield/Blair Athol, The Parks, Port Adelaide
- Outer southern suburbs – Christies Downs, Hackham West/Huntfield Heights, Christies Beach (Alcohol Services South Drug and Australia (DASSA) 2020).

Commissioned AOD service providers, who commenced 1 July 2021, are required to provide services across the Adelaide PHN region with a specific focus on the above areas identified by the HNA.

7.4 Impact of COVID-19 on AOD Service Provision

Between 2022 to 2024, COVID-19 has had minimal impact on AOD service provision with the resumption of face-to-face individual sessions and group programs.

7.5 Priority drugs of concern

Using a population health approach, Adelaide PHN acknowledges that the following drug types cause the most harm in the region: alcohol; methamphetamines; non-medical use of pharmaceuticals including opioids, benzodiazepines, analgesics, and; cannabis; and other drugs of concern such as tobacco, ecstasy (MDMA), cocaine and heroin (Adelaide Primary Health Network (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.

Following NCETA's review in early 2024, all the indications are that meth/amphetamine, alcohol and cannabis use (in that order) will remain the key drivers of demand for AOD treatment among Adelaide PHN funded CSPs for the foreseeable future. This contrasts with PHNs nationally where alcohol, meth/amphetamine and cannabis (in that order) were the key drivers of service demand (NCETA 2024) .

7.5.1 Alcohol

Nationally, in 2019–20, alcohol-related injuries resulted in just over 30,000 hospitalisations (118 per 100,000 population) and almost 1,950 (7.7 per 100,000 population) deaths. Alcohol-related injury accounted for 5.7% of all hospitalised injuries and 14% of injury deaths among Australians in 2019–20 (AIHW 2023b). Alcohol-related harm has a significant impact on Australian society with almost 222,600 Australians estimated to have been the victims of an alcohol-related physical assault in 2020-21 (Australian Institute of Health and Welfare (AIHW) 2020c).

Alcohol use was the second highest risk factor, accounting for 10% of total disease burden in Australia. About 350 deaths were attributed to alcohol use in 2018, 9.7% of all deaths among the Indigenous population. Alcohol use contributed to 12% of the health gap between Indigenous and non-Indigenous Australians. Alcohol use accounted for a larger proportion of the health gap for males compared to females (18% and 7.7%, respectively) (AIHW 2023b).

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 (Australian Institute of Health and Welfare (AIHW) 2020c). About 500,000 people aged 14 and over (32.2%) consumed alcohol at risky levels in South Australia, (41.1% males compared to 23.8% females) between 2022 and 2023 (AIHW 2024h). This was similar to the proportion of people drinking at risky levels in 2019, and there were no changes in the proportion of people drinking more than 10 standard drinks per week on average (25% in 2022–2023) or consuming more than 4 standard drinks in a single day at least once a month (25%) (AIHW 2024h).

Wastewater analyses from Adelaide had median levels of alcohol consumption that were below the average of all Australian capital cities and one that was slightly above. Alcohol consumption in the Adelaide area occurred at higher levels than in regional South Australia. Since August 2021, alcohol consumption in the Adelaide region has declined after a brief peak in June 2022 (approximately 11 litres/1000 people/day in August 2021; 14.5 in June 2022; and 10.5 in October 2023) (NCETA 2024).

Between 2019 and 2022–2023, there was an increase in the proportion of people in South Australia who experienced physical abuse from someone under the influence of alcohol, from 4.4% to 6.1%. Support for alcohol-related policies declined between 2019 and 2022–2023 in South Australia (AIHW 2024h).

7.5.2 Meth/amphetamine

Methamphetamine comes in a range of forms, including powder, paste, liquid, tablets and crystalline and 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 (Department of Health (DoH) 2017b).

After alcohol, amphetamines are the most common drug of concern in South Australia with wastewater analysis indicating that methamphetamine is the predominant stimulant consumed in metropolitan Adelaide.

Three of Adelaide's Wastewater treatment plants indicated mean methamphetamine use levels that were above the Australian capital city average, and one plant was consistent with the average. Since August 2021, methamphetamine consumption in Adelaide has risen with a peak in April 2022 (approx. 1,150 mg/1000 people/day in August 2021; 1,500 mg in April 2022; and 1,420 mg in October 2023). This is well below the peak levels of approximately 2,900mg seen in February 2018 (NCETA 2024).

Adelaide has historically had substantially higher levels of methamphetamine use compared with the other capital cities. According to the 2022-23 National Drug Strategy Household Survey (NDSHS), recent use of methamphetamine was low at only 1.1% in South Australia in the last 12 months (SA Health 2024).

7.5.3 Non-medical use of pharmaceuticals including opioids and benzodiazepines

The range of pharmaceutical drugs commonly used for non-medical reasons include opioids (such as oxycodone, fentanyl, morphine, methadone, pethidine and codeine), benzodiazepines (such as diazepam, temazepam and alprazolam), and other analgesics (such as paracetamol and ibuprofen in preparations combined with codeine) and performance and image enhancing drugs (such as anabolic steroids, phentermine and human growth hormones). The harms that can arise from the use of pharmaceutical drugs depend on the drug used but can include fatal and non-fatal overdose. Harms also include infection and blood vessel occlusion from problematic routes of administration, memory lapses, coordination impairments and aggression (Department of Health (DoH) 2017a).

Recent (i.e., in the past 12 months) non-medical use of painkillers and pharmaceutical stimulants was at 2% and 2.1%, respectively in 2022-23 (SA Health 2024). Alternative pain treatment options are often lacking for people living in low socio-economic or regional areas which may result in increased non-medical use of pharmaceuticals (Bowden et al. 2021).

Opioids and benzodiazepines are the main drug groups associated with unintentional drug-induced deaths in Australia. Between 2018 - 2022 there were 472 unintentional drug induced deaths in the Adelaide PHN region (Penington Institute 2024). .

Patterns of opioid prescription dispensing

Rates of PBS prescriptions dispensed for opioid medicines decreased between 2020-21 and 2016-17, however they were higher in Adelaide PHN (53,999 per 100,000 population) compared to the national rate (48,481 per 100,000). In 2020-21, there were 805,507 opioid prescriptions dispensed in Adelaide PHN, a reduction from 903,761 prescription in 2016-17 (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2022).

There were substantial variations in the rate of dispensing of opioid medicine prescriptions across the region. In 2020-21 the rate of dispensing in the Statistical Area Level 3 (SA3) with the highest rate (Playford) was 3.1 times higher than the SA3 with the lowest rate, Burnside SA3 (30,580 per 100,000 population) (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2022). Playford SA3 had the highest age-standardised rate for dispensed prescribed opioids in South Australia and the highest rate nationally as well, with 93,850 prescriptions per 100,000 population (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2022).

There is also a clear social gradient in the age-standardized rate of dispensed prescribed opiates; SA3 areas with a lower socio-economic status have substantially higher rates of PBS dispensed prescribed opioids (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2022; Roche et al. 2016).

7.5.4 Cannabis

Cannabis remained the most widely used illegal drug in South Australia during 2022-2023 (11,1%) by people aged 14 and over as such carries a significant burden of disease (AIHW 2024h). 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 (Department of Health (DoH) 2017a).

There has been a decline in the Adelaide PHN region in the use of Cannabis. Levels of cannabis use in Adelaide (1500 mg THC/1,000 people/day) were above national capital averages (900mg THC/1,000 people/day), but generally below regional South Australian levels. Cannabis use in Adelaide has declined since August 2021 after a peak in August 2023 (approximately 2100 mg THC/1,000 day in August 2021; 2150 mg in August 2023; and 1500 mg in October 2023). Cannabis use in Adelaide in October 2023 is at approximately the same level as it was in 2012 (NCETA 2024).

The 2022-2023 NDSHS indicates males (13.9%) have higher use of cannabis than females (8.5%) for those aged 14 and over (AIHW 2024h).

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 (Australian Institute of Health and Welfare (AIHW) 2020h).

7.5.5 Other drugs of concern

Ecstasy

Analysis of wastewater suggests that within metropolitan Adelaide levels of MDMA use (50 mg/1,000 people/day) were well below the average capital city levels for MDMA (150 mg/1,000 people/day). MDMA consumption has remained stable and low in Adelaide since August 2021 after experiencing a peak consumption rate in December 2022 (approx. 50 mg/1,000 people/day in August 2021; 120mg in December 2022; and 50 mg/day in October 2023) (NCETA 2024).

In 2022-2023, according to the NDSHS, 1.7% of people in South Australia had used ecstasy in the previous 12 months (AIHW 2024h).

Cocaine

Based on the NDSHS, cocaine use in South Australia has significantly increased from 2.5% in 2019 to 4.7% of the population in 2022-2023 (AIHW 2024h).

Analysis of wastewater suggests that cocaine consumption levels increased markedly in metropolitan Adelaide, since August 2021 (off a low base) and peaked in August 2023 (approx. 225 mg/1,000 population/day in August 2021; 525 mg in August 2023; and 475mg in October 2023) (NCETA 2024).

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 (Department of Health (DoH) 2017a). The proportion of people who smoked tobacco daily in South Australia dropped from 11.9% to 9.0% between 2019 and 2022–2023, marking the lowest level recorded since 2001 when 20% of people in South Australia smoked daily. This means about 100,000 people smoked daily in 2022–2023, down from 200,000 in 2019. This decline was driven by a reduction in daily smoking among people in their 30s (from 12.2% to 7.4%) and 40s (from 18.5% to 10.5%) (AIHW 2024h).

In 2019 in the Adelaide PHN region; 11% of people were daily smokers equivalent to approximately 137,200 people. This is also resulted in an 11% increase since 2016 (Australian Institute of Health and Welfare (AIHW) 2020h). Almost two-thirds (64%) of people in the Adelaide PHN have never smoked, a minimal 3% decrease since 2016 (Australian Institute of Health and Welfare (AIHW) 2020h).

Heroin

Levels of heroin use in Adelaide were very low (60mg/1,000 people/day) and well below the national capital city average (140mg/1,000 people/day), although Adelaide levels were higher than the SA regional centres. Heroin use has declined in Adelaide since August 2021 (110 mg/1000 people/day to 60 mg in October 2023) (NCETA 2024).

7.6 Priority Populations

A number of population groups experience disproportionate levels of ill-health, disability and disparate harms (direct and indirect) associated with AOD use (Department of Health (DoH) 2017a). In the Adelaide PHN region, and in line with the *National Drug Strategy 2017-2026*, they include Aboriginal and Torres Strait Islander people, people with mental health conditions, people from culturally and linguistically diverse communities, young people, people identifying as lesbian, gay, bi-sexual, transgender, intersex, queer or asexual + (LGBTIQA+), people experiencing homelessness and people in contact with the criminal justice system (Department of Health (DoH) 2017a; Adelaide Primary Health Network (APHN) 2020a, 2020c; Purdie et al. 2010).

The *Adelaide PHN Alcohol and Other Drugs Treatment and Quality Framework* also recognizes that some groups are more vulnerable or at-risk and require targeted and considered interventions and the PHN therefore targets the delivery of treatment services to priority populations (Adelaide Primary Health Network (APHN) 2020b).

The following section describes the burden of alcohol and other substance use on priority populations and some of the specific barriers these groups face in accessing treatment.

7.6.1 Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are a priority population in the National Drug Strategy. Compared to other Australians, First Nations people suffer more harm from alcohol, tobacco and other drug use (AIHW 2024h). Mental health & substance use disorders (such as anxiety, depression, and drug use), were the leading disease group contributing to 23% of total burden among First Nations people in 2018 (AIHW 2024i).

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 (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (APHN) 2020b).

In 2021-22, 14.7%of clients accessing AOD treatment services in the Adelaide PHN region identified as Aboriginal and or Torres Strait Islander (Australian Institute of Health and Welfare (AIHW) 2023).

In 2024 stakeholder consultations identified Aboriginal and Torres Strait Islander people as being particularly vulnerable to AOD use and related harms, an excerpt from the consultations below is given as an example: when asked about risk populations in relation to AOD use and misuse (APHN 2024h)

"*It is prevalent in our Aboriginal community, the use of drugs and alcohol."*

Alcohol

According to the 2022-2023 NDSHS, rates of risky drinking among Aboriginal and Torres Strait Islander people have declined substantially, from almost 1 in 2 (48%) in 2010 to 1 in 3 (33%) in 2022–2023. This new rate is almost similar to the national rates for non-indigenous people, however after adjusting for age differences, Aboriginal and Torres Strait Islander people were 1.4 times as likely to have consumed more than 10 standard drinks in one sitting in the previous year (AIHW 2024h) .

Cannabis

In 2022–2023, more than 1 in 4 (28%) First Nations people had used illicit drugs in the previous 12 months. This was consistent with previous years, however the order of the most commonly used illicit drugs did change between 2019 and 2022–2023. Cannabis use increased from 16% of people to 17 % (AIHW 2024h).

Tobacco

One in five (20%) First Nations people smoked tobacco daily in 2022–2023, a substantial decrease from 2010 when more than 1 in 3 (35%) smoked daily. Smoking rates among First Nations people have historically been higher than non-Indigenous people in the NDSHS, and this remained true in 2022–2023 (AIHW 2024h).

Non-medical substance use

Recent findings from the 2022-2023 NDSHS indicate a reduction in the use of pain relief medication and opioids and an increase in cocaine use across Australia. However, there were differences in the proportions of First Nations and non-Indigenous people using these substances. After adjusting for differences in age in 2022–2023:

- First Nations people were 1.4 times as likely as non-Indigenous people to have used any illicit drug in the previous 12 months.

- Non-Indigenous people were 3.3 times as likely as First Nations people to have used ecstasy in the previous 12 months.
- First Nations people were 2.3 times as likely as non-Indigenous people to have used methamphetamine and amphetamine in the previous 12 months.
- First Nations people were 2.2 times as likely as non-Indigenous people to have used pain-relievers and opioids for non-medical purposes in the previous 12 months (AIHW 2024h).

Service gaps

During the 2024 Adelaide PHN consultations, members of Aboriginal and Torres Strait Islander communities acknowledged that Aboriginal Community Controlled Organisations (ACCO) use wellbeing programs to provide AOD support effectively to the community (APHN 2024h). However, ongoing gaps in AOD treatment service provision include access to a full range of services, limited access to culturally safe or secure services, services for families, and a paucity of ongoing support and relapse prevention for those completing intensive treatment (National Drug Research Institute (NDRI) 2014; Adelaide Primary Health Network (APHN) 2020c).

An online survey of Adelaide PHN commissioned AOD treatment service providers in 2022, identified specialist support for family members, partners and friends of clients experiencing AOD issues as a service gap for family members, partners or friends of Aboriginal and Torres Strait Islander people (Adelaide Primary Health Network (APHN) 2022h).

7.6.2 Children and young people

In Australia, young people (aged between 10 and 24 years) are identified as one of the priority groups in the National Drug Strategy 2017–2026, as they are more vulnerable to behaviours associated with alcohol, tobacco and other drug related issues which can lead to adverse health and social outcomes (AIHW 2024h).

In 2022–2023, fewer young people than ever before reported smoking tobacco daily. Only around 10,000 people aged 14–17 smoked daily in Australia in 2022–2023, while around 100,000 people aged 18–24 did so (down from 200,000 in 2019). In contrast to tobacco, there was a sharp increase in the use of vapes and electronic cigarettes (‘e-cigarettes’) among young people between 2019 and 2022–2023:

- Among people aged 14–17, current use of e-cigarettes increased from *1.8% to 9.7%, becoming the age-group with the third-highest proportion of e-cigarette use (AIHW 2024h)
- People aged 18–24 were the most likely to currently use e-cigarettes, increasing from 5.3% in 2019 to 21% in 2022–2023 (AIHW 2024h).

While risky drinking among people aged 18–24 was stable nationally, there were differences by gender. The gap in risky alcohol consumption between young males and young females (45% compared to 40% in 2022–2023) was the smallest seen since the data series began in 2007 (AIHW 2024h).

In 2022–2023, around 1 in 3 people aged 18–24 (35%) or around 800,000 people had used an illicit drug in the previous 12 months, and almost 1 in 2 (49%) or around 1.1 million people in this age group had done so at some point in their lifetime. This is consistent with previous years, as people aged 18–24 have reported higher rates of illicit drug use than the rest of the population since 2001 (AIHW 2024h).

Nationally, in 2018, alcohol and illicit drug use were the leading causes of total burden of disease in males aged 15–24 years and the second and third leading causes (respectively) for females (Australian Institute of Health and Welfare (AIHW) 2022z). 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 (Australian Institute of Health and Welfare (AIHW) 2022z).

7.6.3 Culturally and linguistically diverse communities

Some culturally and linguistically diverse (CALD) communities have higher rates of, or are at higher risk of, alcohol, tobacco, and other drug problems. CALD groupings are broad and experiences with alcohol, tobacco and other drugs are likely to vary widely among people with different cultural and language backgrounds (aihw 2024h; Australian Bureau of Statistics (ABS) 2023a).

In 2022, consultations with stakeholders and commissioned service providers identified that; there was a lack of specialist AOD services to meet the needs of people from CALD communities in the Adelaide PHN region; there was limited capacity among current AOD CSPs to meet the needs of people from CALD communities (Adelaide Primary Health Network (APHN) 2022h).. In recognition of this identified need, in 2022-23, Adelaide PHN commissioned a CALD health service to deliver a specialised AOD treatment services program to people from culturally and linguistically diverse communities.

In 2024, during consultations, stakeholders in the Adelaide PHN region identified a residual gap in AOD service provision to people from CALD communities. These included:

- An overall paucity of services
- Insufficient funds being available for interpreter services
- A lack of awareness of the funds that are available for interpreter services
- A paucity of services for people from CALD communities with severe (as opposed to mild to moderate) AOD problems
- A paucity of services for people from CALD communities with co-occurring SUD and mental health comorbidities (NCETA 2024) (APHN 2024h).

Results of the NDSHS 2022-2023 pointed out an increase in the use of e-cigarettes and vapes and between 2019 (2.3%) and 2022-23 (6.2%) for those born overseas from English speaking countries. There was a decrease in the proportion of people from CALD communities who drank alcohol at risky levels from 39.2% in 2019 to 36.5% in 2022-23. The proportion of people from CALD communities who reported recent use of any illicit drug increased from 18% in 2019 to 19% in 2022-23 (AIHW 2024h).

7.6.4 Lesbian, gay, bisexual, transgender, intersex, queer and asexual + (LGBTIQA+) communities

National trend data from the NDSHS shows that for gay, lesbian and bisexual people from 2019 to 2022-23 there has been a reduction in daily tobacco use from (16.7 to 16.1%), ecstasy (7.4% to 6.7%), inhalants (9.9% to 8.6%), risky alcohol consumption (44% to 38.3%) and tranquilizers from (4% to 3.6%) (AIHW 2024h).

There has been significant increase from 2019 to 2022-23 within these communities for ; e-cigarettes use (6% to 14.6%), cocaine use (8% to 12.5%), hallucinogens use (4.9% to 6.2%), any illicit drug use (36% to 42.2%), and cannabis use (25.9% to 29.7%) (AIHW 2024h).

There is limited data about substance use in LGBTIQA+ 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 LGBTIQA+ living in the Adelaide PHN region are estimates only and are based on limited national data collections and local research studies that capture AOD use in the LGBTIQA+ community.

To gain a better understanding of the health and service needs of our LGBTIQA+ communities, in 2020 Adelaide PHN consulted our memberships groups and interviewed several LGBTIQA+ service providers in the region. LGBTIQA+ 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 LGBTIQA+ community, and treatment services need to be able to cope

with clients with complex issues and in varying life stages (Australian Institute of Health and Welfare (AIHW) 2020i).

A lack of access to appropriate, safe, and inclusive AOD treatment services, and the lack of dedicated LGBTIQA+ AOD treatment services in the region were needs identified by stakeholders who were consulted (Australian Institute of Health and Welfare (AIHW) 2020i). 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 LGBTIQA+ communities due to inadequate data collection also needs to be addressed (Australian Institute of Health and Welfare (AIHW) 2020i).

The *Adelaide PHN Alcohol and other Drugs Treatment and Quality Framework* acknowledges LGBTIQA+ communities as a priority group / population requiring improved access to targeted and considered interventions.

7.6.5 Older people

Harmful use of prescription medications, effects of illicit drug use and alcohol use is increasing in older people (60+ years) in Australia. Older people can be more susceptible to alcohol, tobacco, and other drug problems as a result of difficulties with pain and medication management, isolation, poor health, significant life events and loss of independent living (Department of Health (DoH) 2017a). The largest increase in drug-induced suicides over time are occurring among older Australians, with people aged 60+ years accounting for one-third of all such deaths in 2019 (Penington Institute 2021).

Older people make up a considerable proportion (23%) of Adelaide PHN's population. In 2019, over 1 in 6 people were aged 65 and over and the number and proportion of older people in the region is expected to increase by over 50,000 by 2030 (Public Health Information Development Unit (PHIDU) 2020a). Older people often have unique health circumstances including pain, co-morbidities, and social circumstances such as isolation (Department of Health (DoH) 2017a). These factors are important to consider in the context of AOD use.

Recent national trend data indicate, between 2010 and 2022–2023, the smoking rate among people in their 60s fell slightly from 12.7% to 10.4%, and for people in their 70s it remained stable (5.6% in 2010 and 4.9% in 2022–2023). In 2022–2023, 1 in 3 (33%) people aged 60 to 69 consumed alcohol at risky levels, similar to the proportions of people in their late 20s through to people in their 50s. While people in their 60s and older were also less likely to have used pain relievers and opioids for non-medical purposes in the previous 12 months than those in their 20s, they were more likely to have used them in the last month and were much more likely to have used them in the previous week. As a result, the harms from drug use among older people are more likely to come from non-medical use of pain relivers and opioids than from illegal drugs such as cocaine and ecstasy (AIHW 2024h).

Consultations conducted by NCETA in 2024 found that in the Adelaide PHN region AOD-related use among older people is becoming increasingly prevalent. This which is attributed but not limited to:

- The ageing of the Adelaide population
- Older people are more likely to:
  - be taking multiple medications associated with multiple medical conditions
  - be socially isolated
  - experience changes in physiology that affect the way alcohol and drugs are metabolised
  - experience changes in self-identity because of role transitions
- AOD treatment populations are ageing and experiencing ageing-related health issues for the first time

- Widespread under-recognition of AOD issues among older people
- A generational legacy whereby ‘baby boomers’ have been exposed to more and different patterns of substance use throughout their lives and are continuing their substance use patterns into later life (NCETA 2024).

Stakeholders recognised the complexities associated with addressing this problem. It was noted that while the Adelaide PHN-funded Reach and Refer program had experienced substantial difficulties in engaging general practices in responding to AOD problems among older patients, nevertheless, this was regarded as an increasing problem (NCETA 2024).

7.6.6 People in contact with the criminal justice system

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 (Adelaide Primary Health Network (APHN) 2016d).

National data from 2022-23 indicates that:

- About 2 in 5 (44%) prison entrants were at high risk of alcohol-related harm during the previous 12 months.
- Almost 3 in 4 (71%) prison entrants reported that they currently smoked tobacco.
- Almost 3 in 4 (73%) prison entrants reported using illicit drugs in the previous 12 months.
- The most reported drug used by prison entrants for non-medical purposes was cannabis, with more than half (53%) having used it at least once in the previous 12 months.
- Methamphetamines/amphetamines were also commonly used with 46% of prison entrants reporting using them at least once in the previous 12 months (AIHW 2023c).

Adelaide PHN’s 2024 consultations also identified this cohort as a vulnerable group for AOD use and related harms (APHN 2024h).

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 (Adelaide Primary Health Network (APHN) 2020c).

7.6.7 People with mental health or physical health comorbidity

People with mental health conditions use alcohol, tobacco, and other drugs for the same reasons as other people. However, they may also use substances to 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 work, relationships, health, and safety (Department of Health (DoH) 2017a).

A majority of people with AOD related problems also experience a co-occurring mental health condition. Forty six percent (46%) of people who met the diagnostic criteria for SUD in Australia also met the criteria for an anxiety or mood disorder between 2020 and 2023 (AIHW 2024h).

This highlights the importance of integrating mental health and AOD treatment services. A key challenge in this regard is the potential for siloed funding stream approaches. This can exclude the provision of care to clients who have a condition that sits outside of the parameters for which agencies receive funding (NCETA 2024).

Adelaide PHN has commissioned a service provider to deliver a program to adults experiencing co-occurring AOD use and mental health issues. This is done in collaboration with another service provider and the program prioritises older Australians, First Nations people and people from Culturally and Linguistically Diverse communities. The program uses a collaborative approach to case management that

sees all team members consulting with the assigned worker(s) about ensuring the best outcomes for the client whilst drawing on their collective skills, wisdom and lived experience. Clients can receive up to 12 sessions with an AOD Practitioner, or a Comorbidity Clinician, or a combination of both, complemented by peer support from either service provider, depending on the client's need (Adelaide Primary Health Network (APHN) 2022e).

Alcohol use

Findings from the NDSHS 2022-23 indicate people experiencing high or very high levels of psychological distress were more likely than those who reported low levels of psychological distress to consume alcohol in ways that put their health at risk (39% compared with 30%)(AIHW 2024h).

Tobacco use

People experiencing high or very high levels of psychological distress were much less likely to smoke tobacco daily in 2022–2023 than in 2019, dropping from 21% to 15.3%. People who were experiencing high or very high levels of psychological distress were 4.1 times as likely to currently use e-cigarettes as those who were experiencing low levels in 2022–2023 (AIHW 2024h).

Use of other drugs

In 2022-23, nationally around 1 in 4 (29%) people who reported having a mental health condition used illicit drugs, compared to around 1 in 6 people (15.9%) without a mental health condition. People with a mental health condition are:

- 1.8 times as likely to have used any illicit drug (29% compared with 15.9%).
- 3.9 times as likely to have used methamphetamine and amphetamine (2.7% compared with 0.7%).
- 2.2 times as likely to have used pain-relievers and opioids (3.9% compared with 1.8%).
- 2.1 times as likely to have used inhalants (2.5% compared with 1.2%).
- 2.0 times as likely to have used tranquillisers/sleeping pills (2.8% compared with 1.4%).
- 2.0 times as likely to have used cannabis (19.8% compared with 10.0%) (AIHW 2024h).

7.6.8 People experiencing homelessness

According to NCETA's 2024 consultation, several key stakeholders raised the provision of AOD services to homeless people in the greater Adelaide region as a significant current gap. It is however, noted that the Adelaide PHN does expect its CSPs to provide services to people experiencing homelessness.

NCETA also found that Aboriginal and Torres Strait Islander people were an important sub-group of people experiencing homelessness with high levels of AOD need. There is also evidence that members of the LGBTIQ+ community are more likely to experience homelessness.

These findings are consistent with a 2021 Flinders University study that found that people experiencing homelessness in greater Adelaide had very high levels of unmet need for specialised services such as alcohol or other drug treatment. The study also reported that people experiencing homelessness have a higher likelihood of poor health outcomes compared with the general population which results in higher and more complex health care service needs (NCETA 2024).

7.7 Priority actions

The *National Drug Strategy* (Department of Health (DoH) 2017a) outlines several priority actions around improving the outcomes and experiences of people seeking and accessing treatment services. Through

further research and consultation, Adelaide PHN has identified three key areas where actions are required in the local AOD treatment sector and supporting systems. These are:

- Treatment services actions
- Primary care workforce actions
- System integration actions (Adelaide Primary Health Network (APHN) 2020c).

The following sections examine the components of each of these areas.

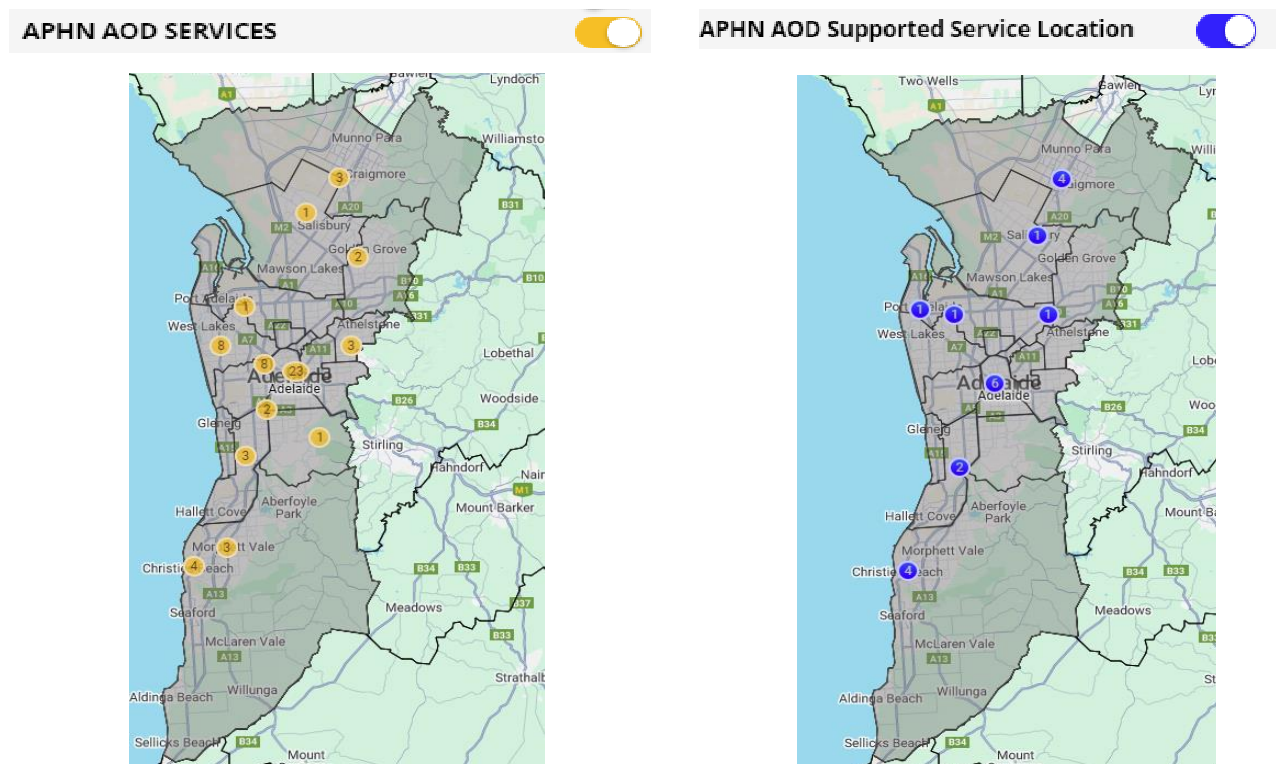
7.7.1 Treatment services actions

Treatment for substance use issues in the Adelaide PHN regions occurs in both health and community services and is provided by a broad range of service providers. Treatment settings include specialist AOD treatment services and primary healthcare services such as general practices and other primary health care services including Aboriginal Community Controlled Health Organisations (Adelaide Primary Health Network (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 (South Australian Network of Drug and Alcohol Services (SANDAS) 2018). Hospitals (emergency and specialist units), mental health providers and family and child protection workers also provide AOD interventions as part of their general services (South Australian Network of Drug and Alcohol Services (SANDAS) 2018).

The local AOD treatments workforce includes a wide range of health and human service professions including clinicians, case-managers, AOD workers, peer-support workers and volunteers, social workers, Aboriginal and Torres Strait Islander health workers, general practitioners, addiction medicine specialists, nurses, pharmacists, psychologists, psychiatrists and allied health workers (South Australian Network of Drug and Alcohol Services (SANDAS) 2018).

Below are maps showing coverage of AOD treatment services in 2024 within Adelaide PHN region which addresses priority population needs. To note, is the maps demonstrates service locations only available via Health Direct Australia.



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.' (Adelaide Primary Health Network (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.

Consultations with key stakeholders support the need to minimise the potential for social conflict and disruption within kinship networks in Aboriginal and Torres Strait Islander communities by ensuring that clients wishing to preserve confidentiality and anonymity should have access to services besides community-controlled (Adelaide Primary Health Network (APHN) 2020c).

Both community-controlled AOD services and mainstream services that are culturally safe and appropriate, are needed to ensure Aboriginal and Torres Strait Islanders people can choose the service that suits their needs.

Adelaide PHN acknowledges that where mainstream organisations are providing services to Aboriginal and Torres Strait Islander people, they need to adapt their programs to consider specific cultural needs and adapt interventions and activities, which when underpinned by culturally specific practices, are more relevant to the person seeking treatment and therefore more effective (Gomez et al. 2014; Adelaide Primary Health Network (APHN) 2020b).

Culturally safe and appropriate services and interventions

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 (Adelaide Primary Health Network (APHN) 2020c), reflecting previous consultation in which the community identified a need to feeling respected and safe within the [MH and] AOD system (Adelaide Primary Health Network (APHN) 2017b).

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 (Adelaide Primary Health Network (APHN) 2020b, 2020c).

Person-centred treatment services

The *National Framework for Alcohol, Tobacco and other Drug Treatment 2019-2029* is clear on the importance of AOD treatment services being person-centred (Commonwealth of Australia 2019a). Person-centred approaches are focused on the needs and rights of the person, recognising individual preferences and inclusion in decision making. Substance use disorders are chronic relapsing conditions usually embedded in a web of other health and social problems. Rates of homelessness, unemployment, and other factors related to social instability are also high amongst individuals seeking treatment for AOD issues, and affect treatment outcomes (Lubman et al. 2017).

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 (Adelaide Primary Health Network (APHN) 2016b, 2016e, 2017b). This is reflected in more recent consultations where stakeholders identified that complexity is often the norm, (Adelaide Primary Health Network (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 (South Australian Network of Drug and Alcohol Services (SANDAS) 2018).

The *Adelaide PHN Alcohol and other Drugs Treatment and Quality Framework* reinforces the need for treatment services and interventions to be person-centred and recognizes that this is ongoing, as services need to be responsive to the changing needs of individuals and the population (Adelaide Primary Health Network (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. Consultations with 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 (Adelaide Primary Health Network (APHN) 2020c).

Family-informed strategies are of particular importance in Aboriginal and Torres Strait Islander communities where family and kinship relationships remain fundamental and it is important to ensure that Aboriginal and Torres Strait Islander people can include family in their treatment journey if they wish (Adelaide Primary Health Network (APHN) 2020c).

Consultations with key stakeholders and commissioned service providers in 2022 identified the importance of and need for identified specialist support for family members, partners and friends of clients experiencing AOD issues as a service gap for the following priority population groups:

- Family members, partners or friends of Aboriginal and Torres Strait Islander people.
- Family members, partners or friends of people who have been in contact with the criminal justice system.
- Family members, partners or friends of young people (Adelaide Primary Health Network (APHN) 2022h).

Adelaide PHN has used the findings of this survey to provide commissioned service providers with increased support for clients' family members partners or friends (Adelaide Primary Health Network (APHN) 2022h).

Measuring performance and outcomes

The *National Drug Strategy* (Department of Health (DoH) 2017a) has determined that it is a priority for the AOD sector to improve the development and sharing of data to measure performance and evaluate outcomes. 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 (Adelaide Primary Health Network (APHN) 2020c).

Adelaide PHN's Alcohol and other Drugs Treatment and Quality Framework, has identified a series of short-term outcomes which underpin the Project Schedules that we use with commissioned service providers (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (APHN) 2020b).

Adelaide PHN has mandated its AOD commissioned service providers to collect client outcomes data using the Australian Outcomes Profile (ATOP). The ATOP is an evidence based 22 item instrument that assesses various parameters of substance use and general health and wellbeing over the preceding four weeks (Adelaide Primary Health Network (APHN) 2021e). It is a patient reported outcome measure (PROM) and clinical risk screening tool, eliciting responses directly from clients and is designed to be incorporated into routine clinical care in AOD treatment settings. The ATOP is usually administered either face-to-face or by telephone by a clinician or researcher and requires minimal training for administration or interpretation.

The ATOP has not been validated for cultural appropriateness when used with Aboriginal and Torres Strait Islander people and as such, Adelaide PHN has provided the additional option of the Alcohol and Drug Outcome Measure (ADOM) (Adelaide Primary Health Network (APHN) 2021e). The ADOM was developed by Te Pou and Matua Raki in New Zealand and has been validated for use with Māori. Aboriginal Community Controlled Health Organisations in Australia have adopted the ADOM for use with Aboriginal and Torres Strait Islander people to record changes in their AOD use, physical and psychological health, and social and emotional wellbeing over time (Adelaide Primary Health Network (APHN) 2021e).

Peer workforce

The value of peer workers in the AOD sector is immense and often quoted as a necessary part of recovery. People seeking help are less likely to feel judged or stigmatized by those who have a similar experience (Department of Health and Human Services (DHHS) 2018). When surveyed, a majority (65%) of AOD workers reported AOD lived experience (personal, family, other), of whom two thirds (63%) declared it to their workplace (Skinner et al. 2020).

In recent years, the Adelaide PHN has implemented a range of measures to increase workforce development activities focussed on the peer workforce. Key stakeholders were supportive of these measures but indicated that there was a substantial opportunity to further enhance the role of peer workers in the provision of AOD services in the Adelaide region. The progress of the mental health sector in enhancing the role of peer workers, was noted as an exemplar in this regard (NCETA 2024).

Stakeholders indicated that incorporating the perspectives and experiences of individuals with lived experience of AOD use problems can enrich service design, delivery, and evaluation. It was suggested that Adelaide PHN could explore mechanisms for meaningful involvement of consumers and carers in decision-making processes, program development, and quality assurance activities. This would help ensure that services are truly responsive to the needs and preferences of those they serve (NCETA 2024).

Key issues included the need for:

- Greater overall utilisation of the peer workforce
- Appropriate education, training, and professional development
- Strategies to encourage peer worker recruitment, retention and wellbeing
- Measures to destigmatise the peer workforce among mainstream service providers
- Measures to ensure that peer workers with spent criminal convictions are not unreasonably excluded from peer roles
- Recognition that in some environments, lived experience may have multiple facets (for example in correctional settings peer workers may require lived experience of both AOD issues and the correctional system itself) (NCETA 2024).

7.7.2 Primary care workforce actions

The primary health care workforce has an important role in the prevention, early intervention, and treatment of substance use issues. However, it has been noted that working in 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. In 2022, following consultations with key SA AOD stakeholders, Adelaide PHN has identified a need to continue to work with DASSA and other stakeholders to build the capacity of the primary health care sector across the Adelaide PHN region to identify and respond to patients experiencing pain management and prescribed opioid health related issues more effectively (Adelaide Primary Health Network (APHN) 2022i).

Findings from NCETA's 2024 consultations reported the need for general practitioners to play a greater role in responding to AOD problems. General practitioners are well placed to offer early / brief intervention services and to manage patients with all but the most complex AOD problems. Yet progress in this area has been disappointing. Stakeholders identified a range gaps in AOD services that involve general practice. These included the need for:

- Programs to address the levels of stigma experienced by AOD patients attending general practices
- More education for GPs concerning the prescribing of drugs of dependence and the use of ScriptCheckSA
- More education for GPs concerning the prescribing of:
    - opioids for persistent non-cancer pain
    - sedative hypnotics for anxiety and insomnia
    - Naloxone when prescribing opioids for persistent pain.
- More education for GPs about their potential role in:
    - Screening and early / brief interventions
    - Opioid agonist therapy
    - Alcohol and other drug withdrawal guidelines.

From a structural perspective, the level of relevant Medicare rebates may also be insufficient to encourage general practitioners to focus on responding to AOD problems among their patients (NCETA 2024).

Consistent prescribing practices

Primary health care workers, including GPs need support to deliver consistent care to people with substance use issues. This has been recognised by the Australian Government's investment in training and education for GPs through the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine. In 2021-22, Adelaide PHN appointed an AOD GP Support Project Officer to support the uptake of the RACGP's online training for GPs for a period of 12 months.

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

In South Australia there is an imbalance in the prescriber – client numbers. On a snapshot day in 2021, there were 3,334 clients receiving pharmacotherapy in SA, a number that has increased since 2011. This represented a rate of 19 per 10,000 of the SA population (compared to 23 per 10,000 nationally). In 2021, 48.6% of SA pharmacotherapy clients received methadone; 47.0% received buprenorphine/naloxone; 3.6% received long-acting injectable buprenorphine; and 0.8% received buprenorphine (Australian Institute of Health and Welfare (AIHW) 2021l).

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

Future of Opioid Agonist Prescribing

Opioid agonist therapy (OAT) is the cornerstone of the treatment of opioid use disorder. One of the most significant challenges facing the provision of OAT services in Australia is the paucity and ageing of opioid agonist prescribers. While this issue has not been examined in South Australia, in NSW opioid agonist therapy (OAT) prescribing is increasingly concentrated in a small group of mature prescribers, and new prescribers are not being retained (Jones et al. 2021).

The situation is likely to be the same in South Australia. There is an ageing cohort of OAT prescribers in this State as elsewhere in Australia. In 2020, in South Australia, there were 261 OAT prescribers, five of whom had 101 or more clients each and a further 12 prescribers who had between 51 and 100 clients each (Australian Institute of Health and Welfare (AIHW) 2021l).

The loss of OAT prescribers through retirement, ill-health or a reduction of working hours would place the ongoing provision of OAT in the Adelaide PHN area at risk. This is particularly the case if prescribers with a large client caseload are lost to the field.

Awareness for screening, early intervention, and referral

Previous consultation with Adelaide PHN stakeholders has prioritised a need for health literacy, early intervention and better education for consumers and professionals across the health sector (Adelaide Primary Health Network (APHN) 2016a, 2016c, 2016d, 2016b). This would be aimed at improving and encouraging the take-up and application of preventative measures. Stakeholders have previously identified that primary health care workers need to be better equipped to address the needs of people experiencing complex health issues. There is a need to ensure health services and programs are sustainable and focus on both early intervention and recovery programs (Adelaide Primary Health Network (APHN) 2016d). For example, an earlier consultation identified the quality use of medicines as a priority to be embedded as a principle across all Adelaide PHN programs, specifically around improving health literacy and education with regards to opioid prescribing (Adelaide Primary Health Network (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. In fact respondents described that GPs are well placed to play a central role in the education and prevention of substance use and dependence and noted that GPs are in a good position

to put early interventions strategies into place, to make appropriate referrals, and to support people throughout their treatment (NSDC GP Working Group 2019).

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

Reducing stigma

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

In previous 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 (Adelaide Primary Health Network (APHN) 2020c).

The communication skills of some prescribers when prescribing medicines which can potentially cause dependence are also limited. Qualitative research conducted into opioid prescribing found some prescribers had limited confidence and skills in relation to communicating with their patients about opioid risks. The research showed that some prescribers only implied some information (e.g. about the risk of dependency), rather than explicitly stating it to consumers (Orima Research 2020).

Normalising the treatment of substance use issues and dependence in the same manner as chronic health conditions will support more people to seek help and treatment. Re-occurrence rates are no higher than other conditions when applying a comprehensive continuity of care (NSDC GP Working Group 2019). Staff familiarity with patients receiving AOD care also reduces feelings of stigmatisation, fear, and avoidance.

7.7.3 System integration

Central to system integration are coordination of care and establishing and maintaining partnerships with key stakeholders both within the AOD sector and the broader health sector. Both issues are explored in further detail below.

Coordination of care

NCETA’s work for Adelaide PHN in 2024 identified that there are approximately 35 AOD services operating across the Adelaide metropolitan area whilst noting that Adelaide PHN funds seven of those providers.

Key stakeholders reported that there is an opportunity to enhance the coordination and integration of these services. There appeared to be a considerable degree of goodwill amongst AOD service providers in the region and State to enhance coordination and integration, particularly at the strategic level. However, this is commonly complicated and inhibited by services’ competitive tendering processes, key performance indicator issues and a lack of awareness of the extent and nature of other available services.

As a result, the goodwill that exists at the structural level does not necessarily translate to the operational level to the extent that is possible.

Some stakeholders indicated that there could also be benefit in having a similar statewide meeting on a yearly basis, perhaps coordinated jointly by both PHNs and/or facilitated independently. These kinds of strategies could facilitate commissioning agencies (such as Adelaide PHN, Country SA PHN and Drug

and Alcohol Services SA) to work more closely together and could pave the way for service co-commissioning across the agencies (NCETA 2024).

Partnerships

Providers, GPs, client/ family representatives, and others have previously 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 (Adelaide Primary Health Network (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 (Alcohol Services South Drug and Australia (DASSA) 2020).

It is 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; and
- 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 (Adelaide Primary Health Network (APHN) 2020b).

7.8 Opportunities and priorities – Alcohol and Other Drugs

Table 14 summarises the priorities arising from the analysis of alcohol and other drugs treatment needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. Below is a list of priorities from the 2024 Needs Assessment.

Table 14 Alcohol and Other Drugs Priority Statements for the Adelaide PHN, 2024

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Priority populations have access to high quality alcohol and other drug treatment services and interventions	*Alcohol and Other Drugs*	*Access*	People in PHN region are able to access appropriate drug and alcohol treatment services	• Adelaide PHN
People requiring AOD treatment services in Adelaide are supported by a sufficient, safe, skilled and appropriate workforce	*Alcohol and Other Drugs*	*Safety and quality of care*	Decrease in harm to population in PHN region from drug and alcohol misuse	• Adelaide PHN
AOD and related services are integrated, holistic and coordinated to improve continuity of care and experiences**	*Alcohol and Other Drugs*	*System integration*	Health care providers in PHN region have an integrated approach to drug and alcohol treatment services	• Adelaide PHN
Priority populations including, but not limited to LGBTIQA+, Aboriginal and Torres Strait Islander people, people experiencing homelessness and people from CALD communities can access safe, inclusive and appropriate alcohol and other drug treatment options**	*Alcohol and Other Drugs*	*Vulnerable population (Non-First Nations specific)*	People in PHN region are able to access appropriate drug and alcohol treatment services	• Adelaide PHN
People experiencing AOD risk can access prevention, early intervention and treatment services*	*Alcohol and Other Drugs*	*Access*	People in PHN region are able to access appropriate drug and alcohol treatment services	• Adelaide PHN
Communities are aware of AOD risk factors and related harm*	*Alcohol and Other Drugs*	*Awareness*	People in PHN region are aware of drug and alcohol risk factors and related harm	• Adelaide PHN

*New priority added in 2024 ** 2024 modified wording

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 the health system and can be delivered in a range of settings, by a range of providers (AIHW 2024f). Primary health care includes a broad range of activities and services, from health promotion, prevention, screening, and 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 (Australian Institute of Health and Welfare (AIHW) 2016).

Primary health care services are delivered in settings such as general practices, community pharmacies and health centres, allied health practices, outreach community settings, via digital communication technologies such as telehealth and video consultations (Australian Institute of Health and Welfare (AIHW) 2016).

8.2 Health Workforce

8.2.1 Summary of identified needs for Health Workforce

Table 15 below summarises the health and service need identified through the needs assessment process for the Health Workforce priority area, through the modelling of GP access relative to community need and 2024 needs assessment activities conducted. Stakeholder engagement activities are ongoing.

Table 15 Summary needs identified for Health Workforce, 2024

Outcomes of the health and service needs analysis – Health Workforce		
Identified Need	**Key issues**	**Evidence / Chapter Section(s)**
Capacity building and improved workforce capability and sustainability	Support practices to investigate and identify where there are opportunities for alternative models of care (place-based models of care) that bring together care providers to improve access and health outcomes for patients.	GPEX report: Modelling for GP Workforce Needs Assessment - current internal document under production for publication
Healthcare providers work together to coordinate and integrate patient care	Over reliance on the individual to navigate and coordinate their own multidisciplinary care.	Multidisciplinary Team Care Needs Assessment Summary Report Kitchen Table report MDT
Communities are aware of multidisciplinary team care and management options for chronic conditions	Lack of knowledge and awareness regarding multidisciplinary team care among community in relation to prevention, management and treatment of chronic conditions.	Multidisciplinary Team Care Needs Assessment Summary Report Kitchen Table report MDT
Multidisciplinary services are affordable, accessible and flexible	Lack of affordable, accessible and flexible service options relating to multidisciplinary care for both community and health professionals.	Multidisciplinary Team Care Needs Assessment Summary Report Kitchen Table report MDT
Multidisciplinary services are culturally safe	Access to culturally sensitive and culturally aware multidisciplinary services and health professionals is limited.	Multidisciplinary Team Care Needs Assessment Summary Report Kitchen Table report MDT

Outcomes of the health and service needs analysis – Health Workforce		
Improved communication among multidisciplinary team members	Lack of communication between health professionals in undertaking comprehensive multidisciplinary care.	Multidisciplinary Team Care Needs Assessment Summary Report Kitchen Table report MDT
Health professionals are aware of and utilise available MDT related MBS items efficiently	Lack of awareness of Chronic Disease Management (CDM), case conferencing and Team Care Arrangement (TCA) MBS items across community and health professionals.	Multidisciplinary Team Care Needs Assessment Summary Report
Health professionals understand their own and other roles within a team care setting	Lack of awareness and understanding of role and scope of different members of a multidisciplinary team.	Multidisciplinary Team Care Needs Assessment Summary Report
Health professionals and technological systems support sharing of clinical information among health professionals	Lack of appropriate infrastructure and resources to support comprehensive multidisciplinary team care arrangements among health professionals.	Multidisciplinary Team Care Needs Assessment Summary Report
Health professionals are aware of and utilise available Team Care Arrangement MBS items efficiently	Team Care Arrangement uptake in the Adelaide PHN region is lower than the national average.	Multidisciplinary Team Care Needs Assessment Summary Report

8.2.2 Results of Health Workforce Modelling

The Workforce Planning and Prioritisation (WPP) program was established by the Department of Health and Aged Care in 2022 to support the transition to college-led GP training. The WPP program aims to support the transition to college-led general practice (GP) training through the provision of advice on planning and prioritisation of GP training placements to meet current and future GP workforce needs (GPEX 2023). Under the Commonwealth's WPP initiative, GPEX was assigned to introduce a model for assessing GP access relative to community need.

The objective of modelling workforce need was to identify areas in South Australia where access to GP services is higher or lower on a relative basis, to inform workforce prioritisation and planning decisions. In South Australia, there are 75 GP catchments within Country SA PHN boundaries, and 19 within Adelaide PHN. In the metropolitan setting, these 19 catchments can be further grouped by Local Health Network (LHN), as the boundaries are closely aligned. There is less consistency in boundaries between country LHNs and GP catchments, nevertheless an approximate assignment can be undertaken.

Depending on their population health profile, different communities may have different levels of need for GP services. Therefore, this modelling incorporates both the existing GP workforce, as well as the profile of the community, to measure access to services relative to need.

The outputs of the modelling were intended to provide a consistent and interpretable view of the combined access-relative to need assessments, as well as the breakdown of the overall assessment into the key subcomponents of access and need.

There are areas of priority within Adelaide PHN where GP access (GP FTE per 100,000 residents) is lowest, and community need is highest.

Community need in this context was defined by a combination of key demographic and socioeconomic indicators to derive an index of community need. These indicators are:

1. Proportion of people in high needs age groups (Children under 5, women aged between 20 and 44, Indigenous residents aged over 55, non-Indigenous residents aged over 65).
2. Proportion of people who need assistance with core activities.
3. Proportion of unemployed people.
4. Proportion of households without access to a motor vehicle.
5. Proportion of people who have not attained Year 12 or equivalent.
6. Proportion of people living with long-term health conditions.

Each catchment was assigned to a GP access and community need decile, with an overall score for access relative to need. Results of the Adelaide metropolitan modelling found that the top 5 areas with the lowest GP access and highest community need were:

1. Marion;
2. Port Adelaide Enfield;
3. West Torrens;
4. Elizabeth; and
5. Onkaparinga

8.3 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, psychologists, pharmacists, dentists, and Aboriginal health workers (AIHW 2024f).

According to Health Workforce Data of 2022, there are 9,564 registered health practitioners within primary care and community settings in the Adelaide PHN region (DOHAC 2024).

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

General Practice

In 2023/24 there were 341 General Practices in the region (APHN 2024j). In 2022/23 there were 337 General Practices in the region, 82 in the SALHN region, 158 in CALHN region and 97 in the NALHN region (APHN 2024b).

General practitioners (GPs)

GPs are central to primary care, they are a gateway to specialist health services, and they have significant role in coordinating services for people with complex care needs at home and in the community (Swerissen et al. 2018).

There has been a 0.4% increase in the number of general practitioners in South Australia between 2021 (5,689) to (5,807) in 2023 ... In 2023/24, there were 1,7229 general practitioners employed in the APHN region, compared to 1,641 in 2022/23 period, a 4.7% increase (DOHAC 2024).

In 2022-23 the percentage of people who had a Medicare -subsidised GP attendance in Adelaide PHN region was 85.07% (AIHW 2024c).

Nurses in general practice

Nursing scope of practice allows nurses to undertake a wide range of tasks within general practice, including immunisation, wound management, health assessments, care planning, coordination of care, chronic disease prevention and management, annual cycles of care, administration and practice management, clinical services, patient education, and nurse-led clinics.

Nurses play a vital role in supporting the primary health care system and should be encouraged and supported to work at their full scope of practice while providing opportunities for professional development, expansion of skills (e.g. become a nurse practitioner) and personal growth.

The number of nurses working in general practice in the region had grown by 20% percent from 2016 to 2021. There was a 9% decline in the number of nurses working in the APHN region in 2023/24 (626) nurses compared to (672) nurses in 2022/23 period (DOHAC 2024).

In 2022/23 almost 230,000 Medicare-subsidised services to over 128,400people in Adelaide PHN were provided by nurse practitioners (26,482 services) and nursing and aboriginal health workers (229,365 services) (DOHAC 2024).

Pharmacy

In 2023 there were 385 Pharmacies in the region, 103 in the SALHN region, 181 in the CALHN region and 101 in the NALHN region (Adelaide Primary Health Network (APHN) 2023d).

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 (National Centre for Immunisation Research and Surveillance (NCIRS) 2021a, 2021b). In 2022, a total of 1,714 pharmacists were working in the Adelaide PHN region, with 1,245 in the community (DOHAC 2024).

Allied health professionals

Care teams involving GPs, pharmacists, nurses and allied health professionals are central to more comprehensive and-integrated care, particularly for people who are at risk, or have complex chronic conditions (Swerissen et al. 2018). The scope and role of allied health in primary health care 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).

In 2022 there were over 1300 allied health professionals in the APHN region (DOHAC 2024). In 2022–23, 1,455,244 allied health attendances were provided through Medicare to 524,913 people in Adelaide PHN region (AIHW 2024c).

Mental health

Clinical psychologists

In 2022, a total of 1,498 psychologists worked in the APHN region with 1,384 working in the community as full time equivalent (DOHAC 2024).

Psychiatrists

Approximately 300 psychiatrists worked in the APHN region in 2022, with 172 working in out of hospital settings, i.e. community (DOHAC 2024).

Mental health nurses

The number of mental health nurses working in the region has grown by 11% from 2016 to 2020 (Department of Health (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 (Department of Health (DoH) 2021c).

Social workers

As at June 2023, there were 1,840 members of the Australian Association of Social Workers in South Australia, an increase from 1,715 members of which 1,355 members were working in metropolitan Adelaide . Nationally, 20% of social workers were employed in the mental health field (AASW 2023), assuming this is consistent within the Adelaide PHN region, this would be equivalent to almost 368 mental health social workers in June 2023(Australian Association of Social Workers (AASW) 2023).

Accredited Mental Health Social Workers (AMHSWs) are highly trained and educated mental health professionals and are one of the few designated allied health professional groups eligible to provide private mental health services to people with diagnosable mental health conditions or people 'at risk' of developing mental health conditions under the Commonwealth Medicare initiative. There are currently more than 2,200 AMHSWs working across Australia, with approximate 60% working in metropolitan areas; no data is currently available to quantify the local AMHSW workforce (Australian Association of Social Workers (AASW) 2019).

Occupational therapists

The 2023 Health workforce data indicates a total of 1,687 Occupational therapists are practising in Adelaide PHN region, with 1,391 practising within the community (DOHAC 2024).

Aboriginal primary health care service providers

Primary health care for Aboriginal and Torres Strait Islander people is delivered by a range of providers, including Aboriginal and Torres Strait Islander specific providers and organisations, and general health service organisations (Swerissen et al. 2018).

Aboriginal Community Controlled Health Services (ACCHO) are primary health care services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community; in the Adelaide PHN region there is one ACCHO.

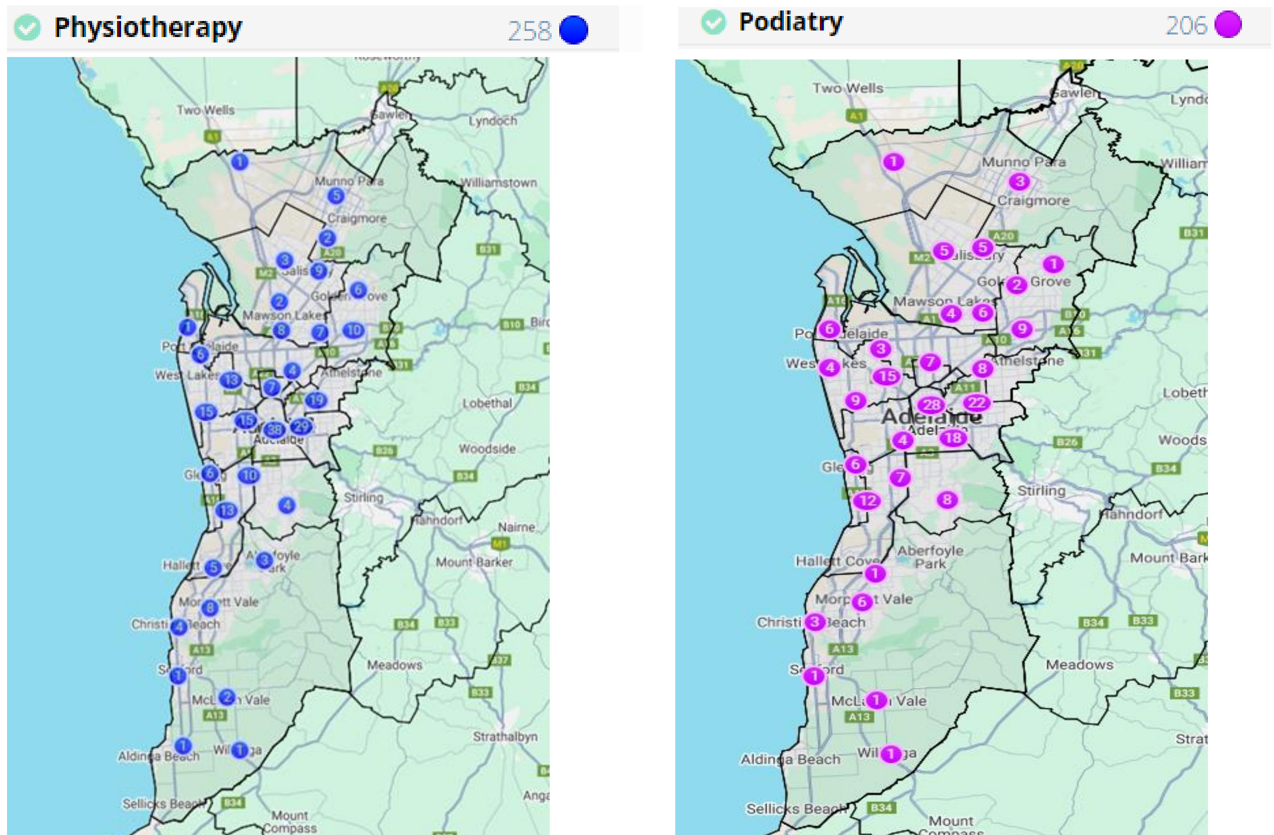
Aboriginal and Torres Strait Islander health practitioners

Aboriginal employment in the health sector is a key enabler in improving Aboriginal population health, yet Aboriginal people remain under-represented (Health Performance Council (HPC) 2017). Aboriginal health practitioners are a distinct class of registered health professionals, providing clinical and primary care for Aboriginal people, their families and community groups (Health Performance Council (HPC) 2017).

In 2022 there were 35 Aboriginal and Torres Strait Islander health practitioners working in the region; a slight decrease from 38 in 2021 (DOHAC 2024).

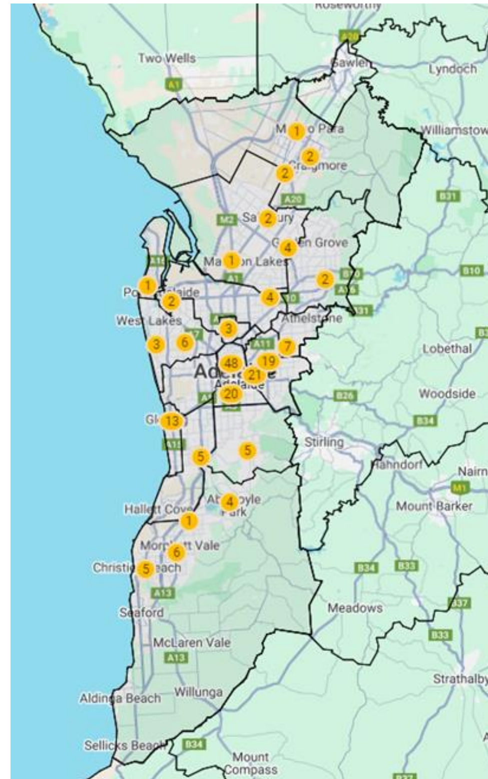
8.3.1 Workforce distribution

The population of the Adelaide PHN region, if divided by the three Local Health Network boundaries, is fairly evenly distributed with 30% of the population living in the southern region, 37% in the central region and 33% in the northern region (profile.id 2022). While some professions are distributed across the region in line with the population distribution, including general practitioners, community pharmacists, practice nurses and Aboriginal Health Practitioners, other professions including Psychologists, Dental Practitioners, Occupational Therapists, Podiatrists and Physiotherapists are not evenly distributed and tend to be centrally focussed (Department of Health (DoH) 2021c). See service mapping below for the year 2024.



Occupational Therapy 70

Psychology 187



8.4 Identified areas for improvement and current barriers

Since 2016, Adelaide PHN has conducted a range of consultations and workshops with our advisory groups, primary health care providers, clinicians from acute and specialist health services, consumers, carers, people with lived-experience, and representatives from peak-bodies to gain insights from, and about, the local health workforce for the purposes of the Needs Assessment. Other data utilised for the development of insights includes the outcomes of internal program reviews, feedback from internal subject matter experts, and statistics from a range of local and national data sources. The following presents a summary of the needs and issues identified from the above-mentioned sources.

8.4.1 Emerging issues for General Practitioner workforce

Adelaide PHN continues to hear from General Practitioners and/or General Practices that workforce shortages, inadequate MBS rebates and the limitations of the Distribution Priority Area (DPA) is having an impact on recruitment and retention of appropriate clinical staff. Further to this, time for GPs to be able to provide appropriate care is becoming more challenging as the workforce continues to decrease while the demand for GP services continues to remain steady or is increasing resulting in substantial pressure on the current workforce.

MBS continues to be at the forefront of discussions with a recent emergency summit being held by the RACGP which called for an immediate and substantial increase in Medicare patient rebates and the bulk-billing incentives (The Royal Australian College of General Practitioners 2022).

The RACGP, Australia's largest representative body for GPs 2024 survey highlights that almost 60% of all GPs surveyed were noted as saying that regulatory and compliance burden was the primary reason for them to cease working as a GP.

RACGP *2024 General Practice: Health of the Nation* report highlights concerning issues that have arisen, including:

- Being undervalued as a GP, indicated by 69% who took the survey
- Understanding and adhering to regulatory and policy challenges
- Managing workload
- Patient access to other medical specialists
- Maintaining income and
- Ensuring equitable access of high-quality care for all patients (RACGP 2024).

Key findings from the *General practice workforce report 2022* (Deloitte 2022) highlight that workforce shortages in some regions are already impacting on accessibility of services, timeliness of service and employment and retention. The report also forecasts a 37% deficit in workforce (in terms of GP supply and demand for services) in major cities in Australia. The modelling estimates that over the next decade (2021-2032) major cities will experience decreases in the supply of GPs (15% reduction in FTE) and GP clinical hours, while demand for GP services is expected to increase by 47% in the same period (Deloitte 2022).

The *National Medical Workforce strategy 2021-2031* (Australian Government Department of Health (DoH) 2022) notes that substantial barriers exist in the attraction, recruitment and retention of Aboriginal and Torres Strait Islander people in health workforce, including financial hardship, limited pathways across education and employment sector, lack of flexible and accessible learning opportunities, and racism and discrimination.

8.4.2 Emerging issues for Multi-Disciplinary Team (MDT) Care

In 2024 Adelaide PHN consulted on multi-disciplinary team care with the community, clinical and GP regional councils, and seven peak bodies representing physiotherapy, exercise physiology, podiatry, psychology and pharmacy including a total of 123 voices. Consultation sought to gain insight into people's knowledge and experiences of multidisciplinary care in primary care settings and what could be done to improve access to high quality, efficient and effective MDT services in the community (APHN 2024k).

There are over 128,500 people with multiple long-term health conditions in Adelaide PHN region which represents 10.1% of the population (Australian Statistics Bureau (ABS) 2022). Approximately 1,880 physiotherapists and 362 podiatrists are working in community and primary health care settings across Adelaide (DOHAC 2024). Commonly reported allied health disciplines in Medicare funded Chronic Disease Management Programme Team Care Arrangement are physiotherapy and podiatry (AIHW 2024j).

There were less than 137,200 GP Management Plan (GPMP) Medicare Benefits Schedule (MBS) services in Adelaide PHN at a rate of 96.6 per 1,000 people which is significantly lower than the Australian rate of 115.9 services per 1,000 (AIHW 2024j). Similarly for Team Care Arrangement (TCA) MBS services, there were less than 122,200 services at a rate of 85.6 per 1,000 people, which is significantly below the national rate of 98.6 per 1,000 (AIHW 2024j) .

The 65-74 age group have the greatest number of TCA items claimed within the 260 GP clinics of the Adelaide PHN region (Adelaide Primary Health Network (APHN) 2023b). Females had a higher rate in the age group 70-74 compared to males for TCA within the Adelaide PHN region (Adelaide Primary Health Network (APHN) 2023b). The top five local government areas within the Adelaide PHN region in 2023 for TCA billing were Salisbury, Onkaparinga, Playford, Port Adelaide and Charles Sturt delivered by 260 GPs in various clinics (Adelaide Primary Health Network (APHN) 2023b).

Emerging issues raised by the community include but are not limited to:

- An over reliance on the individual to navigate and coordinate their own multidisciplinary care.
- Lack of knowledge and awareness regarding multidisciplinary team care among community in relation to prevention, management and treatment of chronic conditions.
- Lack of affordable, accessible and flexible service options relating to multidisciplinary care for both community and health professionals.
- Access to culturally sensitive and culturally aware multi-disciplinary services and health professionals is limited.
- Lack of communication between health professionals in undertaking comprehensive multidisciplinary care.
- Lack of awareness of CDM, case conferencing and TCA MBS items across community and health professionals.
- Lack of awareness and understanding of the role and scope of different members of a multidisciplinary team.
- Lack of appropriate infrastructure and resources to support comprehensive multidisciplinary team care arrangements among health professionals.
- TCA uptake in the Adelaide PHN region is lower than the national average.

Below are some excerpts from community consultation carried out between June and July 2024.

"Under a team care arrangement, you must report back to the GP, sometimes it is noticeable that the GP does not read it. Too much paperwork".

"*The GP has to be good enough to understand that you need a team of specialists. You also have to ask, and it is about the condition you have".*

"*You are only provided a 10 min appointment, and the GP asks you to make another appointment to continue the discussion because you need a long appointment. And even during the long appointment, they are not spending the time to properly understand the issue."*

"*I keep the record of my consult, so I am able to provide it to my future GPs and specialists."*

"You have to call one by one to be able to find available specialists, some people don't have the capacity to do this. We need to think of people struggling with mental health, disabilities, elderly, etc."

"*I didn't know if I could choose a private or public specialist due to waiting list. I still feel very confused as the system is complex. Not even Australians understand the system, imagine migrants*" (APHN 2024l)**.**

8.4.3 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 (Australian Commission on Safety and Quality in Health Care (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 (Adelaide Primary Health Network (APHN) 2019d).

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 integration, care coordination, involvement of carers and family, and access to care. Person-centred care empowers 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 (Royal Australian College of General Practitioners (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 improve and care is coordinated and monitored for quality (Productivity Commission (PC) 2021).

Barriers to person-centred health care

Practitioner knowledge and skills

From the community and consumer perspective, the primary health workforce in Adelaide PHN region

often lacked the skills and knowledge to provide truly safe and quality health care services. Specific areas previously identified for improvement include disability, children's developmental and behavioural issues, and the needs of specific population groups including Aboriginal and Torres Strait Islander peoples, older people, and people from culturally and linguistically diverse backgrounds (Adelaide Primary Health Network (APHN) 2016b, 2017c, 2021a).

Previous consultations with Adelaide PHN Councils determined that the health literacy of health professionals was also a barrier to person centred health care (Adelaide Primary Health Network (APHN) 2016a, 2016c, 2016b, 2016d, 2017c, 2021a). Council members commented that improving health literacy would result in the following positive impacts:

- Increased access to appropriate, available services;
- Improved 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
- Improved 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 (Adelaide Primary Health Network (APHN) 2018c).

Primary health workforce knowledge on immunisation, myths and realities, funded and non-funded vaccines, vaccine catch-up programs and best approaches to vaccine hesitant people is often lacking. Access to education and mentoring from people with clinical expertise and quality communication and presentation skills is essential for primary health care providers. It is important they have greater understanding of the vast vaccination landscape across General Practice, Community Health, Local Council and Pharmacy as this informs patients of choice for opportunistic vaccination (Adelaide Primary Health Network (APHN) 2022c).

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 (Adelaide Primary Health Network (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 (Adelaide Primary Health Network (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-based falls and balance classes delivered 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-based 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 (Adelaide Primary Health Network (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 (Productivity Commission (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, instead value is based on time and complexity of the service provision rather than impact of care on health outcomes (Productivity Commission (PC) 2021). Whilst there are over 40 Medicare Benefits Schedule (MBS) payments dedicated to preventive health and management of specific chronic conditions available, they are inflexible, complicated and relatively narrow in their focus (Productivity Commission (PC) 2021).

8.4.4 Coordinated and integrated care

Adelaide PHN has commissioned several 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 (Adelaide Primary Health Network (APHN) 2021c, 2021f).

Formalised approaches to collaboration within teams and between organisations can significantly improve health outcomes. Collaborative models differ, reflecting local needs and operating environments but success commonly depends on dedicating time, space and resources for collaboration. This includes having designated workers and activities to promote collaboration, clear governance and accountability mechanisms, and funding contributions from all partnering organisations (Productivity Commission (PC) 2021).

Within general practice, collaboration can involve teamwork between a general practitioner (GP), nurse, allied health professionals and administrative staff. 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 (Adelaide Primary Health Network (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 (Productivity Commission (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 Primary Health Network (APHN) 2016a, 2016c, 2016d, 2016b, 2016e, 2021a).

For consumers, poor communication reduces transparency, restricts understanding, and results in consumers being unempowered (Adelaide Primary Health Network (APHN) 2016c, 2016d, 2016b, 2016e, 2021a).

The lack of timely clinical communication about patients and associated issues, and issues with general communication around service changes and availability were identified as a substantial barrier to collaboration between GPs and their acute sector colleagues (Adelaide Primary Health Network (APHN) 2019c, 2021a).

Previously and recently identified challenges of providing timely and quality clinical communication between providers included (Adelaide Primary Health Network (APHN) 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.

Furthermore, there are few financial incentives for collaboration, and barriers such as professional and information silos, strategic and policy misalignment, and funding constraints making it difficult for workers, managers and leaders to collaborate (Adelaide Primary Health Network (APHN) 2021a; Productivity Commission (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 underserviced groups and populations, at-home palliative care, services in the after-hours period, as well as overall preventive care and condition management (Adelaide Primary Health Network (APHN) 2018c, 2019c, 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 (Adelaide Primary Health Network (APHN) 2019c, 2021a). An excerpt from recent 2024 consultation is given as an example; ***“trying to find a specialist was difficult and when I found them, there was a long waiting list”*** (APHN 2024l)***.***

Access to services is also hampered by the lack of clear processes and follow-up once a person is discharged from a service (Adelaide Primary Health Network (APHN) 2019c).

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 (Adelaide Primary Health Network (APHN) 2019c, 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 (Adelaide Primary Health Network (APHN) 2019c, 2019e, 2021a).

8.4.5 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 LGBTIQA+ communities, have been raised in all Adelaide PHN consultations conducted between 2016 to 2024. The workforce-specific issues are summarised below.

Aboriginal and Torres Strait Islander people

In previous consultations, the lack of respect and sensitivity from service providers and the need to ensure that health services particularly Adelaide PHN commissioned services are culturally safe for Aboriginal people were reoccurring themes across multiple community consultations (Adelaide Primary Health Network (APHN) 2016d, 2016e, 2017b, 2018b, 2021a).

This finding was reiterated in the *Aboriginal and Torres Strait Islander Health Needs Assessment for the Adelaide Primary Health Network* (Hossain et al. 2022).

Consultations with Adelaide PHN membership groups and Aboriginal community stakeholders identified a range of workforce-related barriers that impact the delivery of, and access to, health services for Aboriginal people (Adelaide Primary Health Network (APHN) 2016a, 2016b, 2021a).

They included financial barriers; limited cultural sensitivity and safety; poor perceptions about care and experiences of racism; poor support, communication and coordination between services; long wait times, and poor follow up.

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

- Being treated with dignity and respect and without prejudice;
- Providers that can address the specific needs of Aboriginal and Torres Strait Islander people;
- Well-coordinated holistic approach to service delivery;
- 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 Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2021-2031 identifies the following areas of focus to improve services for Aboriginal and Torres Strait Islander people (DoH 2022):

- Aboriginal and Torres Strait Islander people are represented and supported across all health disciplines, roles and functions.

- The Aboriginal and Torres Strait Islander health workforce has the necessary skills, capacity and leadership across all health disciplines, roles and functions.
- Aboriginal and Torres Strait Islander people are employed in culturally safe and responsive workplace environments that are free of racism across health and all related sectors.
- There are sufficient numbers of Aboriginal and Torres Strait Islander students studying and completing health qualifications to meet the future health care needs of Aboriginal and Torres Strait Islander peoples.
- Aboriginal and Torres Strait Islander health students have successful transitions into the workforce and can access clear career pathway options.

Culturally and linguistically diverse communities

Key stakeholders representing the multicultural sector, from primary health care and research backgrounds 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 Primary Health Network (APHN) 2017d, 2017c, 2021a, 2022a). Consultations done in 2024 also indicated that language barriers remain a challenge to accessing primary health care. An except below from the community conversations is provided as an example:

"…. attended doctors in Spanish, travelling long distances to see them as they feel these doctors understand the language…."(APHN 2024l)**.**

In addition, 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 (Australian Institute of Health and Welfare (AIHW) 2017).

Lesbian, gay, bisexual, transgender, intersex, queer and asexual + (LGBTIQA+) communities

In previous Adelaide PHN consultations, several workforce-specific barriers impacting on the accessibility, appropriateness and effectiveness of primary health care in our region were raised by members of the LGBTIQA+ community. Specifically, it was identified that 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, 2024).

These issues are reflective of national and international research (Australian Government Department Health 2019; Mullens et al. 2017; South Australian Rainbow Advocacy Alliance (SARAA) 2019; Penelope Strauss et al. 2017; Waling et al. 2019; Strauss et al. 2017).

Fear of and experiences of stigma, abuse and discrimination are reoccurring issues impacting access to primary health services identified in recent consultations with Adelaide PHN Councils and stakeholders (Adelaide Primary Health Network (APHN) 2020a, 2022a; Health Consumers Queensland 2022). Below are few excerpts from the 2024 consultation with LGBTIQA+ communities on experiences accessing multi-disciplinary team care services:

"First endocrinologist was abusive, put in a complaint to AHPRA."

"Specialists do not want to consider the possibility of Intersex and will look for other much less plausible explanations" (APHN 2024l)***.***

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

8.4.6 Continuous quality improvement to improve health outcomes

The use of data to support and inform continuous quality improvement in general practice is supported nationally (Department of Health (DoH) 2021d). Monitoring the quality of care is central to person-centred care, and data driven improvement is one of the four foundational elements of High-Performing Primary Care (Bodenheimer et al. 2014).

In 2022/2023, 90% of practices in our region participated in the PIP QI (Adelaide Primary Health Network (APHN) 2023d) incentive payment made 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.

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 (Adelaide Primary Health Network (APHN) 2018c, 2021c).

8.4.7 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 when delivering 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 (Department of Health (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 (Productivity Commission (PC) 2021).

Adelaide PHN, and all PHNs, have a responsibility to contribute to the provision of a skilled primary health care workforce which meets the needs of the community, the health care system and changing models of care through supporting health care providers to improve their skills.

The GP Roundtables held in 2018-2019 identified that general practitioners require education, training and business support for them and their practice teams. Further interrogation of the information gathered at the Roundtables, and additional information from the Adelaide PHN Council members highlighted specific areas of workforce support and development (Adelaide Primary Health Network (APHN) 2019a, 2021a):

- Future and reforms
  - Information on State and Commonwealth initiatives
  - Vision for general practice and primary health care
  - New models of care and innovation / disruption

- Professional development
    - Education and training for general practices teams, including GPs, PMs, PNs and front of house staff
    - GP only networking
    - Access to quality resources and development opportunities in local areas, via webinars
- Working together
    - Team-based care between health care providers (including but not limited to general practice, nursing, pharmacy, allied health, mental health providers), both primary and tertiary, public and private
    - Relationships with other organisations – GP bodies, LHNs, NGOs.

Immunisation

Australia's national aspirational immunisation coverage target is 95% for children at 5 years of age. Reaching this aspirational target will give Australia enough herd immunity to stop the spread of measles and other vaccine-preventable diseases. Currently at PHN-level, Adelaide PHN report that 95% of 5-year-old children are fully immunised and 95% of Aboriginal and Torres Strait Islander children are fully immunised at 5 years of age (DOHAC 2023) (Department of Health and Aged Care (DOHAC) 2022c).

General Practice Nurses (GPNs) are an integral part of immunisation program service delivery. According to the NCIRS Annual Immunisation Coverage Report (2021), 85% of childhood immunisations are delivered through General Practice in South Australia, with nurses taking responsibility for administering many of the vaccines. Additionally, Local Council Immunisation Services provide the second highest number of childhood vaccines, and almost all adolescent vaccines. It is important for GPNs and Council Immunisation Nurses to be equipped with sufficient knowledge of the immunisation program recommendations to provide appropriate education to patients and opportunistic intervention (Halcomb and Hickman 2016).

According to the Australian Nursing and Midwifery Federation, nurses have a professional responsibility to promote the benefits of immunisation to inform decision making, provide evidence-based information, understand how to respond to myths and answer questions professionally and confidently and to advocate for populations and communities who face barriers to accessing vaccines (Australian Nursing & Midwifery Federation 2020).

It has taken over two decades of assisting General Practices to achieve this high immunisation coverage, and it is important for General Practices and Local Councils to develop sustainable systems for vaccinating children, adolescents, and adults which must be continued in the context of a changing health care environment. High vaccination coverage cannot be maintained with one-time or short-term efforts. This must be accompanied by a high-quality program where vaccines have been stored and administered according to best practice by providers who have the required skills, confidence and competence.

Immunisation programs will continue to expand and become more complex as more vaccines are developed and improved vaccines replace existing vaccines, ultimately resulting in schedule changes. Ongoing support for General Practices and Local Councils to develop and implement strategies to increase and sustain vaccination coverage is necessary to create lasting, effective immunisation delivery systems. General Practice Nurses and Local Council Nurses will continue to require support, mentoring, education and training to confidently provide a safe, efficient and effective vaccine program. As the Adelaide PHN has a broad lens over the entire vaccine landscape, it is well positioned to ensure quality and timely immunisation support and education are available.

8.4.8 Living with COVID-19 and Long Covid

Long COVID or post-acute COVID-19 is a new chronic condition that has emerged since the start of the COVID-19 pandemic in 2019; it is estimated to affect between 5–10% of COVID-19 cases. Long COVID refers to the long-term symptoms that some people experience after they have had a COVID-19 infection (DOHAC 2024b) . Common symptoms can include fatigue, cough, breathlessness, joint or muscle pain, chest pain, change in sense of taste or smell, anxiety and/or low mood (Health Direct 2024) . Several studies have reported increased health-care use and costs as well as patient reports of limitations on their daily activities and a reduced quality of life (AIHW 2022) .

Adelaide PHN continues to support our local GPs, general practice staff, pharmacy, allied health and other primary health care providers working across Adelaide to better understand the strategy for living with COVID-19 in the Adelaide PHN region, to ensure providers adequately respond to local needs and utilise all available resources, including digital technologies, multi-layered workforces, local services and appropriate infection control policies and procedures. We need to maintain and adapt the systems and structures currently in place to continue to support the primary health workforce in preparedness to manage ongoing infection rates in the community, while maintaining appropriate access, healthcare services and models of care for all people living in the Adelaide PHN region.

8.5 Opportunities and priorities – Health Workforce

Table 16 summarises the priorities arising from the analysis of the health workforce needs identified in the Adelaide PHN region and the opportunities for how they will be addressed.

Table 16 Health Workforce Priority Statements for the Adelaide PHN, 2024

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Support practitioners to improve communication and build relationships with other health care providers	Health Workforce	Continuity of care	Adelaide PHN supports general practices and other health care providers to provide quality care to patients	• Adelaide PHN • Primary Health Care providers • SA Health • LHNs • Commissioned Service Providers
Support primary health care providers to adopt and implement appropriate infrastructure and resources to deliver patient-centred models of care **	Health Workforce	Care coordination	Adelaide PHN supports general practices and other health care providers to provide quality care to patients	• Adelaide PHN • Primary Health Care providers • SA Health • LHNs • Commissioned Service Providers
Primary health care providers are supported to improve their cultural competency and clinical skills to safely support the region's diverse population	Health Workforce	Appropriate care (including cultural safety)	Local Workforce has suitable cultural and clinical skills to address health needs of the Adelaide PHN region	• Adelaide PHN • Primary Health • Care providers • Education and training providers • Commissioned Service Providers
Develop and maintain the capacity and capability of the primary health care workforce to be flexible in a changing health landscape **	Health Workforce	Appropriate care (including cultural safety)	Adelaide PHN supports general practices and other health care providers to provide quality care to patients	• Adelaide PHN • Primary Health Care providers • SA Health • LHNs • AMA • RACGP

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Identify and support the capacity and capability of the Primary Healthcare Workforce to work with cohorts of patients in need of equitable access to healthcare services	Health Workforce	Appropriate care (including cultural safety)	Adelaide PHN supports general practices and other health care providers to provide quality care to patients	• Adelaide PHN • Primary Health Care providers • SA Health • LHNs • AMA • RACGP • GPEX • Department of Defence

** New priority added in 2024*

*** 2024 modified wording*

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 (Australian Digital Health Agency 2017).

In metropolitan Adelaide, Adelaide PHN has been advancing digital health transformation in the local healthcare system through the provision of education, training, and support; advocacy; partnership; and commissioned activities. Our efforts are building the digital health capabilities of the health workforce and encouraging and enabling general practices and other health care providers implement a number of national, state-based and other digital health initiatives such as My Health Record, Electronic prescribing, Telehealth, Secure messaging, Clinical extraction tools, and Electronic shared care planning tools.

9.1 Digital Health landscape

Primary health care providers in the Adelaide PHN region are reasonably well connected to digital health and actively participate in digital health initiatives. The following provides a snapshot of some of the digital health activities of primary health care providers, primarily general practices, in the region.

9.2 Digital Health Needs Identification

9.2.1 Summary of identified needs for Digital Health

Table 17 below summarises the health and service needs identified through the needs assessment process for the digital health priority area. The evidence against each of these statements is provided within this chapter.

Table 17 Summary of needs identified for Digital Health, 2023

Outcomes of the health and service needs analysis – Digital Health		
Identified Need	**Key issues**	**Evidence/Section**
Digital Health Use	• General Practitioners need support to maintain digital health knowledge base to ensure consistent use of digital health technology. • General Practitioners and patients need support to ensure correct, consistent, and fully functional use of digital health tools. • General Practitioners need support to navigate interoperable capacity in clinical systems to facilitate timely and efficient exchange of clinical information. • There are opportunities to educate patients and healthcare providers about the importance of consistent effective and quality communication, including use of digital systems, both with the patient and between health care providers • Care providers need support to ensure they have a clear understanding and capacity to respond to the impacts of digital health technologies on population groups to prevent adverse consequences. • General Practitioners need timely access to discharge summaries for General Practitioners.	9.3 Results of Digital Health 9.4 Clinical information systems and extraction tools
Digital Health Awareness	• Patients need support to raise their awareness of available training and education around digital technologies. • Health care professionals need support to increase their awareness of the digital health tools that are freely available for use by Health Care Professionals. • General Practitioners need support to raise awareness and understanding of Digital Health tools, including how these tools can create more efficiency for practices and assist with better patient experience.	9.3 Results of Digital Health 9.4 Clinical information systems and extraction tools
Digital Health User Preferences	• The general public, particularly vulnerable populations require a comprehensive/sound knowledge base in the use of telehealth. • Patients have would like a choice as to when they can use telehealth.	9.3 Results of Digital Health 9.4 Clinical information systems and extraction tools

9.3 Results of Digital Health consultations

In 2023, multiple consultation activities were undertaken in order to gain a greater understanding of the digital health needs of the Adelaide PHN population.

Digital Health Capability and Readiness Initiative

In April 2023, a Digital Health Capability and Readiness Initiative was undertaken to better understand the spectrum of digital health maturity across general practices in the Adelaide PHN.

Adelaide PHN engaged Semantic Consulting to deliver a Digital Health Maturity Assessment for general practices across the region. The purpose of the Digital Health Maturity Assessment was to better understand the spectrum of digital health maturity across general practice, in order to support a differentiated approach to digital health change and adoption based upon digital maturity.

Using a standard set of questions and an established scoring methodology a survey was sent to all practices in the region, although completion was optional. The survey was branded as the Digital Health Capability and Readiness Initiative and was typically completed by practice managers (or GPs in the case of solo GP practices). In addition, a webinar was held, during which a walkthrough of the survey was given, and practice managers given the opportunity to ask questions.

The survey was opened in early-March 2023, with the first results received the same day and the final survey results received on 17th April 2023. In total, 118 practices completed the assessment. Key themes that emerged from the consultation included:

- **Fax machine usage is high** – 115 practices (97%) are using a fax machine.
- **Little uptake of cloud-based practice management systems** – No practices have moved to cloud-based practice management systems such as Helix or MediRecords, and work is needed to encourage practices in this direction for security, interoperability and business efficiency reasons.
- **Facetime and Zoom continue to be used for telehealth** – Where practices use video-based telehealth, Facetime and Skype continue to be widely used, despite not being fit for purpose and lacking appropriate security for use in healthcare.
- **Work remains to drive the meaningful use of digital health solutions** – Whilst the availability of ICT infrastructure, technology and digital health solutions is reasonably good, considerable work remains to get practices using these existing solutions to full effect. The analytic dashboard tools will help with this process.
- **Critical work is required on cyber-security and disaster recovery** – Knowledge and practice regarding cyber-security and disaster recovery continues to be problematic and requires specific attention to address critical vulnerabilities.
- **Issues with sending patient information via email** – 63 practices (54%) send patient information via email either “Frequently” or “Occasionally”, despite the fact it is insecure and violates privacy law. Urgent work is required to address this and the medico-legal challenges that it raises.
- **Strong adoption of the My Health Record** – Adoption of the My Health Record is very good, with only 4 practices (3%) not using the My Health Record. However, work remains to increase the percentage of clinicians using the My Health Record within each practice.
- **Digital literacy amongst health providers remains a challenge** – Digital literacy amongst healthcare providers remains an ongoing challenge and is likely to be more of an issue than acknowledged in the survey.
- **GP digital literacy is lower than other roles within the practice** – The digital literacy of GPs is slightly lower than the digital literacy of practice managers, practice nurses and administrative staff.

- **Staff turnover is an issue for some practices** – 50 practices (24%) “Strongly agree”, “Agree” or “Neither agree nor disagree” that “The practice experiences high staff turnover which affects adoption and use of digital technologies”. This should be carefully considered when implementing new digital health solutions.
- **Many practices would like training and education on digital health** – Many comments refer to wanting more education/ training opportunities on digital health.

GP Council Meeting

Additionally, in August 2023, attendees at the Adelaide PHN GP Council meeting were asked for their feedback on the use of digital health technology, specifically telehealth. Comments from the nine participants were themed into the overarching areas of digital health awareness, digital health use and digital health user preferences. Some key points included:

- While telehealth is now part of core business, and telehealth guidelines exist there is limited knowledge of the guidelines and where to access them.
- There is a need for additional education to ensure that GPs are able to fully utilise the capabilities of their existing software and data and how best to identify areas of potential quality improvement.
- There is concern that telephone consultations more than 20 minutes are not funded as equally as video consultations.
- Equity is a consideration for some populations and the use of telehealth increases.

Digital Health Online Survey

To complement the opinions of GPs, a short, anonymous online survey for community members and other health professionals was distributed to obtain feedback on digital health awareness, use and preferences. There were 114 respondents who completed the online digital health survey (60 health professionals; 49 community members and 5 carers). Below is a high-level summary of responses received.

Of those respondents that answered the question related to identity:

- 17% identified as members of the CALD community
- 13% identified that they were living with a disability
- 8% identified as LGBTIQA+
- 2% identified that they were living with ***several*** chronic conditions

Overall:

- Over 70% of participants rated their confidence in using digital health tools with a score of 7 out of 10 or higher.
- Both Health Professionals and Carers and Community Members indicated that they prefer secure platforms to fax and/or email for the transfer of patient data.
- When a face-to-face visit is not appropriate or required, the majority would prefer a telehealth appointment via a phone call.
- Respondents noted they would like to see:
  - More information on where and how patient data is stored and used
  - Better adaption of digital health between GPs, specialists and hospitals
  - The use of secure referral and data sharing platforms
  - More information about digital health tools available and education about how to use them, particularly for CALD communities

Health Professionals:

- Are aware of and have used electronic prescriptions, scripts, electronic referrals, My Health Record and wearable devices for health tracking.
- Are not aware of PHN Exchange and Provider Connect Australia.
- Would prefer to upload patient prescriptions to an Active Script List.
- Noted peak professional organisations are their primary source of digital health information.

Carers and Community Members:

- Have used electronic prescriptions, online booking systems, My Health Record and wearable devices for health tracking.
- Are not aware of social prescribing platforms.
- Would prefer to receive prescriptions via a text message.
- Noted government websites such as SA Health are their primary sources of digital health information.

Digital Health Kitchen Table

Feedback was also received from community members via three 'Kitchen Tables' that were facilitated by Adelaide PHN Community Advisory Council members. Questions sought to gain insight into people's knowledge and experiences utilising digital health.

In total, 29 participants attended the three sessions in August 2023. A diverse group of community members attended including:

- People from culturally and linguistically diverse backgrounds;
- Veterans; and
- Youth.

Of those who stated their age and gender, the majority of participants were male and within either the 24 and under, or 61–80-year age groups. During the kitchen tables, five primary questions were asked relating to user preferences, how confident participants were with engaging with their care team via telehealth, a question about telehealth appointment guidance and preparation, the benefits of telehealth and their level of comfort receiving information about healthcare needs via. technology (e.g. text, over apps etc).

Digital Health Focus Areas

The responses from all consultation activities undertaken in 2023, were themed and grouped under the focus areas of digital health awareness, digital health use and digital health user preferences (Table 18). Five statements under each area were then voted on a prioritisation session that was held with Adelaide PHN council members in September 2023.

Table 18 Focus Areas and Key Issues: Digital health

Focus Area	Key Issues Identified: 2023 Digital Health Consultations
Digital Health Awareness	• There is a lack of awareness of available training and education around digital technologies for patients. • There is a lack of awareness of the digital health tools that are freely available for use by Health Care Professionals • There are gaps in the knowledge base of the general public, particularly vulnerable populations, in the use of telehealth. • There is a lack of awareness of telehealth use in the community. • There are concerns with the transfer of patient data through unsecure channels.
Digital Health Use	• There is a lack of awareness of available training and education around digital technologies for patients. • There is a lack of awareness of the digital health tools that are freely available for use by Health Care Professionals • There are gaps in the knowledge base of the general public, particularly vulnerable populations, in the use of telehealth. • There is a lack of awareness of telehealth use in the community. • There are concerns with the transfer of patient data through unsecure channels
User Preferences	• Patients would like a choice as to when they can use telehealth. • Telehealth may exacerbate social isolation among some population groups. • There is concern amongst patients that non-verbal cues and physical symptoms may be missed during telehealth consultations. • Telehealth isn't seen as a reliable option when face-to-face visits are not possible by some population groups and health professionals.

	• There may be an overreliance by patients on face-to-face consults

9.4 Clinical information systems and extraction tools

Primary health care services in the Adelaide region use a wide range of clinical information systems to collect, store and manage data that supports patient care, operational management, and quality improvement. In 2022/23, 100% of the general practices in the region are computerised and use clinical information systems, the most common being *Best Practice (55.6%), Medical Director (32.6%)*, and *Zedmed* (8.7%). (Adelaide Primary Health Network (APHN) 2023d)

Many practices are using clinical auditing tools to analyse their patient data to improve quality and safety. Approximately 82% of Adelaide PHN practices have been issued PenCS licences. (Adelaide Primary Health Network (APHN) 2023e)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 2022/2023, 90% of practices in our region participated in the PIP QI (Adelaide Primary Health Network (APHN) 2022f) (Adelaide Primary Health Network (APHN) 2023b).

In August 2024, Adelaide PHN made the decision to shift to Primary Sense, a clinical decision support, population health management and data extraction tool that analyses and manages general practice data in a confidential way. Primary Sense will further enhance Adelaide PHNs data analytics capabilities and enable practices to better identify at-risk populations and implement targeted interventions using the John Hopkins AGG risk stratification tool and real time data in prompts and alerts. This transition will ultimately drive improvements in patient care and health outcomes across the Adelaide region.

9.4.1 My Health Record

My Health Record is Australia's national electronic health record. My Health Record is an online repository for documents and data containing information about an individual’s health and healthcare. My Health Record can be easily accessed by individuals, doctors, specialists or hospitals, allowing timely access to health information to assist decision making, diagnosis and care coordination. The information can come from various sources including the consumer themselves, their healthcare providers and Medicare (My Health Record 2021).

Increasing the use of My Health Record within our region remains a digital health priority for Adelaide PHN, and we are working closely with the Australian Digital Health Agency, and the South Australian Local Health Networks to connect specialists, general practices, residential aged care homes and community health organisations to My Health Record.

As of September 2023, 344 pharmacies in the region had registered for the My Health Record (Adelaide Primary Health Network (APHN) 2023f) 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 202 specialists registered for the My Health Record.

9.4.2 Telehealth

Telehealth has the potential to solve not only issues arising during pandemics, but also improve access to healthcare for vulnerable and underserved populations. The use of telehealth could also make the system more responsive and flexible to patients’ needs. At the onset of COVID-19 in March 2020, new telehealth items were funded from to support a virtualised treatment approach to help

protect patients and health providers from COVID-19 by removing the need for physical meetings (Scott 2021).

In January 2022, the MBS telehealth items introduced on a temporary basis in response to the COVID-19 pandemic were made permanent by the Australian Government (Department of Health and Aged Care (DOHAC) 2022f). The decision by the Commonwealth Government to make the telehealth MBS items permanently available is aimed at improving access to healthcare particularly for vulnerable and underserved populations.

In the reporting period of July 2022 - June 2023, there were a total of 722,291 cross views of data in the My Health Record (MyHR). This included 341,274 documents viewed which were uploaded by other HPI-Os and 381,017 documents uploaded which were viewed by other HPI-Os. This is a substantial increase in activity from 288,533 total cross views recorded in FY 21/22 (representing a 150% increase) for each of the three measures since the last reporting period (Adelaide Primary Health Network (APHN) 2023f).

While continuing to promote the use of telehealth by General Practitioners, there is scope to further expand Adelaide PHN's Telehealth Access program to other healthcare professional and organisations. In December 2021, Primary Health Networks received funding to support the Australian Government's response to the Royal Commission into Aged Care Quality and Safety. A cardinal activity under PHN's Aged Care Schedule is to support Residential Aged Care Homes (RACHs) to increase availability and use of telehealth care for aged care residents. As of September 2023, 86 out of the 150 RACHs have agreed to participate in Adelaide PHNs telehealth in RACH program to fund appropriate telehealth facilities and equipment to enable their residents to virtually consult when needed with their primary health care professionals, specialists, and other clinicians.

9.4.3 Secure Messaging

Secure messaging is a key aspect of the National Digital Health Strategy and is a core foundational capability required to enable interoperability and safe, seamless, secure, and confidential information sharing across all healthcare providers. Secure Message Delivery (SMD) is an approach to digital health communication using widely supported information technology standards (Australian Digital Health Agency 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 (Australian Digital Health Agency 2020).

Since mid-2020 Adelaide PHN has been supporting health providers in the region to adopt secure messaging services through a collaborative project with SA Health. According to the March 2022, SMD adoption report from Digital Health SA, 82% of 504 eligible GPs across SA are confirmed to have successfully adopted SMD up from 78% in December 2022. The rate of adoption for general practices within the Adelaide PHN region followed a similar trend with 324 of 337 (96%) general practices in the metro area having SMD activated in their Clinical Information Systems to receive specialist letters and discharge summaries from the hospitals in South Australia (Adelaide Primary Health Network (APHN) 2023g).

HealthLink is the digital asset of choice for secure messaging for SA Health as well as for primary health care providers with over 320,050 referral letters sent and received within SA as of. Our internal mapping of secure messaging applications used by primary care providers also corroborates the dominance of HealthLink as the preferred platform for secure message delivery. According to Adelaide PHN data retrieved as of October 2023, General Practices stated that they were set up with

one or more secure messaging platforms, with 63% of General Practices having HealthLink software, 26% with Argus software, 18% with Medical Objects software and 16% with ReferralNet software (53 of 330) (Adelaide Primary Health Network (APHN) 2023f).

To further normalize the use of interoperable Secure Messaging systems across the region, there is need for Adelaide PHN to provide guidance to healthcare organisations, including General Practices, on how to set up robust governance, policies, and processes that encourage the consistent use of these channels by healthcare providers and their staff.

9.4.4 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 (Australian Digital Health Agency 2021).

Throughout 2020/21 Adelaide PHN engaged with general practices and over 300 pharmacies to offer support specific to fast-track implementation of the national electronic prescribing program (APHN 2021f). As of October 2023, 80% of General Practices (i.e. 271 of 337) reported that they were participating in Electronic Prescribing (Adelaide Primary Health Network (APHN) 2023f).

Identified areas for improvement and current barriers

Since 2016, Adelaide PHN has sought advice and feedback via surveys, consultations and workshops from our Clinical, Community Advisory and Network Leadership groups, primary health care providers, and clinicians from acute and specialist health services about the digital health needs in the region. A summary of the consultations undertaken in 2023 in the digital health space are summarised above in section 9.2. These findings, combined with outcomes of internal program review processes, intelligence from internal subject matter experts, and statistics from a range of local and national data sources also provide insights about the digital health needs in the region. The following section provides a summary of the key issues and needs identified.

9.4.5 Use of digital health tools

Although the use of digital health tools amongst health care professionals has increased over the past few years, there are still areas of opportunity to increase awareness and the appropriate use of digital health tools. Kitchen table participants also highlighted that there is a lack of awareness of available training and education around digital technologies use for patients.

From previous analysis of secure messaging vendor data (APHN 2020e), we are aware that most General Practices and Specialists have the HealthLink Secure Messaging System, however only 27% of General Practice and 50% of Specialists use this platform to send information out. Of the survey respondents from General Practice, 43% reported that they do not send anything via Secure Messaging, and 10% were unaware that their practice had access to the HealthLink platform.

While secure messaging overall has increased, certain components such as eRequesting, a process that transfers requests from general practice clinical information systems directly to the pathology or diagnostic imaging provider via secure electronic communication, need more attention. In September 2022, 43.3% of general practices had eRequesting for Clinpath and or Australian Clinical Labs enabled (Adelaide Primary Health Network (APHN) 2022f). Similarly, in 2022 the number of cross views of data in the My Health Record (MyHR) has increased substantially (approximately 150%) since 2020/2022 (Adelaide Primary Health Network (APHN) 2022g).

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 (Adelaide Primary Health Network (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 previous consultations and workshops with our membership groups, consumers, clinicians, and providers (Adelaide Primary Health Network (APHN) 2016a, 2016d, 2016b, 2019c, 2019e, 2021a).

However, a lack of timely and quality clinical communication between person, primary and acute health services is an issue that has been consistently raised in consultations and workshops with our membership groups, consumers, clinicians, and providers (APHN 2016a, 2016b, 2016c, 2019a, 2019b).

The lack of timely clinical communication about patients and associated issues, and issues with general communication around service availability and changes was identified as a substantial barrier to collaboration between GPs and their acute sector colleagues (Adelaide Primary Health Network (APHN) 2019c, 2021a). This issue was also identified in the consultations undertaken in 2023. 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 (The Commonwealth Fund (TCF) 2019). This need can be addressed by continued improvements in the appropriate and consistent use of digital health technologies, like secure messaging and My Health Record, to send timely discharge summaries, and will support patient transitions between hospital care to their general practitioner and care team.

9.4.6 Awareness of digital health tools and understanding of benefits

Responses from Digital Health Capability and Readiness Initiative indicate that there is little uptake of cloud-based practice management systems. Where practices use video-based telehealth, Facetime and Skype continue to be widely used, despite not being fit for purpose and lacking appropriate security for use in healthcare (Adelaide Primary Health Network (APHN) 2023h).

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 also a barrier identified in the Adelaide PHN region. Whilst the availability of technology and digital health solutions is reasonably good, considerable work remains to get practices using these existing solutions to full effect.

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 (Australian Digital Health Agency 2020).

Previously, 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) (Adelaide Primary Health Network (APHN) 2018c).

Responses from the community also indicated that while aware of digital health technology, there were many opportunities and a desire for additional education about their use.

Both the GP and community feedback also indicated there were opportunities for education related to cyber security and digital safety.

9.4.7 User preferences

It was noted through the consultations that the general public, particularly vulnerable populations require a comprehensive/sound knowledge base in the use of telehealth. Community members and GPs also indicated it is important for patients to have a choice as to when they can use telehealth (Adelaide Primary Health Network (APHN) 2023h, 2023i, 2023j, 2023k).

9.4.8 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 (Adelaide Primary Health Network (APHN) 2018c, 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 (Adelaide Primary Health Network (APHN) 2019e). Results from the Digital Health Capability and Readiness Initiative were consistent with these previous findings, and some practices also highlighted that high staff turnover affects adoption and use of digital technologies.

9.4.9 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 (Adelaide Primary Health Network (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 (Royal Australian College of General Practitioners (RACGP) 2020).

Interoperability, set up time, and cost were also identified by general practices as barriers to them effectively implementing digital secure messaging services (Adelaide Primary Health Network (APHN) 2020d). This is reflective of the barriers identified for general practices in the *ADHA roadmap* (2020) – the high cost of investment in expensive technologies, systems and support, and lack of education and training for practice staff in using technology.

According to the MBS data for 2021/22, South Australia ranked 5th of 8 states and territories in Australia in terms of MBS Telehealth item claims despite the telehealth policy changes during and after COVID-19 (Department of Health and Aged Care (DOHAC) 2022g). De Guzman (2022) argues that although permanent funding is necessary for telehealth sustainability, other factors such as presence of time pressures, consumer preferences and perceived capacity to provide high-quality patient care virtually must be considered to encourage long-term telehealth adoption and sustainable change in primary care in Australia. White (2022) supports the view that more needs to be done to improve telehealth going forward. Specifically, there is a need to effectively train clinicians to competently utilize and be confident using this telehealth and educate patients on necessary skills and etiquette.

9.5 Opportunities and priorities – Digital Health

Table 19 summarises the priorities arising from the analysis of digital health needs identified in the Adelaide PHN region and the opportunities for how they will be addressed. One additional priority was identified as a result of consultation activities undertaken in 2023.

Table 19 Digital Health Priority Statements for the Adelaide PHN, 2023

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Primary health care providers have access to resources and support to improve digital health literacy	Digital Health	Practice support	Health care providers are aware of the digital health systems and technologies	• Adelaide PHN • Primary Health Care providers • ADHA • SA Health • LHNs
Primary health care providers are supported to adopt and fully implement digital health technologies	Digital Health	System integration	Adelaide PHN supports health care providers to use digital health systems to improve patient care and communication**	• Adelaide PHN • Primary Health Care providers • ADHA • SA Health • LHNs
Primary care providers are supported to use digital health tools to share clinical information and improve timeliness of communication	Digital Health	Continuity of care	Adelaide PHN supports health care providers to use digital health systems to improve patient care and communication**	• Adelaide PHN • Primary Health Care providers • ADHA • SA Health • LHNs
Primary care providers are supported to use digital health tools that improve safety and quality of care	Digital Health	Safety and quality of care	Digital health enables better coordinated care and better informed treatment decisions	• Adelaide PHN • Primary Health Care providers • ADHA • SA Health • LHNs

Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Residents within Adelaide PHN are informed and enabled to proactively utilize digital health technology with their care providers*	Digital Health	User Preferences	Patients and carers are confident in the use of digital health resulting in good experiences and improved health outcomes	• *Patients and carers* • *Adelaide PHN* • *Primary Health Care providers* • *ADHA* • *SA Health* • *LHNs*

**New priority added in 2023*

*** 2023 small update to wording*

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