



Australian Government

Department of Health

phn

An Australian Government Initiative

Primary Health Network Program Needs Assessment Reporting Template

This template may be used to submit the Primary Health Network's (PHN's) Needs Assessment to the Department of Health (the Department) by **15 November 2019**.

Name of Primary Health Network

Perth North

When submitting this Needs Assessment to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Report has been endorsed by the CEO.

Instructions for using this template

Overview

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

The template includes sections to record needs for:

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

Further information for PHNs on the development of Needs Assessments is provided on the Department's website (www.health.gov.au/PHN), including the *PHN Needs Assessment Guide*, the Mental Health and Drug and Alcohol PHN Circulars, and the Drug and Alcohol Needs Assessment Tool and Checklist (via PHN secure site).

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

Format

The Needs Assessment report template consists of the following:

- Section 1 – Narrative
- Section 2 – Outcomes of the health needs analysis
- Section 3 – Outcomes of the service needs analysis
- Section 4 – Opportunities, priorities and options
- Section 5 – Checklist

PHN reports must be in a Word document and provide the information as specified in Sections 1-5.

Limited supplementary information may be provided in separate attachments if necessary. Attachments should not be used as a substitute for completing the necessary information as required in Sections 1-5.

While the PHN may include a range of material on their website, for the purposes of public reporting the PHN is required to make the tables in Section 2 and Section 3 publicly available on their website.

Submission Process

The Needs Assessment report must be submitted to the Department, via a mechanism specified by the Department, on or before **15 November 2019**.

Reporting Period

This Needs Assessment report will be for a three-year period and cover 1 July 2019 to 30 June 2022. It can be reviewed and updated as needed during this period.

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SECTION 1 – NARRATIVE

Needs Assessment Process and Issues

The Perth North Primary Health Needs Assessment consolidated the key themes and issues of Western Australian's population health and service provision needs. A consultation plan was developed and included internal and external consultation processes to source qualitative data. This included the development of a digital portal for the collection of qualitative information from consumers and service providers. A wide range of data sources, available publicly or on request from data custodians informed the Needs Assessment. Access to improved data sets in the 2018 Needs Assessment included improved sources for health workforce data, admitted and emergency department hospital admissions and alcohol and other drug prevalence and service utilisation. Please note that for confidentiality reasons, some data sources have been removed from the public-facing version of the Needs Assessment.

Selection of Topics

Identified Health Needs (HN) and Service Needs (SN) align with the Primary Health Network Pillars.

Health Needs for each Pillar include:

- General Population Health: HN1.1 to HN1.9.
- Aged Care: HN1.3 including mental health HN2.9.
- Mental Health: HN2.1 to HN2.9.
- Alcohol and other drugs: HN3.1 to HN3.12.
- Aboriginal health needs HN4.1 and HN4.7

The Health Workforce Pillar included service needs for:

- General Population Health: SN1.1 to SN1.11.
- Aged Care: SN1.3 including mental health SN2.9.
- Mental Health: SN2.1 to SN2.10.
- Alcohol and other drugs: SN3.1 to SN3.8.
- Aboriginal Health: SN4.1 to SN4.8.

The Digital Health Pillar is an enabler of improved service access, service needs for this Pillar include SN1.11.

Data Sources

All topics covered were informed by a broad review of publicly available data sets, data obtained from selected Western Australian government agencies, a review of the research literature, as well as internal and external consultation. The following are additional considerations of the data for each topic.

Note: Information in red text is sourced from confidential data sources and is in-confidence. These data cannot be released to external agencies. Please visit www.wapha.org.au to obtain a public version of this document.

General population health

A digital survey "A snapshot view of primary care" collected qualitative data regarding the barriers to accessing health services by community members. The information collected from the survey was used in Section 3 - Outcomes of the service needs analysis. Localised qualitative information was sourced

through three Working Groups, the Metropolitan Clinical Council, the Metropolitan Consumer Advisory Council and other reports and consultations undertaken by the Primary Health Network as part of normal business.

The development of the Needs Assessment was guided by an internal Steering Committee and included an extensive internal review process. As part of this process, a decision was made to remove specific reference to humanitarian migrants. Instead, the health and service needs of humanitarian migrants has been included within the broader discussions of Culturally and Linguistically Diverse populations and other vulnerable groups in HN 1.2.

Mental health

The Mental Health Needs Assessment supports priorities from the Fifth National Mental Health and Suicide Prevention Plan such as integrated planning and service delivery, suicide prevention, treatment coordination for severe and complex mental illnesses, and reduction of stigma and discrimination. Data were obtained from a range of sources including Medicare Benefits Scheme, mental health-related hospitalisations (AIHW), suicide data (ABS), and the Public Health Information Development Unit (PHIDU), as well as qualitative data provided in stakeholder consultations. In addition, the Integrated Atlas of Mental Health and Alcohol and Other Drugs and the [redacted] tool were used to help identify gaps in service provision across Perth North PHN.

Alcohol and other drugs

The Alcohol and Other Drug section of the Needs Assessment has made use of national reports and studies on alcohol and other drug use in Australia and the impact of alcohol and other drugs on health. This general information has been complemented where possible with more detailed place-based hospital, emergency and alcohol and other drug treatment data. Stakeholder feedback was also used to guide the investigation into alcohol and other drug related health and service needs.

Aboriginal Health

The gap in health outcomes between Aboriginal and non-Aboriginal Australians is well documented, particularly around life expectancy, chronic disease prevalence and potentially preventable hospitalisations. Where data was available this Needs Assessment has described the specific health and service needs of Aboriginal West Australians. Specific priorities have been developed to address the need for a culturally appropriate, holistic and integrated approach to Aboriginal health and wellbeing. Where Aboriginal specific data has not been available, Aboriginal populations have been included in the analysis of total populations. All identified priorities in this Needs Assessment will also apply to the Aboriginal populations within the identified priority locations.

Additional Data Needs and Gaps

Where possible, health and service needs analysis has been undertaken at Statistical Area Level 3 (SA3s). SA3s are designed to provide a regional breakdown of Australia. They generally have a population of between 30,000 and 130,000 people. In the major cities, SA3s represent the area serviced by a major transport and commercial hub and often closely align to large urban Local Government Areas. Throughout the Needs Assessment, comparisons have been made between state and national rates and Perth South and Country WA Primary Health Networks administered by the WA Primary Health Alliance. Where possible data has been tested for statistical significance.

It should be noted that despite consolidating data from a range of sources, gaps remain in data collection and availability regarding health and service needs within Perth North PHN. Importantly, WA Primary Health Alliance highlights that an absence of data does not reflect an absence of a health or service need and, through consultation with local stakeholders, it is hoped that needs have been presented in this Needs Assessment as accurately as possible. Further evidence should continue to be collected to identify areas and populations of need within Perth North PHN.

General population health

The prison population is known to have poorer physical and mental health when compared to the general population. Within population data sets that are used throughout this Needs Assessment, people who are incarcerated are included in the population where the prison is located. It is not possible to exclude prisoners from population datasets, so it is likely that areas with prisons will show high rates of health indicators commonly experienced by prisoners. In Perth North PHN, there are prisons located in Chidlow and Swan.

Comorbid chronic conditions have been highlighted as an area of health and service need throughout discussions with stakeholders. Populations living with multiple, long-term conditions have poorer overall health outcomes, and higher rates of engagement with health services and health care costs, including potentially preventable hospitalisations. Data collections linking comorbid chronic conditions are limited and the only available sources identified were health surveys and literature reviews. Additionally, stakeholders highlighted an observed relationship between mental health conditions and chronic conditions, again limited data sources were available to explore this observation.

Adequate levels of health literacy within the community was highlighted as a mechanism to improve self-management of a health condition and improve health outcomes. Data for health literacy levels in Western Australia and across Perth North PHN is not available. This has meant that specific sub-regions where low levels of health literacy may be contributing to poor chronic disease self-management are not identified.

Mental health

We note that there are limitations in using Medicare Benefits Scheme (MBS) data to capture mental health-specific service utilisation, particularly for non-government organisations that do not use MBS billing and for general practitioners, who may bill against general MBS items.

Alcohol and other drugs

There is limited access to place-based information about alcohol and other drug use, health needs and service utilisation. WA Primary Health Alliance staff consistently note the need for finer grained place-based information for each PHN (e.g. to a SA3 or even SA2 level), but this is rarely available. For example, the alcohol and other drug treatment service data is only released by the Australian Institute of Health and Welfare (AIHW) at a PHN level.

Aboriginal Health

The interpretation of Aboriginal health data was limited by the small population sizes within Statistical Areas. Aboriginal data is commonly presented in different Statistical Areas, known as Indigenous Areas (IARE), or as the general Greater Perth (Perth North and South PHNs) and Rest of WA (Country WA PHN). Small population sizes can produce unstable rates that can greatly fluctuate on an annual basis. Additionally, there are limitations in the accuracy of total number of Aboriginal people due to non-compliant participation in the census, lack of self-identification, plus the highly mobile nature of Aboriginal populations.

To ensure accurate statistical analysis of Aboriginal health and service need, the following data sets were excluded: avoidable mortality by cause, palliative care public hospitalisations. The under-identification of Aboriginal people within health data collections remains a limitation for data analysis. Several available data sets within this Needs Assessment did not include specific Aboriginal statistics for analysis, this included: cancer screening, childhood obesity, homelessness, potentially preventable hospitalisations and chronic disease risk factors.

SECTION 2 – OUTCOMES OF THE HEALTH NEEDS ANALYSIS

General Population Health

| Outcomes of the health needs analysis | | |
|---|--|--|
| Identified Need | Key Issue | Description of Evidence |
| HN1.1 Poor health outcomes in disadvantaged areas. | <i>Socio-economic factors including poor rates of educational attainment, financial and housing instability, and low rates of employment are associated with long-term physical and mental health problems.</i> | <p>Socio-economic Index for Areas (SEIFA) defines the relative social and economic disadvantage within a region. Indicators reflecting disadvantage include low income, low educational attainment, high unemployment, and reliance on welfare for income and housing support.</p> <p>Whole of PHN</p> <p><i>Socio-economic disadvantage for whole of population</i></p> <p>Despite above average rates of socio-economic advantage in the Perth North PHN (SEIFA 1,045) compared to Perth South PHN (SEIFA 1,020), Country WA PHN (SEIFA 983), state (SEIFA 1,022) and national averages (SEIFA 1,000), pockets within the PHN continue to experience high disadvantage. More than one in six (17%) of children in Perth North PHN live in single parent families, with 16% of families with children dependent on welfare.¹</p> <p>Place-based</p> <p><i>Socio-economic disadvantage for whole of population</i></p> <p>Areas of high socio-economic disadvantage are located in the Swan, Wanneroo and Stirling SA3 catchments. Swan has a significantly higher rate of unemployment (7%) and government support as a main source of income (24.1 ASR per 100). Stirling has significantly higher rates of unemployment (7%) and government housing (41%) while Wanneroo has significantly higher rates of welfare-dependent families (12%) and unemployment (8%).¹</p> |
| HN1.2 Vulnerable population groups need targeted support. | <i>People from minority groups can be more vulnerable to poorer physical and mental health.</i> | <p>People in vulnerable groups are more likely than the general population to experience poor health outcomes due to physical, social, and economic factors. Vulnerable groups include:</p> <ul style="list-style-type: none"> • Culturally and linguistically diverse (CALD) people • People who are homeless |

Outcomes of the health needs analysis

- People living with a severe disability
- People who care for someone with a disability
- People who are developmentally vulnerable
- People who are victims of domestic violence.

Whole of PHN

People born overseas

Close to one in five people in Perth North PHN was born in a non-English speaking country (188,694; 19%), which is significantly higher than the state (16%) and national (18%) averages. The top three countries of origin are India (2.1% of the PHN population), Vietnam (1.2%) and Italy (1.1%). More than one in ten residents born in a non-English speaking country have poor English proficiency (21,764), accounting for a higher proportion of the Perth North PHN population compared to the state average (2.3% vs 1.9%).¹

Disability and carers

In Perth North PHN, 3.9% of the population are living with either a profound or severe disability, while the proportion of carers (aged 15 years and over) who provide unpaid assistance to those with a disability is 9.8%.¹ Carers may experience a decline in their physical, mental and emotional health, and adverse financial and social impacts as a result of their care-giving responsibilities. Carers frequently experience physical pain, chronic conditions and use more prescription medications than the general population. Physical pain may be more prevalent in carers due to the physically demanding nature of some caring roles and a lack of time to seek treatment for themselves.^{2, 3}

Homelessness

In 2016, it was estimated that 2,719 people in Perth North PHN experienced homelessness. In this instance, 'homeless' includes⁴:

- Persons living in improvised dwellings, tents, or sleeping out
- Persons in supported accommodation for the homeless
- Persons staying temporarily with other households
- Persons living in boarding houses
- Persons in other temporary lodgings

Outcomes of the health needs analysis

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| | | <ul style="list-style-type: none"> • Persons living in ‘severely’ crowded dwellings. <p>Included within this category are 1,001 people who live in ‘severely’ crowded dwellings; this is defined as requiring at least four extra bedrooms to accommodate the people usually living there.⁴ The number of people living in ‘severely’ crowded dwellings was similar in Perth South PHN and in Perth North PHN.</p> <p>The Registry Week data collection asks people experiencing homelessness about their health on an annual basis. In WA, collections between 2010 to 2017 indicated that asthma, heat exhaustion and hepatitis C were the health conditions impacting most on people who were experiencing homelessness.⁵</p> <p><i>Developmentally vulnerable children</i></p> <p>The Australian Early Development Census (AEDC) measures the development of children across the nation during their first year of full-time school. Children’s development is measured in five domains:</p> <ul style="list-style-type: none"> • Physical health • Social competency • Emotional maturity • Language and cognitive skills • Communication and general knowledge. <p>The proportion of developmentally vulnerable children in Perth North PHN is similar to state and national rates, however, a number of sub-regions within Perth North PHN were significantly lower than the PHN rate.¹</p> <p><i>Domestic violence</i></p> <p>One in six Australian women and one in sixteen men (since the age of fifteen) have been subjected to physical and/or sexual violence by a current or previous cohabiting partner.⁶ Identified as being most at risk are⁷:</p> <ul style="list-style-type: none"> • Aboriginal women • Young women • Pregnant women • Women experiencing disabilities • Women experiencing financial hardships |
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Outcomes of the health needs analysis

- Women and men who experienced or witnessed abuse or domestic violence as children.

Domestic violence is one of the greatest health risk factors for Australian women aged 25 to 44. In 2011, it contributed to more burden of disease (the impact of illness, disability and premature death) than any other risk factor.⁷ Domestic violence is a leading cause of homelessness for women with children. In Australia during 2016 to 2017, approximately 72,000 women, 34,000 children and 9,000 men seeking homelessness services reported that domestic violence caused or contributed to their homelessness.⁷

Place-based

People born overseas

The areas with the highest proportion of residents born in non-English speaking countries include Bayswater-Bassendean (25%), Stirling (25%) and Perth City (24%). The proportion of residents with poor English proficiency is also high in these areas at 3.8%, 3.8% and 2.9% respectively.¹

Disability and carers

Bayswater-Bassendean (4.8%) and Stirling (4.3%) have significantly higher rates of people living with a profound or severe disability. The proportion of the population aged 15 and over providing unpaid care for someone with a disability is significantly higher in Cottesloe-Claremont (11%) and Mundaring (11%).¹

Homelessness

The highest number of people who are experiencing homelessness was estimated in 2016 to be in Perth City (886), Stirling (443) and Wanneroo (367). This includes those living in severely crowded dwellings Stirling (239), Wanneroo (232), and Swan (157).⁴

Developmentally vulnerable children

Mundaring (24%), Kalamunda (23%) and Swan (23%) had significantly higher percentages compared to the Perth North PHN for children scoring developmental vulnerabilities in one or more domains.¹

A consultation conducted in Midland in 2018 explored local young vulnerable mothers' perspectives, experiences and perceived barriers to using services. Barriers included lack of (or inconvenient) transport, lack of affordable services, services being located in hard to reach places, or difficulty finding parking or that when it was available, it was

| Outcomes of the health needs analysis | | |
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| | | sometimes expensive. Levels of cultural awareness among service providers impacted Aboriginal and CALD mother's access to services. ⁸ |
| HN1.3 Older people need targeted support. | <i>Older populations have higher prevalence rates of chronic conditions and exacerbations of their conditions, leading to ED presentations, potentially preventable hospitalisations and acute care.</i> | <p>Older adults are typically higher users of health services, as many health conditions and associated disabilities become more prevalent with age.⁹ A study including 6,200 adults in Western Australia identified some chronic conditions as two to four times more prevalent in people aged over 65 years compared to the entire Western Australia sample.⁹ People over the age of 65 years have the highest Potentially Preventable Hospitalisations (PPH) rates in each of the five key conditions reviewed by the National Health Performance Authority in 2015.¹⁰</p> <p>PPHs are hospital admissions that may have been prevented through the provision of appropriate preventative health interventions and early disease management (see HN1.9). Palliative and end of life care are likely to be an increasing burden on services as the older generation continues to grow.</p> <p>Whole of PHN</p> <p><i>Ageing population</i></p> <p>The proportion of residents aged 65 years and over in Perth North PHN (13%; 137,593) is similar to the state average (14%; 346,182). While the total population of older people is expected to increase to 201,407 by 2025, this represents approximately the same proportion of the total population.^{1,11}</p> <p><i>Palliative care</i></p> <p>More people are living longer with chronic life-limiting conditions; an estimated 30% of Australians aged 65 years and over live with three or more chronic conditions.¹² More serious life-limiting chronic conditions such as dementia, cardiovascular, respiratory diseases and cancers are also becoming more prevalent. When asked where they would prefer to die, most healthy Australians nominate their home. However, the statistics on place of death indicate that this is relatively uncommon; only 16% of people die at home, 20% of people die in hospices and 10% in nursing homes, while the remainder die in hospitals. This results in a high cost burden for the health system and potentially a poorer quality of death.¹³ In Australia, WA reported the lowest proportion of palliative care hospitalisations in public hospitals between 2015 to 2016.¹⁴ This low rate may be attributed to the higher proportion of palliative care services provided by the private sector and the availability of affordable non-government services.</p> <p>In Australia, WA is reported to have among the lowest rate of permanent residential aged care residents (11.1 per 100,000 vs national rate of 18) and palliative care-related prescriptions (1,546 per 100,000 vs national rate of 3,069).</p> |

Outcomes of the health needs analysis

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| | | <p>Despite this, the cost per patient in WA is among the highest in the nation, with high government cost per patient for palliative care-related medications (\$71 per patient on average vs national average cost of \$54 per patient) and average Medicare benefit paid on palliative medicine services per patient (\$632 vs national average of \$410). Alongside these high patient costs, WA has the highest rate of palliative medicine attendances including in hospitals or home visits (604 per 100,000 vs national rate of 292) and palliative medicine case conferences (73 per 100,000 vs national rate of 36). Consistent with patterns observed in other medical fields, the rate of FTE specialist palliative medicine physicians is lowest in WA (0.8 per 100,000).¹⁴</p> <p>Place-based</p> <p><i>Ageing population (refer to Table 7 and Table 26)</i></p> <p>Within the Perth North PHN, Cottesloe-Claremont (18%), Mundaring (17%), Kalamunda (16%), Stirling (16%) and Bayswater-Bassendean (15%) reported the highest proportion of residents aged 65 years or older in 2016. Stirling (30,376), Joondalup (21,937), and Wanneroo (18,637) reported the highest numbers of residents aged 65 years and older.¹</p> <p>In 2025, the largest number of residents aged over 65 years is projected to be in Stirling with 38,316 (12% of the projected population) and the highest proportion of residents aged over 65 years projected to be in Mundaring with 19.4% of the projected population (12, 168 people aged 65 years and older).^{1,11}</p> <p>Despite being home to 6,531 residents aged 70 years or older, Kalamunda SA3 has the lowest proportion of residential aged care places per 1,000 population aged 70 years and over (37.2).¹⁵ Mundaring SA3 and Joondalup SA3 also had low proportions at 41.5 and 46.6, respectively.</p> <p>[This section has been redacted for data confidentiality reasons]</p> |
| <p>HN1.4 There is a need to modify lifestyle risk behaviours.</p> | <p>Targeting improvements in lifestyle behaviours and modifiable risk factors to prevent and manage chronic disease, in addition to</p> | <p>Whole of PHN</p> <p><i>Adults</i></p> <p>Nearly three in four adults (males: 71 ASR per 100; females: 72) in Perth North PHN have at least one of the four risk factors for chronic disease (obesity, current smoker, low rate of physical activity, high-risk alcohol consumption); this</p> |

Outcomes of the health needs analysis

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| | <p><i>improving overall mental and physical wellbeing among children and adults.</i></p> | <p>is similar than state (male and females: 74 ASR per 100) and national rates (males: 76 ASR per 100; females: 79). Compared to state rates for individual risk factors, Perth North PHN has:¹</p> <ul style="list-style-type: none"> • Similar rates of overweight - two in five males (42 ASR per 100) and one in three females (30) • Significantly lower rates of obesity - one in five people (males: 22 ASR per 100; females: 22) • Significantly lower rates of smoking - one in six males (17) and one in nine females (11) • Significantly lower rates of participation in physical activity - more than two thirds of adults (61) • Similar rates of high alcohol intake - nearly one in five adults (19). <p>Place-based</p> <p><i>Adults</i></p> <p>Compared to Perth North PHN averages, the areas with the highest rates of composite risk where both males (72) and females (73) have at least one of the four risk factors includes (ASR per 100):¹</p> <ul style="list-style-type: none"> • Wanneroo (males: 80; females: 79) • Swan (males: 79; females 78) • Mundaring (males: 76) • Kalamunda (males: 76). <p>When compared to PHN averages, the following areas have significantly higher rates of smoking and risky drinking:¹</p> <ul style="list-style-type: none"> • High smoking rates in Swan (males: 21; females: 14) • High smoking rates in Mundaring (males: 21; females: 13), Wanneroo (males: 19; females:13) and Kalamunda (males only: 19) • risky alcohol consumption in Cottesloe-Claremont (26), Joondalup (21) and Mundaring (25). |
| <p>HN1.5 People living with chronic conditions need accessible primary care.</p> | <p><i>People living with chronic conditions are at risk of developing secondary conditions (comorbidities) and</i></p> | <p>Chronic conditions vary in severity but can impact on a person’s functional capacity and quality of life. Half of all Australians are living with a chronic condition (arthritis, asthma, back pain and problems, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and mental health conditions). Nearly a quarter of Australians suffer from two or more of these chronic conditions.^{16,17} Those living with at least one chronic condition are more likely to die prematurely, and those living with multiple chronic conditions (comorbidities) have poorer</p> |

Outcomes of the health needs analysis

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| | <p>more likely to die prematurely. People living with multiple chronic conditions have higher levels of health care needs, and experience poorer long-term health outcomes.</p> | <p>overall health outcomes, and higher rates of engagement with health services and health care costs, including potentially preventable hospitalisations.^{10,16}</p> <p>Whole of PHN</p> <p><i>Chronic conditions</i></p> <p>Perth North PHN has a similar rate of chronic conditions compared to state and national rates.</p> <p><i>Median age of death and avoidable deaths (refer to Table 16)</i></p> <p>The median age of premature death in Perth North PHN is 81 years, similar to Perth South PHN and national rates, and similar to the state rate of 80 years. Avoidable mortality includes deaths from conditions that are considered avoidable, given timely and effective health care.¹</p> <p>Place-based</p> <p><i>Chronic conditions</i></p> <p>Significantly higher rates of specific chronic conditions were prevalent in (ASR per 100):¹</p> <ul style="list-style-type: none"> • Bayswater-Bassendean: mental health and behavioural problems (14.1), circulatory system diseases (16.3) and respiratory diseases (31.8) • Joondalup and Kalamunda: respiratory diseases (30.5) and (33.9) respectively • Stirling: diabetes (6), high blood cholesterol (35.1), mental health and behavioural problems (14.2), respiratory diseases (31.7) and arthritis (15.5) • Swan: diabetes (6.3), circulatory system (16.7), asthma (10.2) and musculoskeletal conditions (29) • Wanneroo: diabetes (6.3) and high cholesterol (34.6). <p><i>Median age of death and avoidable deaths</i></p> <p>The lowest median age of death is in Swan (77 years), Mundaring (77 years), Kalamunda (78 years) and Wanneroo (79 years), all below Perth North PHN, state and national averages. When compared to the PHN average, significantly high rates of avoidable death are reported in:¹</p> <ul style="list-style-type: none"> • Swan (circulatory system disease and ischemic heart disease) |
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| Outcomes of the health needs analysis | | |
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| | | <ul style="list-style-type: none"> Perth City (respiratory system diseases) Mundaring (transport accidents) Bayswater-Bassendean (circulatory system diseases and ischemic heart disease). |
| HN1.6 People with chronic conditions need to be able to effectively self-manage. | <i>The majority of chronic conditions require effective management, including medication management, to prevent progression and to avoid potentially preventable hospitalisations</i> | <p>Poorly managed chronic conditions can lead to potentially preventable hospitalisations (PPHs), preventable ED presentations and higher readmission rates. PPHs are described and further discussed in HN1.9.</p> <p>Whole of PHN</p> <p>Lower levels of individual health literacy are also associated with higher rates of hospitalisation and use of emergency care, poorer ability to take medications appropriately and interpret health labels and messages, and poor knowledge of their condition for self-management.¹⁸</p> <p>It has been estimated that people with low levels of individual health literacy are between one and a half to three times more likely to experience an adverse outcome.¹⁸ An adequate level of health-literacy is required for those with chronic conditions to understand care plans, medication, lifestyle changes, and possible long-term health outcomes of the condition to reduce acute phases and disability.¹⁸ Data for health literacy levels in Western Australia and across Perth North PHN are not available and further research is needed to identify specific sub-regions where low levels of health literacy in Perth North PHN may be contributing to poor chronic disease self-management and medication compliance.</p> <p><i>Potentially preventable hospitalisations (PPHs) for chronic conditions</i></p> <p>In 2017, the Department of Health and the WA Primary Health Alliance co-authored the <i>Potentially Preventable Hospitalisation Hotspots in Western Australia</i>. A hotspot is an area that shows a rate of hospitalisation of at least 1.5 times over the state average for a three-year period 2013-14 to 2015-16. Perth North PHN had 11 PPH hotspots for chronic conditions. These were for diabetes complications, COPD, angina and iron deficiency. Two hotspots were located in Bayswater-Bassendean (SA3) for diabetes complications, two in Swan (SA3) and one in Stirling (SA3). Two COPD hotspots were located in Swan (SA3) and one in Stirling (SA3). Only one hotspot was identified for angina and iron deficiency anaemia, both located in Swan (SA3).¹⁹</p> |
| HN1.7 There is a need to prevent the | <i>People with chronic conditions are at</i> | <i>Comorbidities</i> |

Outcomes of the health needs analysis

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| <p>development of comorbid physical and mental chronic conditions.</p> | <p><i>higher risk of developing comorbid chronic conditions (physical and mental) that will exacerbate their pre-existing conditions.</i></p> | <p>Chronic conditions have a substantial impact on the population, the health system and individuals. A self-report survey in 2014-15 revealed that 50% Australians has at least one of eight selected common chronic conditions:^{17,20}</p> <ul style="list-style-type: none"> • Arthritis • Asthma • Back pain and problems • Cancer • Cardiovascular disease • Chronic obstructive pulmonary disease (COPD) • Diabetes • Mental health conditions. <p>Comorbidity refers to the occurrence of two or more diseases in a person at one time. While the existence of these multiple health conditions may be unrelated, in many instances—and particularly in relation to chronic diseases—there is some association between them with a range of chronic diseases sharing common risk factors. Understanding more about comorbidities can provide vital information for prevention, management and treatment of chronic diseases¹⁶.</p> <p>The rate of comorbidity and the number of chronic disease increases with age. Almost one in three people aged 65 and over reported having three or more chronic diseases, compared with just 2.4% of those under 45.²¹</p> <p>Some chronic conditions are a risk factor for developing further chronic conditions. For example, having diabetes is known to be a risk factor for developing cardiovascular disease. The Australian Bureau of Statistics (ABS) 2014-15 National Health Survey (NHS) collected information on the most frequent comorbidities of respondents. People with cardiovascular disease reported high rates of comorbid diabetes (63%), cancer (51%) and COPD (49%), and those with arthritis reported high rates of COPD (52%), diabetes (41%) and cardiovascular disease (41%).²²</p> <p><i>Comorbidities: mental health and chronic conditions</i></p> <p>Research indicates a correlation between comorbidities and an increased risk of depression. The prevalence of depression is shown to increase as the number of chronic conditions increases. For example close to one third of people with two (27%), three (30%) of four (31%) chronic conditions were also depressed²³. In the National Health</p> |
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Outcomes of the health needs analysis

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| | | <p>Survey 2014 to 2015, those with COPD, back pain and asthma also reported high rates of a comorbid mental health condition (38%, 30% and 29% respectively).²²</p> <p>People with a severe mental health condition and physical comorbidity have a shorter life expectancy relative to the general population. Medication use, psychosocial and lifestyle factors contribute to the reduced physical health of mental health consumers.²⁴ The most prevalent health issues found in those with severe mental illness are cardiovascular disease and type 2 diabetes.</p> <p>Data for comorbidities in Western Australia and across Perth North PHN is not available and further research is needed to identify specific sub-regions with high instances of comorbidities, including mental health.</p> |
| <p>HN1.8 There is a need to reduce after-hours and non-urgent ED attendances.</p> | <p><i>People presenting to ED with non-urgent conditions may lack access, availability, or awareness of appropriate and affordable primary care services.</i></p> | <p>High rates of lower urgency emergency department (ED) attendances indicate there may be a gap in primary care services.</p> <p>Whole of PHN</p> <p>Lower urgency ED presentations are defined as:</p> <ul style="list-style-type: none"> • had an emergency presentation type of visit • had a triage category of 4 (semi-urgent) or 5 (non-urgent) • did not arrive by ambulance, or police or correctional vehicle, and • was not admitted to the hospital, not referred to another hospital, or did not die. • after hours presentations are defined as those outside of 8am-8pm weekdays (excluding public holidays) and outside 8am-1pm Saturdays. <p>[This section has been redacted for data confidentiality reasons]</p> |
| <p>HN1.9 Earlier intervention in a range of conditions to prevent higher than state rates for specific potentially preventable conditions</p> | <p><i>Potentially preventable hospitalisations may be treated, or better managed at an earlier stage, in primary care.</i></p> | <p>Potentially Preventable Hospitalisations (PPHs) are admissions to hospital for a condition where the hospitalisation could have been prevented through the provision of appropriate primary and community-based care.¹⁹ In 2017, the Department of Health and the WA Primary Health Alliance co-authored the <i>Potentially Preventable Hospitalisation Hotspots in Western Australia</i>. A hotspot is an area that shows a rate of hospitalisation of at least 1.5 times over the state average for a three-year period to 2015-16. The report identified 32 hotspots in the Perth North PHN¹⁹.</p> |

Outcomes of the health needs analysis

(acute, chronic and vaccine preventable).

Place-based

Potentially Preventable Hospitalisations (PPHs) for acute, chronic and vaccine preventable conditions (refer to Table 17)

PPH Hotspots were identified in the following SA3 locations¹⁹.

- Bayswater-Bassendean (SA3): diabetes complications
- Cottesloe-Claremont (SA3): dental conditions
- Joondalup (SA3): dental conditions
- Mundaring (SA3): vaccine preventable
- Perth City (SA3) dental conditions
- Stirling (SA3): convulsions and epilepsy, diabetes complications, COPD and vaccine preventable
- Swan (SA3): UTI, cellulitis, convulsions and epilepsy, diabetes complications, COPD, angina and iron deficiency anaemia
- Wanneroo (SA3): convulsions and epilepsy, diabetes, COPD, angina, congestive heart failure and vaccine preventable.

The PPH hotspots report identified hotspots by Statistical Area 2 (SA2) which provides a more precise location for improvement of chronic disease management. PPHs were identified in the following SA2 locations.¹⁹

- The majority of acute and chronic conditions in Swan SA2
- Acute convulsions, the majority of chronic conditions, and vaccine preventable conditions in Wanneroo SA2
- Acute convulsions, chronic diabetes complications and COPD, and vaccine preventable conditions in Stirling SA2
- Chronic diabetes complications in Bayswater-Bassendean SA2
- Vaccine preventable conditions in Mundaring SA2
- Acute dental conditions in Cottesloe-Claremont, Joondalup and Perth City SA2.

Dental conditions are the most frequent PPH in Perth North PHN, followed by diabetes complications and COPD. Dental condition PPHs are located in mostly affluent areas and are associated with private health insurance hospital admissions while diabetes complications and COPD PPH hotspots were predominately located in Swan (SA3).

| Outcomes of the health needs analysis | | |
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| | | Congestive heart failure only accounted for one hotspot in Perth North PHN, in Alexander Heights-Koondoola, at 1.6 times the state average ¹⁹ . |
| HN1.10 There is a need to reduce overweight and obesity rates. | Health interventions are essential for treating those already living with obesity. | <p>Obesity represents a major health and societal issue for Australia. The most recent Australian Health Survey (2011-2012), highlights that 63% of adults are now overweight or obese, with 28% classified as obese. Projections suggest that by 2025, the prevalence of overweight and obesity will increase to over 70%, with approximately one third of the adult Australian population classified as obese.²⁵</p> <p>Health interventions are essential for treating those already living with obesity. Health practitioners play a significant role in identifying, supporting and treating people who are overweight and obese. However, issues around access, availability, appropriateness and affordability of treatments are impeding the delivery of effective health interventions.²⁶</p> <p>Whole of PHN</p> <p><i>Adults</i></p> <p>Compared to the Australian rate Perth North PHN had a significantly higher rate of overweight males and females however, rates of obesity were not elevated.¹</p> <p><i>Children</i></p> <p>Perth North PHN has significantly higher rates of overweight (but not obese) children (19 ASR per 100) compared to the national rate (18), and a higher rate than Perth South PHN (19), Country WA PHN (18) and state rates (19). This appears to be largely driven by significantly higher rates of overweight boys (23) compared to state (18.9) and national (18.3) rates. Perth North PHN has similar rates of childhood obesity (5.7 ASR per 100) to Perth South PHN (6.4), Country WA PHN (6.2), state (6.1) and national rates (7.5).</p> <p>Place-based</p> <p><i>Adults</i></p> <p>When compared to the PHN average, the following areas have significantly higher rates of overweight and/or obesity (ASR per 100):¹</p> <ul style="list-style-type: none"> • Obese males (27) and overweight and obese females (31; 27) in Swan |

Outcomes of the health needs analysis

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| | | <ul style="list-style-type: none"> • Obese males (29) and females (29) in Wanneroo • Obese males (25) and females (25) in Kalamunda. <p><i>Children</i></p> <p>Significantly higher rates of overweight and/or obese children were observed for (ASR per 100):¹</p> <ul style="list-style-type: none"> • Overweight and obese males (25; 7.4) and females (17; 7.5) in Wanneroo • Significantly higher rates of obese males (6.9) and females (7.1) in Swan. • Significantly higher rates of overweight males in Bayswater - Bassendean (23.3), Joondalup (23.6), Kalamunda (21.9), Mundaring (21.8), Stirling (23.2) and Swan (22.2). |
| <p>HN1.11 There is a need to better manage heart failure a high-cost, complex chronic condition.</p> | <p><i>Best-practice management of people with chronic heart failure involves evidence-based, multidisciplinary care.</i></p> | <p>The most common cause of chronic heart failure is coronary heart disease and prior myocardial infarction, hypertension and diabetes²⁷</p> <p>Better management of heart failure can prevent readmissions, decrease costs and improve the overall quality of care being delivered to patients.²⁸ The evidence supporting multidisciplinary heart failure disease management programs is well-established.²⁹ A multidisciplinary model of care for people with heart failure significantly reduces readmissions, deaths and improves patients’ quality of life.³⁰</p> <p>Placed-Based</p> <p><i>Risk Factors</i></p> <p>Risk factors for heart failure include age, family history, smoking, poor diet, obesity, diabetes, high cholesterol, excessive alcohol consumption and inadequate physical activity.³⁰</p> <p>Statistical Areas with residents with significant risk factors for heart failure were Swan, Wanneroo and Bayswater-Bassendean. Swan had a significantly higher prevalence of diabetes and a significant proportion of males with at least one of four risk factors, i.e. current smoker, high alcohol intake, obesity and low exercise levels. Wanneroo had a significant proportion of males and females with one of four risk factors for chronic disease and significantly higher rates of diabetes. Bayswater-Bassendean had a significantly higher rate of residents with high blood pressure and residents that were overweight. ¹</p> |

Outcomes of the health needs analysis

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| | | <p><i>Prevalence</i></p> <p>In 2014, it was estimated that there were 480,000 people aged 18 years or more with heart failure, representing 2.1% of the adult population.²⁹ The prevalence of heart failure rises steeply with age and is rare in people younger than 50 years. Two-thirds of Australian adults with heart failure are aged 65 years or over.³⁰ Worldwide the prevalence of heart failure is increasing, this is likely associated with the ageing demographic and improved survival of patients with heart failure, due to the availability of diagnostic technology and more efficacious therapy.²⁹</p> <p>The prevalence of circulatory system diseases including heart failure in Perth North PHN was similar to state and national rates.¹</p> <p>Statistical Areas within Perth North PHN with rates significantly above the Perth North PHN rate were Swan (16.7) and Bayswater-Bassendean (16.3).¹</p> <p><i>Avoidable Mortality</i></p> <p>When compared to the PHN average, significantly high rates of avoidable death for Circulatory System Diseases including heart failure are reported in Bayswater-Bassendean (40) and Swan (40.6). Avoidable mortality includes deaths from conditions that are considered avoidable, given timely and effective health care.¹</p> <p><i>Chronic Heart Failure Potentially Preventable Hospitalisation (PPH) Hotspot</i></p> <p>Potentially preventable hospitalisations (PPHs) are admissions to hospital for a condition where the hospitalisation could have been prevented through the provision of appropriate primary and community-based care. The 2017, <i>Potentially Preventable Hospitalisation Hotspots in Western Australia</i> report identified Wanneroo as a hotspot for Chronic Heart Failure PPHs.¹⁹</p> |
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Primary Mental Health Care (including Suicide Prevention)

| Outcomes of the health needs analysis | | |
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| Identified Need | Key Issue | Description of Evidence |
| HN2.1 Reduce the harmful effects of mental health conditions on a person's health outcomes. | <i>Mental health conditions, including depression, are widely recognised as being a significant risk factor for suicide and self-harm.</i> | <p>Globally, for every suicide, there are approximately 20 suicide attempts.³¹ Since 2014, the number of Australians who died by suicide has averaged around 3,000 annually³²; while for over a decade, more than 20,000 Australians have been admitted to hospital annually as a result of intentionally self-inflicted injuries.³¹</p> <p>Mental health conditions such as major depression, psychotic illnesses and eating disorders are associated with an increased risk of suicide³³ especially after discharge from hospital or when treatment has been reduced,³⁴ and people with harmful alcohol or drug use have a higher risk of dying by suicide than the general population.³⁵</p> <p>In 2018, the rate of suicide in Western Australia was 14.7 per 100,000 compared to 12.1 per 100,000 in Australia overall.³² Across Australia, mood disorders, including depression, were the most common co-morbidity (43.9% of suicide deaths) followed by problems related to substance use (29.4%).³² It is also widely recognised that there are a range of factors related to suicide deaths that are not diagnosable health conditions and that are not systematically recorded on death certificates in Australia. A pilot study by the Australian Bureau of Statistics (ABS) based on coroner-referred deaths in 2017 highlighted psychosocial factors such as past history of self-harm, relationship issues, legal and financial concerns, and disability as being most commonly associated with suicide deaths.³⁶</p> <p>Whole PHN <i>Suicide</i></p> <p>Suicide was the ninth leading cause of death in Perth North PHN, accounting for 2.5% of deaths from all causes (ASR=12.7 per 100,000).³⁷ The rate ratio relative to all of Australia was 1.06.</p> <p><i>Depression and intentional self-harm</i></p> <p>Perth North had a similar hospitalisation rate for depression (ASR=11 per 10,000) compared to the national average (ASR=12 per 10,000). However, the hospitalisation rate for intentional self-harm (ASR=19 per 10,000) was higher than the national average (ASR=17 per 10,000).³⁸</p> <p><i>Youth suicide</i></p> |

Outcomes of the health needs analysis

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| | | <p>In 2018, suicide remained the leading cause of death for children between 5 and 17 years of age in Australia, accounting for 22.3% of deaths from all causes in this age group.³² The rate for male children (3.0 per 100,000) was substantially higher than for females (2.0 per 100,000). In 2014-18, Western Australia had the third highest rate of suicide among 5-17-year-olds, with a rate of 3.1 per 100,000 compared to the national rate of 2.4 per 100,000.³²</p> <p>The 2014 state Ombudsman’s investigation into 36 suicide deaths by youth aged 13-17 years discussed several factors associated with suicide, these include demographic characteristics (i.e. being male and homeless), mental health conditions, suicidal ideation and behaviour, harmful alcohol and drug use, experiencing child maltreatment and adverse family experiences. One or more of these factors was prevalent in the suicide deaths of the 36 young people.³⁹</p> <p>Place-based Suicide</p> <p>Mundaring, Kalamunda and Bayswater – Bassendean SA3s had the top three suicide rates in Perth North.³⁷ These areas all had suicide rates that were above the WA rate and at least 1.2 times the national rate.</p> <p><i>Depression and intentional self-harm</i></p> <p>Perth City SA3 had the highest hospitalisation rate for depression (ASR=15 per 10,000) and Wanneroo SA3 had the highest hospitalisation rate for intentional self-harm (ASR=23 per 10,000).³⁸ We note that intentional self-harm hospitalisation data do not differentiate between suicide attempts and self-injury without suicidal intent. A large, nationally representative survey of self-injury in Australia⁴⁰ reported that self-injury was primarily not about intended suicide and that it often occurred in the absence of suicidal thoughts (51.9%) and in the absence of a lifetime history of suicide attempts (73.7%). Therefore, areas with high hospitalisation rates for intentional self-harm will not necessarily correspond to areas with high rates of suicide.</p> |
| <p>HN2.2 Perinatal care for the mother and baby to act as a protective factor to prevent future mental health problems</p> | <p><i>Pregnant women and women who have just given birth are more likely to experience depression.</i></p> | <p>Data from the 2010 Australian National Infant Feeding Survey⁴¹ showed that one in five mothers of children aged 24 months or less had been diagnosed with depression. More than half of these mothers reported that their diagnosed depression was perinatal (that is, the depression was diagnosed from pregnancy until the child’s first birthday). Perinatal depression was most commonly reported among mothers who:</p> <ul style="list-style-type: none"> • were younger (aged under 25) • were smokers |

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| | | <ul style="list-style-type: none"> • came from lower income households • spoke English at home • were overweight or obese • had an emergency caesarean section. <p>Whole PHN</p> <p>Although Perth North PHN had the highest number of births in Western Australia (n=41,345 births between 2013 and 2015), it has a relatively low fertility rate (1.83) compared to state (1.89) and national rates (1.88).⁴²</p> <p>Place-based</p> <p>There are no statistics available on the prevalence of perinatal depression by region. However, areas with a relatively high number of births are likely to have a higher demand for perinatal mental health services. Within Perth North PHN, the highest number of births between 2013 and 2015 was in Stirling SA3 (n=8,930) and the highest fertility rate was in Wanneroo SA3 (2.07).¹</p> |
| HN2.3 Reduce impact of mental health conditions on medium and long-term physical health morbidity and multi-morbidities. | <i>People with chronic conditions are at higher risk of developing comorbid physical and mental health conditions or exacerbation of pre-existing conditions.</i> | Comorbidity can involve more than one mental health condition, or one mental health condition and one or more physical conditions. Mental health problems are known to have high rates of comorbidity with chronic physical conditions. ⁴³ Around one in nine Australians aged between 16 and 85 years had a mental health condition and physical condition at the same time. ⁴⁴ People living in the most disadvantaged areas of Australia were 65% more likely to have a comorbidity than those living in the least disadvantaged areas. ⁴⁴ |
| HN2.4 People with persistent mental health conditions need to be able to access appropriate and timely primary care to avoid hospitalisations. | <i>People living with severe and complex mental health conditions are more likely to present to hospitals when primary health care is not accessible.</i> | <p>Whole PHN</p> <p><i>Schizophrenia and delusional disorders</i></p> <p>Overall, Perth North had a lower rate of hospitalisations (ASR=16 per 10,000) for schizophrenia and delusional disorders compared to the national average (ASR=19 per 10,000).³⁸</p> <p><i>Bipolar and mood disorders, excluding depressive episodes</i></p> <p>Perth North had a higher hospitalisation rate (ASR=14 per 10,000) for bipolar and mood disorders compared to the national average (ASR=11 per 10,000).³⁸</p> |

| Outcomes of the health needs analysis | | |
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| | | <p>Place-based</p> <p><i>Schizophrenia and delusional disorders</i></p> <p>Perth City SA3 had the highest hospitalisation rate (ASR=29 per 10,000) for schizophrenia and delusional disorders in Perth North. This rate was 1.5 times the national average and 1.8 times the PHN average.³⁸</p> <p><i>Bipolar and mood disorders, excluding depressive episodes</i></p> <p>Perth City and Stirling SA3s had the highest hospitalisation rate (ASR=18 per 10,000) for bipolar and mood disorders in Perth North.³⁸ Cottesloe – Claremont SA3 also had a hospitalisation rate above the PHN average.</p> |
| HN2.5 Children and youth are a priority, along with early intervention to improve access and outcomes. | <i>There are sub-regions in Perth North PHN with a relatively high prevalence of mental health conditions among youth.</i> | [This section has been redacted for data confidentiality reasons] |
| HN2.6 Vulnerable groups have a high demand for mental health services. | <i>Minority groups, such as CALD and LGBTI, are more vulnerable to poor mental health.</i> | <p>Please refer to the General Population Health section above for a full discussion of the social determinants of health and the health needs of CALD populations.</p> <p><i>Culturally and linguistically diverse (CALD)</i></p> <p>The prevalence of mental health conditions is lower for people born in non-English speaking countries (8.4% for males and 16% for females) compared to people born in Australia (20% for males and 24% for females).⁴⁵ However, research shows that the mental health of migrants tends to deteriorate after the first year in Australia due to stress caused by acculturation, language and social difficulties and difficulties in finding employment.⁴⁶ Moreover, many culturally and linguistically diverse (CALD) residents will have difficulty accessing mental health services because of these barriers. Perth North PHN has the largest CALD population in Western Australia, with Stirling SA3 having the highest number of CALD residents (47,975) in the PHN.^{1,37}</p> <p><i>Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) populations</i></p> <p>The term 'LGBTI' includes all people whose sexual orientation, gender identity or sex differ from heterosexual or male/female sex and gender norms.⁴⁸ As a minority group, LGBTI people are particularly vulnerable to poor</p> |

Outcomes of the health needs analysis

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| | | <p>mental health due to discrimination and exclusion as key determinants of health.⁴⁹ Studies indicate a high prevalence of mental health disorders among LGBTI people, with at least 36% of transgender and 24% of gay, lesbian and bisexual Australians meeting the criteria for experiencing a major depressive episode in 2005, compared with 6.8% of the general population.⁵⁰ Rates of depression, anxiety and poor mental health are highest among transgender and bisexual people, especially bisexual women.⁵¹</p> <p>To achieve Rainbow Tick accreditation, WA Primary Health Alliance (WAPHA) is required to meet six standards. As part of Standard 3 - Consumer Participation, WAPHA conducted a qualitative Community Engagement survey to help inform health service planning and ensure that health services are safe, welcoming and inclusive of the needs of lesbian, gay, bisexual, transgender, and intersex (LGBTI) people. The survey commenced on 3rd November 2018 at Fair Day (the launch of WA's Pride Month) and was available throughout the month online.</p> <p>There were 212 respondents. Almost half of respondents were aged in their twenties or thirties and 92% resided in the Perth metropolitan area. Of the 212 respondents, there were 172 (81%) that were lesbian, gay, bisexual, transgender or intersex (LGBTI), 33 (16%) that were not LGBTI, and 7 (3%) that preferred not to answer. About 56% of respondents were female (n=118) and 37% were male (n=78). There were 16 respondents (8%) who identified as gender diverse, indeterminate, intersex or preferred not to disclose their gender.</p> <p>The survey asked respondents questions regarding their utilisation of health services and what changes or improvements would make healthcare services more accessible for LGBTI people.</p> <p>The survey responses indicated that LGBTI consumers want to be treated as 'substantively equal' to their heterosexual counterparts and that they seek health providers who are inclusive, non-judgmental and well-informed about issues related to LGBTI health. It highlighted the importance of explicitly stating support for the LGBTI community by displaying a Rainbow flag, ally sticker or inclusive posters of same sex families. A recurring theme in the survey was education and training: mandatory LGBTI awareness training for all medical practitioners would help providers to be better informed and make health services more inclusive.</p> |
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| <p>HN2.7 Consumer capacity to respond to mental health conditions by raising awareness of mental health and treatment options.</p> | <p><i>Patients have limited understanding how to access the right care at the right time in the right place.</i></p> | <p>Stakeholder feedback indicates that mental health patients often have difficulty navigating the health system due to its complexity.⁵² It is important that patients and/or carers know how to access the right care early on, to prevent the need for hospitalisation. It is also important that coordinated care is provided for patients in the community, after they have been discharged from hospital. Poor discharge practices have been shown to result in readmission to hospital within 28 days and more serious adverse outcomes for patients and their families.⁵²</p> <p>There is a wide range of mental health awareness campaigns across Australia including RUOK Day, Suicide Prevention Day, and Mental Health Week. However, information in these campaigns is generally limited to telephone helplines and there is little or no information about accessing services in a primary care setting. Moreover, information about primary mental health care such as PORTS and Better Access is not readily available in preliminary Google searches for mental health care in WA. This means that many patients may be unaware of how to access services and navigate the mental health system. Stronger online messaging regarding primary care services (for example “talk to your GP”) is needed to supplement existing mental health awareness campaigns.</p> |
| <p>HN2.8 Psychosocial support. Community based non-clinical mental health services, known as psychosocial supports, to assist people with severe mental health conditions that result in psychosocial disability through reduced functional capacity.</p> | <p><i>Demand for mental health community support services by those with a psychosocial disability and non-NDIS populations.</i></p> | <p>New psychosocial supports will reduce the service gap between mainstream mental health services and the National Disability Insurance Scheme (NDIS), as well as continuing the supports provided to existing clients of Commonwealth-funded psychosocial services, improving mental health outcomes and reducing inequity in service availability.</p> <p>[This section has been redacted for data confidentiality reasons]</p> |

| Outcomes of the health needs analysis | | |
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| HN2.9 Mental health in residential aged care facilities. | <i>Older adults in residential aged care facilities require access to targeted mental health support services.</i> | [This section has been redacted for data confidentiality reasons] |
| HN2.10 The 'missing middle'. | <i>There is a demand for services to address the needs of the 'missing middle' – clients with complex and/or co-occurring mental health conditions.</i> | The 'missing middle' is a term used to describe clients who are too unwell to be effectively treated in the primary mental health system but are not unwell enough to be treated in the state-based mental health system. Orygen and headspace ⁵³ indicated that, of the 26% of young people in any given year with a mental health condition, around 12% are likely to be experiencing a more moderate-to-severe and complex mental health issue and may be missing out on care. The increasing level of complexity and severity of presentations has placed existing primary care services under strain, with about 90% of headspace centres nationally reporting that wait times are a major concern. ⁵⁴ A report by headspace ⁵⁴ identified six key actions to meet the growing demand for services including “augmenting the existing headspace platform to provide better care for young people with more severe and complex conditions (the missing middle)” (p.11). |

Alcohol and Other Drug Treatment Needs

| Outcomes of the health needs analysis | | |
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| Identified Need | Key Issue | Description of Evidence |
| HN3.1 For many people, alcohol consumption needs to be reduced to lower their risk of disease and injury. | <i>Drinking more than recommended is common and increases the risk of disease and injury.</i> | <p>Alcohol was reported as the third highest risk factor (behind tobacco use and high body mass) contributing to disease burden in Australia, accounting for 5.1% of the overall burden of disease and injury.⁵⁵</p> <p>Limiting daily alcohol consumption (no more than two standard drinks per day) and avoiding single occasion heavy drinking (no more than four standard drinks on a single occasion) is recommended to reduce harm.⁵⁶</p> <p>The National Drug Strategy Household Survey (NDSHS) found that 17% of Australians consumed more than two standard drinks per day.⁵⁷ An estimated 26% of Australians (fourteen years or older) drink more than four standard drinks at least once per month (risky single occasion drinking).⁵⁷ This indicates that a high percentage of the population are vulnerable to disease and injury caused by alcohol use.</p> <p>Place-based</p> <p><i>Alcohol consumption</i></p> <p>Social health atlases published by the Public Health Information Development Unit (PHIDU) give place-based estimates of at-risk drinking based on the NHSDS. Estimated rates of high alcohol intake are significantly higher than state wide rates for residents of the Cottesloe – Claremont, Joondalup, and Mundaring SA3s.</p> <p><i>Alcohol consumption - National Alcohol Sales Data Project</i></p> <p>Per capita estimates of consumption from the National Alcohol Sales Data Project were highest in the Perth City SA3, at more than double the estimates seen in the rest of Perth North PHN.⁵⁸ It likely that this is due to people visiting bars and restaurants in the SA3 and is unlikely to reflect the consumption of residents alone.</p> |

Outcomes of the health needs analysis

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| <p>HN3.2 Harmful drug use needs to be reduced to promote better health.</p> | <p><i>Drug use is common and can have harmful health consequences.</i></p> | <p>Australia</p> <p>For the purposes of this document, we have used the term drug use to include illegal drugs and the misuse of pharmaceuticals. Drug use was estimated to have accounted for 2.3% of Australia’s burden of disease and injury, making it an important health issue (this excludes tobacco, see HN3.11). The 2016 National Drug Strategy Household Survey (NDSHS) estimated that 43 percent of Australian’s aged fourteen and over had used drugs at some point in their life and 8.6 % had used drugs in the past month. These estimates have not changed significantly from the 2013 survey. The most common recently (past month) used drug was cannabis (5.8% of people), followed by cocaine (0.8%), ecstasy (0.7%), and meth/amphetamines (0.6%).</p> <p>There are growing concerns about the use of performance and image enhancing drugs (PIEDs), including anabolic steroids, peptides and hormones, taken to improve body image and/or enhance sporting performance. The 2016 NDSHS found that 0.6% of people had misused steroids at some point in their life, up from 0.3% in 2001, but not significantly higher rate of use recorded in 2013.</p> <p>The average age of initiation (first use) of steroids recorded in the NDSHS has been getting older and is now around 30 years of age up from nineteen years of age in 2001. Due to the frequent intravenous use of steroids, the health risks associated with intravenous drug use are an important consideration (see HN3.8). There is evidence that usage is particularly high among gay and bisexual men (see HN3.12).</p> |
| <p>HN3.3 People living with, or at risk of, alcohol and/or other drug dependence have considerable health needs.</p> | <p><i>Alcohol and/or other drug dependence is a major component of the total burden of disease due to alcohol and other drug use.</i></p> | <p>Of the diseases linked to alcohol use, alcohol dependence is the greatest single cause of disability-adjusted life year (DALY) burden⁵⁹, accounting for 31% of Australia’s burden of disease due to alcohol. Overall, alcohol dependence accounts for 1.5% of Australia’s burden of disease.⁵⁹ Alcohol dependence was the leading cause of alcohol-attributed hospitalisations (2015 data) for men (17% of alcohol-attributed hospitalisations) and women (26%).⁶⁰</p> <p>Similarly, illicit drug dependence accounts for 31% of the total burden of disease and injury due to illicit drugs.⁵⁹ According to the report, most of the non-fatal burden of illicit drug dependence is due to opioids (38%) and amphetamines (20%), with cocaine and cannabis accounting for smaller components (8.6% and 7.5% respectively).</p> <p>Young people and young to middle aged adults, men in particular, are most vulnerable to drug and alcohol dependence.⁵⁹ Alcohol dependence among 15-44 year-olds accounts for 72% of the overall burden due to</p> |

Outcomes of the health needs analysis

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| | | <p>alcohol dependence, and is mostly experienced by men.⁵⁹ Most of the burden of illicit drug dependence is also experienced by men (72%) and 25-44 year-olds experience 61% of the total burden.⁵⁹</p> <p>While the overall burden of disease due to illicit drug use is generally higher in remote or very remote areas, major cities carry the highest age standardised rate of disease burden due to illicit drug dependence, which is more than 1.5 times the rate in remote and very remote regions.⁵⁹ The age standardised rate of burden due to alcohol dependence is highest in very remote regions and higher among more socioeconomically disadvantaged groups.⁵⁹</p> <p>Place-based</p> <p><i>Alcohol and other drug dependence</i></p> <p>While we do not have place-based estimates of the burden of disease due to drug dependence, data on disease burden by remoteness suggest greater health needs associated with illicit drug dependence in metropolitan regions in comparison to remote areas.</p> <p>[This section has been redacted for data confidentiality reasons]</p> <p>In Perth North PHN, 28% of treatment episodes at publicly funded alcohol and other drug treatment providers were for alcohol problems.⁶¹ This was lower than the 39% in Country WA PHN and the same as the 28% seen in Perth South PHN.⁶¹ Amphetamines were the principal drug of concern for 36% of episodes, accounting for a higher share of episodes than alcohol.⁶¹ Cannabis accounted for 21% of clients and heroin 7.8%.⁶¹ In line with our expectations from burden of disease reports, most of those seeking treatment were men (63%), and 71% were in the 10-39 age group.⁶¹</p> <p><i>Drug consumption estimates from the National Wastewater Drug Monitoring Program (NWDMP)</i></p> <p>Given that Australia wide reports highlighted the high contribution of opioids and amphetamines to the burden of illicit drug dependence, place-based consumption information may highlight areas with higher need. The NWDMP reported the estimated consumption of two pharmaceutical opioids with misuse potential (Oxycodone and Fentanyl) as well as heroin. Lower consumption of Oxycodone was estimated at most WA test sites compared to the average across all sites (National)⁶².</p> |
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Outcomes of the health needs analysis

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| | | <p>We do not currently have access to MBS data on prescription opioids, which would could add another layer of place-based information.</p> |
| <p>HN3.4 There is a need for increased awareness about drug overdose. People at risk of overdose need targeted support.</p> | <p><i>Drug overdose and accidental poisoning is a growing problem. Increasingly, overdose victims do not fit the traditional profile of heroin addicts.</i></p> | <p>Australia</p> <p>Australia wide, accidental poisoning was the leading cause of burden from illicit drug use, accounting for 33% of the total burden.⁵⁹ This is mainly attributed to opioid use, which accounts for 51% of accidental poisonings due to illicit drugs.⁵⁹ Amphetamines, cannabis, and cocaine account for smaller components of the burden of accidental poisonings, at 7.3%, 5.4%, and 1.1% respectively.⁵⁹ Alcohol related suicides are discussed separately in health need HN3.5.</p> <p>Australia’s Annual Overdose Report, produced by the Penington Institute, reported 2,177 drug-related deaths in 2016.⁶³ Most deaths were due to opioids and often involved multiple alcohol and other drug use. Accidental deaths due to drug use increased from 904 deaths in 2002 to 1,704 in 2016.⁶³ According to a 2016 report by the Australian Bureau of Statistics, 70% of opioid overdoses are from pharmaceutical opioids. The Penington report found Western Australia experienced a 2.7-fold increase in accidental drug-related deaths involving pharmaceutical opioids between the 2002 to 2006 and 2012 to 2016 periods. Middle-aged people were found to be most at-risk of overdose, with around 70% of overdose victims in the 30-59-year-old age bracket. Increasing rates of overdose deaths in regional Australia were also noted.</p> <p>Place-based</p> <p>[This section has been redacted for data confidentiality reasons]</p> <p><i>Drug consumption estimates from the National Wastewater Drug Monitoring Program (NWDMP)</i></p> <p>Given that opioids are largely responsible for overdoses, place-based information about opioid consumption may indicate populations at higher risk of overdose. The NWDMP reported the estimated consumption of two pharmaceutical opioids with potential for misuse (Oxycodone and Fentanyl) as well as heroin. Lower consumption of Oxycodone was estimated at most WA test sites compared to the average across all sites (national)⁶².</p> |

Outcomes of the health needs analysis

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| | | <p>We do not currently have access to MBS data on prescription opioids, which could add another layer of place-based information.</p> |
| <p>HN3.5 Reducing suicides and self-inflicted injuries will involve addressing those that are due to alcohol and other drug use.</p> | <p><i>A significant portion of the burden of suicide and self-harm is due to alcohol and other drug use.</i></p> | <p>Australia</p> <p>Suicide and self-inflicted injuries were explored as linked diseases in the Australian Institute of Health and Welfare’s (AIHW) report on the impact of alcohol and illicit drug use on the burden of disease and injury in Australia. This reported that 7.8% of the total burden of disease and injury attributed to alcohol use was due to suicides and self-inflicted injuries. Alcohol use accounted for 14% of the total burden of disease due to suicide and self-inflicted injuries. Eleven per cent of the burden of disease due to illicit drugs was found to be due to suicide and self-inflicted injury. Broken down by drug type, opioids accounted for 2.9% of the burden of suicide and self-harm, amphetamines accounted for 2.7%, and cocaine accounted for 3.9%. Illicit drug use was attributed to 11.5% of the burden of suicides and self-inflicted injuries for men compared to 4.0% for women.</p> <p>Australia wide, there were 3,128 suicide deaths in Australia in 2017.³² In its most recent release, the ABS reported on the proportion of suicides with co-morbidities mentioned as factors contributing to death.³² Findings of alcohol and other drugs in the blood were noted in 14% of suicides and 30% noted mental and behavioural problems due to alcohol and drugs (F10-F19, which includes dependence).³² Mental and behavioural problems due to alcohol and drugs were noted in 42% of suicides for people aged 25-44³², making alcohol and other drug related suicides particularly concerning for this cohort. Suicide and self-inflicted injuries is discussed in HN2.1.</p> <p>Place-based</p> <p><i>Suicide and self-inflicted injury</i></p> <p>Place-based information on suicides and self-inflicted injuries is discussed in the Mental Health section.</p> <p>We do not have place-based information on suicides caused by alcohol and other drug use; however, remoteness can give some indication of areas that may be higher need. The burden of suicide and self-inflicted injuries due to alcohol and other drug use is highest in very remote regions, followed by remote regions.⁵⁹ This would suggest a lower burden in Perth North PHN compared to Country WA PHN. Lower</p> |

Outcomes of the health needs analysis

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| | | <p>socioeconomic populations are also at higher risk of suicides and self-inflicted injuries due to alcohol and other drug use</p> <p>[This section has been redacted for data confidentiality reasons]</p> |
| <p>HN3.6 Alcohol consumption causes multiple chronic diseases resulting in complex health needs.</p> | <p><i>Alcohol use is the cause of multiple chronic diseases.</i></p> | <p>Australia</p> <p>The Australian Institute Health and Welfare has reported that 18% of the burden of disease for cancers can be attributed to alcohol. By cancer type, the percentage of disease burden due to alcohol use ranged from 40% for liver, 37% for mouth and pharyngeal, 22% for laryngeal, 21% for oesophageal, 10% for breast, and 5.4% for bowel.⁵⁹ In 2015, cancers were the overall leading cause of alcohol attributed deaths (36% of the 5,785 alcohol-attributed deaths in 2015).⁶⁰ Breast cancer was the leading cause of alcohol attributed deaths for women (18% of alcohol attributed deaths) and liver disease were the leading cause for men (18 per cent of alcohol attributed deaths).⁶⁰</p> <p>Illicit drug use accounts for 21% of the total burden of disease due to liver cancer and is a long-term consequence of contracting hepatitis C (see HN3.8 for information on unsafe injecting practices). The other reported chronic conditions linked to alcohol use were chronic liver disease (6.4%), cardiovascular diseases (5.6 per of total burden due to alcohol), epilepsy (3.5%), and pancreatitis (0.2%). This highlights the potential to improve health through reduced drinking, but also the complex comorbidities that some alcohol users face.</p> <p>While injury and alcohol dependence dominate the burden of disease due to alcohol in the 15-24 and 25-44 age groups, cancers account for a much higher share of the burden of disease in the 45-64, 65-84, and 85 years and over age groups.⁵⁹ Cancers account for the highest share of the burden of disease due to alcohol in the 65-84 age bracket, accounting for 41% of the total burden due to alcohol in men and 48% in women.⁵⁹ The burden of cardiovascular diseases due to alcohol increases with age.⁵⁹</p> <p>Within the WA Primary Health Alliance’s health snapshot survey, six respondents listed alcohol and other drug use as one of their health issues. While this is a small cohort, these six respondents all listed other health issues, highlighting the comorbidities associated with alcohol and other drug use. Additional health issues included:</p> |

Outcomes of the health needs analysis

| | | <table border="1"> <thead> <tr> <th data-bbox="1178 264 1335 292"><u>Comorbidity</u></th> <th data-bbox="1581 233 1727 292"><u>Number of respondents</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="1193 312 1469 339">Mental health conditions</td> <td data-bbox="1700 312 1720 339">5</td> </tr> <tr> <td data-bbox="1193 355 1442 383">Cardiovascular disease</td> <td data-bbox="1700 355 1720 383">2</td> </tr> <tr> <td data-bbox="1193 399 1503 426">Muscular skeletal conditions</td> <td data-bbox="1700 399 1720 426">2</td> </tr> <tr> <td data-bbox="1193 442 1272 469">Cancer</td> <td data-bbox="1700 442 1720 469">2</td> </tr> <tr> <td data-bbox="1193 485 1290 512">Diabetes</td> <td data-bbox="1700 485 1720 512">2</td> </tr> </tbody> </table> | <u>Comorbidity</u> | <u>Number of respondents</u> | Mental health conditions | 5 | Cardiovascular disease | 2 | Muscular skeletal conditions | 2 | Cancer | 2 | Diabetes | 2 |
|---|---|---|--------------------|------------------------------|--------------------------|---|------------------------|---|------------------------------|---|--------|---|----------|---|
| <u>Comorbidity</u> | <u>Number of respondents</u> | | | | | | | | | | | | | |
| Mental health conditions | 5 | | | | | | | | | | | | | |
| Cardiovascular disease | 2 | | | | | | | | | | | | | |
| Muscular skeletal conditions | 2 | | | | | | | | | | | | | |
| Cancer | 2 | | | | | | | | | | | | | |
| Diabetes | 2 | | | | | | | | | | | | | |
| <p>HN3.7 The co-occurrence of mental health conditions and alcohol and other drug use disorders creates complex health needs.</p> | <p><i>Drug and alcohol use and mental health disorders often co-occur.</i></p> | <p>Australia</p> <p>Drug and alcohol use disorders may also co-occur with mental health conditions without necessarily playing a causal role. People with mental health conditions can “self-medicate” leading to a co-occurring harmful alcohol and other drug use. There can be indirect causal relationships between alcohol and other drug use and mental health, and/or there can be shared risk factors (i.e. biological, psychological, social, or environmental) that make co-occurrence more likely.⁶⁴ In fact, estimates based on the National Survey of Mental Health and Wellbeing indicate more than one-third of people (31% of men, 44% of women) with harmful use of alcohol and other drugs have a co-occurring affective or anxiety disorder.</p> <p>The 2010 report on the Australian National Survey of Psychotic Illness found 58% of men and 39% of women with a psychotic illness had a lifetime history of harmful alcohol use or dependence, which is higher</p> | | | | | | | | | | | | |

Outcomes of the health needs analysis

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| | | <p>than the 35% and 14% in the general population.⁶⁵ Sixty-three percent of males and 42% of females surveyed reported a lifetime history of illicit drug use or dependence, compared to 12% of males and 5% of females in the general population.⁶⁵ The survey also found higher rates (58% of men and 39% of women) of harmful alcohol use or dependence among people with a psychotic mental health conditions compared to the general population.⁶⁵</p> <p>There were six respondents to the WA Primary Health Alliance’s health snapshot survey who listed alcohol and other drug use as one of their health issues, five of whom also listed mental health conditions.</p> <p>Mental health conditions can be caused by alcohol and other drug use, but this is reported to contribute only a small component to the burden of disease due to alcohol and other drug use.⁵⁹ Illicit drug use is linked to schizophrenia, anxiety disorders and depressive disorders, however, these contributed small percentages (0.5, 0.3 and 0.3% respectively) to the total burden of disease due to illicit drugs.⁵⁹ Furthermore, 0.3% of the burden of schizophrenia, 0.1% of depressive disorders, and 0.1% of anxiety disorders were attributed to illicit drug use.⁵⁹</p> |
| <p>HN3.8 The risk of contracting blood-borne viruses can be mitigated by using safe injecting practices.</p> | <p><i>Blood borne-viruses due to intravenous drug use are preventable yet continue to occur.</i></p> | <p>Australia</p> <p>Unsafe injecting practices accounted for 18% of the burden of disease due to illicit drugs, and 0.4% of Australia’s total burden of disease.⁶⁶ Using shared needles/syringes increases the risk of contracting HIV and hepatitis B and C. Most of the burden of disease due to unsafe injecting practices is attributed to chronic liver disease (65%) followed by liver cancer (34%), both of which are long term consequences of hepatitis B and hepatitis C infection.⁶⁶ HIV/AIDS accounts for a comparably small 1.4% share of the burden of disease due to unsafe injecting practices.⁶⁶ A large proportion of the burden of disease due to hepatitis B and hepatitis C is due to unsafe injecting practices (43% and 83% respectively).⁶⁶</p> <p>A vaccine for hepatitis B has been available since 1982. It is currently recommended that all babies and adolescents are vaccinated, and since 2001 babies receive their first hepatitis B vaccine soon after birth.⁶⁷ No vaccination is available for hepatitis C, although antiviral treatment is available (the uptake of antiviral treatment is discussed in SN3.5).</p> <p>The prison population is at high risk of contracting hepatitis B and C. In a national health survey of prisoners conducted by the Kirby Institute in 2013, 31% tested positive for the hepatitis C antibody and 18% for the hepatitis B core-antibody.⁶⁸ Western Australia had the highest rate of prison entrants with a history of</p> |

Outcomes of the health needs analysis

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| | | <p>injecting drug use.⁶⁸ While providing health care to prisoners is not part of WA Primary Health Alliance’s remit, many are released to re-join society and resume use of the public health system.</p> <p>Place-based</p> <p><i>Blood-borne viruses</i></p> <p>Overall, hospitalisation rates for hepatitis B and C are low across WA and more detailed place-based reporting is therefore not appropriate. Place-based estimates of the rates of intravenous drug use are not available.</p> |
| <p>HN3.9 Prevention of Fetal Alcohol Syndrome (FASD) and meeting the health needs of those affected by FASD.</p> | <p><i>There is increasing recognition about the health consequences of drinking during pregnancy; however, there are indications of high rates of FASD in some communities.</i></p> | <p>Current Australian guidelines to reduce health risks from drinking state:</p> <p><i>“For women who are pregnant or planning a pregnancy, or are breastfeeding, not drinking is the safest option. Maternal alcohol consumption can harm the developing foetus or breastfeeding baby.”⁵⁶</i></p> <p>Place-based</p> <p><i>Fetal Alcohol Syndrome (FASD)</i></p> <p>In a study of 99 young Western Australians in detention, (36%) were diagnosed with FASD.⁶⁹ This speaks to the lifelong consequences of FASD for individuals and the effect on communities.</p> |
| <p>HN3.10 Respond to the alcohol and other drug related health needs of children and adolescents.</p> | <p><i>While there is evidence that drug and alcohol use among children and adolescents has reduced, it is important to ensure the health needs of those that do choose to use alcohol and other drugs are met.</i></p> | <p>Australia</p> <p>During our Needs Assessment consultation with regional WA Primary Health Alliance offices, there were concerns about a lack of alcohol and other drug services for children and adolescents and a growing need for these services in some areas was raised.⁷⁰</p> <p>Current Australian guidelines to reduce health risks from drinking state:</p> <p><i>“For children and young people aged under 18, not drinking alcohol is the safest option. Alcohol may adversely affect brain function and lead to alcohol-related problems later in life.”⁵⁶</i></p> <p>The National Drug and Alcohol Strategy Survey included Australians in the fourteen to nineteen-year-old age group. Twenty-three percent of this age group reported having tried drugs and 9.1% reported having recently (in the past year) used drugs.</p> |

Outcomes of the health needs analysis

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| | | <p>Western Australia</p> <p>The Australian School Students Alcohol and Drug Survey has surveyed Western Australian school students aged twelve to seventeen at three yearly intervals since 1984 on their drug and alcohol use. There has been a trend of declining rates, particularly in the last few decades, of students that drink. In 1999 around 36% of students surveyed reported having used alcohol in the past week, in comparison to 14% in the 2014 survey.⁷¹</p> <p>Over this time period the number of students reporting never having consumed alcohol increased from 10% to 32%.⁷¹ Of the students who reported consuming alcohol in the last week, there has been a general trend of increasing single occasion risk drinking (more than 4 standard drinks on a single occasion) over the lifetime of the survey.⁷¹ In 2014, 6% of students report using an illicit drug in the past week, down from 17% in 1984.⁷¹</p> <p><i>Young Australians Alcohol Reporting System (YAARS)</i></p> <p>The National Drug Research Institute (NDRI) conducts the Young Australians Alcohol Reporting System (YAARS), a survey of drinking habits of 14-19-year-olds focusing on the most recent risky drinking session of the heaviest 25% of drinkers by age and gender. Most of those surveyed in WA (87%) were in the Perth metropolitan area.⁷² When asked about their most recent risky drinking, 16% reported having been injured (including cuts and bruises).⁷² Most had not engaged in safety strategies to limit their drinking (e.g. alternating between alcoholic and non-alcoholic beverages) or drink in a less risky manner (e.g. avoid drinking games).⁷²</p> |
| <p>HN3.11 Reduce smoking rates, particularly among vulnerable populations.</p> | <p><i>Smoking is the leading risk factor contributing to Australia's burden of disease. Although smoking rates have declined overall, they remain high among people with alcohol and other drug problems, mental</i></p> | <p>A reported 9% of the total burden of disease in Australia can be attributed to tobacco use – the greatest single risk factor contributing to disease burden.⁵⁵ Twenty-two percent of the burden of cancer, 12% of the burden of cardiovascular disease, 36% of respiratory disease, 3.5% of endocrine disease and 0.5% of infections were attributed to tobacco use. Smoking rates in Australia have been steadily reducing and in 2016, 12% of Australians smoked daily compared to 24% in 1991.⁷³</p> <p>Smoking rates among people receiving alcohol and other drug treatment are very high, estimated between 74% and 98%.⁶⁴ Tobacco accounts for the highest rate of mortality among people with alcohol and other drug and mental health conditions.⁶⁴</p> |

Outcomes of the health needs analysis

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| | <p><i>health conditions, and for Aboriginal people.</i></p> | <p>The 2010 report on the Australian National Survey of Psychotic Illness found that two-thirds of people of people with psychosis are smokers. This proportion had not reduced since the 1997-1998 survey, despite smoking rates reducing among the general population over this period.</p> <p>Place based</p> <p><i>Smoking</i></p> <p>Social health atlases published by the Public Health Information Development Unit (PHIDU) give place-based estimates of smoking based on the NHSDS. This highlighted significantly high rates of smoking among men living in Mundaring and men and women living in Swan relative to state wide rates (for each gender)</p> <p>At publicly funded alcohol and other drug treatment services, nicotine is rarely the principle drug of concern, accounting for just 0.5% of clients in Perth North PHN from 2016 to 2017.⁶¹ Some PHNs have a much higher proportion of clients at alcohol and other drug services primarily for nicotine addiction, such as Country SA (7.9%), Adelaide (5.5%), and Western Queensland (5.1%).⁶¹ At the state level, the Australian Institute of Health and Welfare has also released the additional drug of concern. Although nicotine was the principal drug of concern in 0.3% of episodes, it is listed as an additional drug of concern in 20% of episodes.⁶¹</p> |
| <p>HN3.12 Higher levels of harmful alcohol and drug use among the LGBTI community may increase their health risks.</p> | <p><i>Higher levels of drug use among the LGBTI community.</i></p> | <p>The National Drug and Alcohol Strategy Survey reported that 42% of homosexual/bisexual people had recently used drugs, compared to 14.5% of heterosexual people. This was the highest percentage of any of the social characteristics explored, which included education, labour force status, spoken language, remoteness, marital status, indigenous status, household composition and sexual orientation.</p> <p>A study of 2,733 gay and bisexual men in Australia found that 4.4% used anabolic androgenic steroids,⁷⁴ consistent with international studies finding higher use among gay and bisexual men in comparison to heterosexual men. Given that gay and bisexual men are already at a higher risk of blood borne viruses, safe-injecting practices among anabolic steroid users are particularly important. The health risks associated with intravenous drug used are discussed in HN3.8.</p> |
| <p>HN3.13 Injuries and assault resulting from alcohol and other drug use.</p> | <p><i>Injuries and assaults can be reduced by reducing harmful alcohol and other drug use.</i></p> | <p>Twenty-six per cent of the burden of disease due to alcohol was estimated to have been due to accidental injuries and assault (suicide and self-inflicted injuries are discussed in HN3.5).⁷⁵ Large percentages of the burden of disease due to injuries such as road traffic accidents and drownings were due to alcohol (see</p> |

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summary below).⁷⁵ Results of the National Drug Strategy Household Survey found that single occasion risky drinkers (>4 standard drinks at least once per month) were 8.1 times more likely to have injured themselves or someone else in the last 12 months than low-risk drinkers.⁷⁶ These reports both highlight the short-term health risks associated with drinking.

| Injury type | % of burden due to alcohol use |
|---|--------------------------------|
| Other land transport injuries | 34.9 |
| Road traffic injuries - motorcyclists | 33 |
| Other road traffic injuries | 30.2 |
| Road traffic injuries - motor vehicle occupants | 29.7 |
| Homicide and violence | 22.5 |
| Drowning | 20.6 |
| Other unintentional injuries | 19.3 |
| Fire, burns and scalds | 17.8 |
| Accidental poisoning | 17.3 |
| Falls | 11.9 |

Accidental injuries (suicide and self-inflicted are discussed **HN3.5**) accounted for 39% of the burden of disease due to illicit drugs, but this was mainly due to accidental poisoning (discussed in detail in **HN3.4**). The remaining injuries linked to illicit drug use were road traffic injuries, accounting for 5.6% of the burden of disease due to illicit drug use. 5.2% of the burden of road traffic injuries were due to illicit drug use. Overall, alcohol use is responsible for a larger share of the burden of injury than illicit drug use.

Aboriginal Health (including Aboriginal chronic disease)

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| Identified Need | Key Issue | Description of Evidence |
| HN4.1 Poor health outcomes in disadvantaged areas. | <i>Socio-economic factors including poor rates of educational attainment, financial and housing instability, and low rates of employment are associated with long-term intergenerational physical and mental health problems.</i> | <p>The Indigenous Relative Socio-economic Outcome Index (IRSEO) represents the Indigenous Areas (IAREs) of social and economic disadvantage among Aboriginal people. Indicators reflecting disadvantage include low income, low educational attainment, high unemployment, and reliance on welfare for income and housing support.⁷⁷</p> <p>Greater Perth region</p> <p><i>Socio-economic disadvantage for Aboriginal population</i></p> <p>Aboriginal people living in the Greater Perth area are relatively less socio-economically disadvantaged (IRSEO=37) than state (IRSEO=56) and national (IRSEO=43) Aboriginal populations. However, the indicators of disadvantage are consistently poorer for Aboriginal people living in Perth North PHN, with one in five (20%) Aboriginal people unemployed, and nearly half of families solo-parented (48%) and one third jobless (36%).⁷⁷</p> <p>Place based</p> <p><i>Socio-economic disadvantage for Aboriginal population (IARE)</i></p> <p>Bassendean had the highest Indigenous Relative Socioeconomic Outcome Index (IRSEO) score (51), reflecting the highest disadvantage in the Perth North PHN. Additionally, Bassendean reported the highest rate in the PHN of Aboriginal single-parent families with children (59%), Aboriginal low-income families (18%), houses rented by the Government Housing Authority (27%), and dwellings without internet connection (27%).⁷⁷</p> <p>Stirling and Bassendean experience socio-economic disadvantage at rates that are significantly higher than the rest of the PHN. The highest proportion for jobless families with children (44%) is in Stirling and for single-parent families with children (59%), low-income families (14%), children in jobless families (44%) and houses rented by the Government Housing Authority (24%) is in Bassendean. Swan has the second highest IRSEO score of disadvantage (40) in the PHN, as well as the lowest rate of employment among all</p> |

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| | | Aboriginal residents (22%) and specifically for Aboriginal women (44%). ⁷⁷ |
| HN4.2 There is a need for accessible culturally secure primary care for Aboriginal people. | Aboriginal people have poorer health outcomes, including early onset and poor management of long-term health conditions, high mortality and morbidity, and poorer maternal and child health outcomes. | <p>The gap in health outcomes between Aboriginal and non-Aboriginal Australians is well documented, particularly around life expectancy, infant mortality, child mortality, chronic disease prevalence, potentially preventable hospitalisations and the burden of disease.⁷⁸ Chronic disease contributes significantly to the differences in life expectancy between Aboriginal and non-Aboriginal people. Aboriginal people experience 2.3 times the rate of disease burden, with an age standardised death rate for chronic disease 3.8 times the rate among non-Aboriginal people. In WA, 60% of Aboriginal people have been diagnosed with at least one chronic condition.⁷⁹</p> <p>Greater Perth and Whole of PHN</p> <p><i>Aboriginal population</i></p> <p>A lower proportion of Aboriginal people live in Perth North PHN (1.4%) than Perth South PHN (1.8%) and state (3.1%) rates, but this still accounts for a total of 14,103 Aboriginal people.⁷⁷</p> <p><i>Aboriginal morbidity and mortality</i></p> <p>In the five-year period between 2008 to 2012, 65% of deaths among Aboriginal people occurred before the age of 65, compared with 19% of deaths among non-Aboriginal people. The mortality rate for Aboriginal people was 1.6 times that of non-Aboriginal people (age-standardised rates of 981 and 596 deaths per 100,000 population, respectively). The largest difference between Aboriginal and non-Aboriginal mortality rates was for people aged 35-44, with male and female Aboriginal death rates 3.9 and 4.5 times the non-Aboriginal rates, respectively.⁸⁰</p> <p>From 2011-2015, cardiovascular disease was the leading cause of death for Aboriginal people, being responsible for 24% of the deaths of those living in WA. The next most common causes of death were neoplasms (mainly cancers) which were responsible for 21% of deaths, followed by external causes (injury) (15%).⁷⁹</p> <p>Aboriginal people born between 2010 to 2012 have a life expectancy of 65 years for males and 70 years for females. These expectancies are 10.6 years and 9.5 years less than non-Aboriginal males and females, respectively.⁸¹</p> |

Outcomes of the health needs analysis

Aboriginal hospital admissions for chronic conditions

Aboriginal hospital admissions for chronic conditions were significantly higher in WA (2,575 per 100,00 ASR) compared to Australia (2,034 per 100,000 ASR). In Perth North PHN, the Indigenous Area of Bayswater (3,087) has a significantly higher rate of hospital admissions for chronic disease compared to Australia. High rates were also prevalent in Stirling (2,293), Perth (2,282), Bassendean (2,788) and Mundaring-Swan View (1,788).⁷⁷

Aboriginal maternal and child health

Compared to the population state rate, Aboriginal mothers living in Greater Perth are over five times more likely to smoke during pregnancy. Aboriginal babies are 2.5 times more likely than non-Aboriginal babies to be of low birth weight and Aboriginal children are twice as likely to be developmentally vulnerable on one or more domains, and nearly three times as likely on two or more domains.⁷⁷

Domestic violence in the Aboriginal population

One in six Australian women and one in 16 men have been subjected, since the age of 15, to physical and/or sexual violence by a current or previous cohabiting partner.⁶ Domestic violence occurs at higher rates for Aboriginal Australians and is known to have negative mental, emotional and physical implications on victims, including increasing the risk of homelessness. In 2014 to 2015, Aboriginal women were 32 times more likely to be hospitalised due to domestic violence than non-Aboriginal women, while Aboriginal men were 23 times more likely to be hospitalised than non-Aboriginal men.⁷

Place-based

Aboriginal population

In the Perth North PHN, the SA3s with the highest proportion of Aboriginal residents are located in Mundaring (3.6% of total SA3 population), Swan (2.7%) and Kalamunda (1.8%), with the highest number of Aboriginal people living in Swan (3,516), Wanneroo (2,706) and Stirling (2,079).⁷⁷

Aboriginal maternal and child health (IAREs)

Within the Perth North PHN, indicators of poor Aboriginal maternal health include smoking during pregnancy in Perth (60%), Stirling (50%), Bassendean (48%) and Joondalup (48%). Significantly higher

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| | | <p>proportions of low birth weight babies in IAREs of Wanneroo-North-East (22%), and Stirling (21%). More than half of Aboriginal children in Stirling (54%) and Bayswater (52%) are developmentally vulnerable across one or more physical, social, cognitive and emotional indicators.⁷⁷</p> <p><i>Note: The impact of alcohol consumption and Foetal Alcohol Syndrome is discussed in the alcohol and other drug section.</i></p> <p><i>Aboriginal hospital admissions (IAREs)</i></p> <p>There are high rates of total hospital admissions for Aboriginal people living in IAREs of Perth (58,239 ASR per 100,000 Aboriginal persons), Bayswater (39,566) and Bassendean (37,505), all well above the Greater Perth average (28,985). Admissions in the Perth North PHN that are significantly higher than the national Aboriginal rate include⁷⁷:</p> <ul style="list-style-type: none"> • Bassendean (circulatory system and digestive system) • Bayswater (mental health problems, circulatory system diseases and injury, poisoning and other external causes) • Perth (mental health problems, respiratory system, digestive system and injury, poisoning and other external causes) • Stirling (mental health problems and injury, poisoning and other external causes) • Swan (circulatory system diseases). |
| HN4.4 Reduce harmful effects of mental health conditions on a person's health outcomes | <i>Mental illness and disorders are widely recognised as being a significant risk factor for suicide and self-harm.</i> | <p>Mental health conditions such as major depression, psychotic illnesses and eating disorders are associated with an increased risk of suicide³³ especially after discharge from hospital or when treatment has been reduced,³⁴ and people with harmful alcohol or drug use have a higher risk of dying by suicide than the general population.³⁵</p> <p><i>Youth suicide</i></p> <p>In WA, suicide is the main cause of preventable deaths for 15-24 year old's.³² The 2014 state Ombudsman's investigation into 36 suicide deaths by youth aged 13-17 years discussed several factors associated with suicide, these include demographic characteristics (i.e. being male and homeless), mental health conditions, suicidal ideation and behaviour, harmful alcohol and other drug use, experiencing child maltreatment and adverse family experiences. One or more of these factors was prevalent in the suicide</p> |

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| | | deaths of the 36 young people. ³⁹ Aboriginal youth made up 36% of suicide deaths, despite accounting for only 6% of the youth population in the state. |
| HN4.5 Servicing unmet need and increasing accessibility for vulnerable populations who are not engaged with health care services. | <i>Minority groups, including people who are Aboriginal, are more vulnerable to poor mental health.</i> | The 2014-15 National Aboriginal and Torres Strait Islander Social Survey ⁸² reported that nearly 33% of Aboriginal people aged over 15 years had high or very high levels of psychological distress - more than twice the rate of non-Aboriginal Australians. Moreover, mental ill health represents a significant barrier to accessing health services. Approximately 23% of Aboriginal people with a diagnosed long-term mental health condition indicated having difficulty accessing health services, compared to 10% of Aboriginal people with no long-term health conditions and 13% with other long-term health conditions. ⁸² Within Perth North, Swan SA3 has the highest number (3,516) and Mundaring SA3 has the highest proportion (3.6%) of Aboriginal residents. |
| HN4.6 Reduce harmful effects of alcohol and other drug consumption on health outcomes. | <i>Drinking more than recommended is common and increases the risk of disease and injury.</i> | Limiting daily alcohol consumption and avoiding single occasion heavy drinking is recommended to reduce harm. Current Australian guidelines published by the National Health and Medical Research Council to reduce health risks from drinking recommend drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury, and drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion. ⁵⁶ The disease burden due to alcohol experienced by Aboriginal people is 3.1 times that of non-Aboriginal people, accounting for 8.1 per cent of the health gap. ⁸³ For Aboriginal men, alcohol use disorders account for 5.8% of the total burden of disease and injury, second only to coronary heart disease. For men aged 25-44, alcohol use disorders were the leading contributor to disease burden. Alcohol use disorders account for 2.3% of the disease burden experienced by Aboriginal women. ⁸³ |
| HN4.7 Reduce the harmful effects of smoking on health. | <i>Smoking remains a major health concern, particularly for Aboriginal people</i> | A reported nine per cent of the total burden of disease in Australia can be attributed to tobacco use – the greatest single risk factor contribution to disease burden. ⁵⁵ Twenty-two per cent of the burden of cancer, 12% of the burden of cardiovascular disease, 36 per cent of respiratory disease, 3.5 per cent of endocrine disease and 0.5 per cent of infections were attributed to tobacco use. Smoking rates in Australia have been steadily reducing and in 2016, 12 per cent of Australians smoked daily compared to 24 per cent in 1991. ⁷³ The disease burden due to tobacco use experienced by Aboriginal people is 4.6 times that of non-Aboriginal people, and accounts for 23 per cent of the health gap. ⁸³ |

SECTION 3 – OUTCOMES OF THE SERVICE NEEDS ANALYSIS

This section summarises the findings of the service needs analysis in the table below. For more information refer to Table 2 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Additional rows may be added as required.

General Population Health

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| Identified Need | Key Issue | Description of Evidence |
| SN1.1 More health professionals and primary care services are needed in some economically disadvantage areas. | <i>Inadequate supply of primary care services to meet demand, particularly in areas of high socio-economic disadvantage where there are poor health outcomes and higher demand for primary care services.</i> | <p>Western Australia utilised primary care at lower than national rates with the second lowest level of Australian Government expenditure on general practitioners per person in 2015 to 2016. An ageing GP workforce and a move by younger Australian-trained GPs toward part-time employment will have significant impacts on access to primary care.⁸⁴</p> <p>A recent GP workforce study estimated that 21% of the GP workforce will retire by the end of 2021. This comprises an estimated 500 metropolitan general practitioners at a loss of 437 FTE. With a move toward greater work/life balance by many younger GPs there is a need to train 2.1 Australian-trained GPs to gain one full time clinician.⁸⁴</p> <p>A 2018 survey of WA health care consumers asked about consumer access to general practice and primary health care; 75% of respondents always visit the same practice and try to see the same GP each time, while 17% of respondents would be happy to visit any GP within their regular practice and only 5% would visit any general practice to access a convenient appointment. When asked what would improve their access to primary health care, the main themes were affordability, flexible appointment times and an increase in clinician availability and FTE.⁸⁵</p> <p>Note: Information regarding the FTE of health professionals is sourced from the National Health Workforce Data Set which does not specify if the workforce is employed in the primary care or tertiary care sector.</p> <p>Whole of PHN</p> <p><i>Allied health workforce supply</i></p> |

Outcomes of the service needs analysis

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| | | <p>Perth North PHN has a relatively high number of full-time equivalent health practitioners per 10,000 resident population especially nurses (125.7), midwives (7.2), dental practitioners (10.4), occupational therapists (9.7), pharmacists (11.6), and physiotherapists (13.0). Some of these high numbers can be attributed to the four hospitals (Sir Charles Gairdner Hospital, Royal Perth Hospital, Joondalup Health Campus and Midland Public Hospital) located in the Perth North PHN region.</p> <p><i>Access to general practice</i></p> <p>The total number of general practices available in WA is 653. Perth North PHN residents had access to (248) general practices, similar to Perth South PHN (250).⁸⁶ Perth North PHN had a similar supply of GPs (8.7) compared to Perth South PHN, state and national rates.⁸⁷</p> <p>Place-based</p> <p><i>Allied health workforce supply</i></p> <p>Low health professional to population ratios exist across nearly all disciplines in Mundaring, Swan, Wanneroo, and Kalamunda.</p> <p><i>Access to general practice</i></p> <p>Mundaring (7), Kalamunda (14) and Bayswater-Bassendean (18) had the lowest supply of general practice while Wanneroo (45), Perth City (44) and Joondalup (35) had the largest supply of general practice in Perth North PHN.⁸⁶ Highest GP to population ratios are in Perth City (29.8 per 10,000 resident population), Cottesloe-Claremont (22.7), Joondalup (15.1)), with all other regions lower than state (13.4) and national averages (13.6). Particularly low GP to population ratios are in Mundaring (7.7 per 10,000 resident population), Stirling (7.4), Wanneroo (9.8), Bayswater-Bassendean (8.9) and Kalamunda (10).⁸⁷</p> |
| <p>SN1.2 There is a need for appropriately targeted services for vulnerable groups, particularly sub-</p> | <p><i>Services should be targeted to specific high-risk groups, to increase accessibility and acceptability for vulnerable people.</i></p> | <p>Whole of PHN</p> <p>There is a lack of multidisciplinary, community-based services in some areas of Perth North PHN which may impact on the support available to assist people to manage their social, cultural and economic circumstances. Consultation with local stakeholders identified a particular lack of culturally appropriate services for CALD populations, residents with poor English proficiency and newly arrived immigrants.⁸⁸ Access to after-hours primary care services is also a specific area of concern for people from CALD backgrounds across Perth North PHN. Further mapping is required to ascertain the full</p> |

Outcomes of the service needs analysis

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| <p>regions with culturally and linguistically diverse populations.</p> | | <p>range of services offered to vulnerable communities to identify program and service gaps for vulnerable groups across the region.</p> <p>Place-based</p> <p>There are no existing CALD-specific resources or groups evident in the Bayswater region,⁸⁸ where there is the highest proportion of the CALD population in Perth North PHN (25% of Bassendean-Bayswater population is born overseas).⁴⁷</p> |
| <p>SN1.3 There is a need for targeted services for older adults who use high rates of primary care resources, particularly GP services.</p> | <p><i>As the population of older adults continues to grow, there will be an increasing number accessing primary care for complex chronic condition management, particularly GP services.</i></p> | <p>The use of primary health resources by older adults has increased considerably in the past 15 years, with rates higher than expected from population growth. This is largely due to people living longer, more people acquiring and being diagnosed with more conditions, and each condition being managed for a longer period of time. Older adults (aged 65 years and over) are significantly more likely to have used a primary, hospital-based or allied health service than younger adults (16 to 64 years), but significantly less likely to have used mental or alternative health services.⁸⁹</p> <p>In particular, GPs play a significant role in the lives of many older adults as primary health care providers and as a point of referral to other health services. In 2012-13, older adults in Australia visited their GP 10.4 times on average, with people over 60 accounting for 57% of those who attended a GP more than 20 times, and 45% of those who attended between 12 and 19 times.²¹</p> <p>Aged care services in Australia are funded and delivered in regions called Aged Care Planning Regions. In Perth North PHN, these regions are called Metro North and Metro East.⁹⁰</p> <p>Whole of PHN</p> <p>Despite a growing ageing population in Perth North PHN, the proportion of aged care places (per 1,000 people aged over 70 years) is 75.5, which is below the state rate (76.0).¹⁵ Qualitative feedback indicates there is also difficulty recruiting GPs and registered nurses to work in residential aged care facilities across Perth North PHN.⁸⁸ Improved access to a GP after hours in residential aged care, particularly for phone orders for medications, would assist staff to manage residents in aged care facilities rather than transferring them to an emergency department.⁹¹</p> <p>Home Care Packages are available for older Australians to access affordable care services at home. There are four levels of home care packages depending on the level of care need, which is determined by an aged care assessment. The levels range from level 1 (basic care needs) to level 4 (high-level care needs). As at 31st December 2018, there were a total of 8183 home care packages in Western Australia and about 41% of these were at Level 4.⁹⁰</p> |

Outcomes of the service needs analysis

In WA, the Home and Community Care (HACC) programme has commenced transition to the Commonwealth Home Care Support Programme (CHSP). CHSP is an entry level home help programme for people requiring temporary or short-term care including; community and home support, meals and food services, and respite care. Applications and eligibility assessments for CHSP are sought through the My Aged Care website. System navigation and access to internet connectivity have been identified as barriers to accessing these services. Additionally, a growing ageing population in Perth North PHN will continue to increase demand for all aged care services.

The target population for CHSP people aged 65 years and over and Aboriginal people aged 50-64 years. The following information relates to CHSP clients in Western Australia in 2017-18.⁹²

- 91.9% of clients were in the target population.
- 63.2% of clients were female.
- The highest proportion of CALD clients was in the 90-94 years age group (20.7%) and the lowest was in the 0-49 years age group (4.5%).
- The proportion of Indigenous clients decreased with age: the highest proportion was in the 0-49 years age group (60.2%).
- 27.2% of clients lived alone
- 8.1% of clients had one or more dependents.
- The five most common services utilised were: allied health and therapy, flexible respite, centre-based respite, cottage respite, and assistance with care and housing.
- The highest expenditure was for flexible respite.
- The highest number of hours were for cottage respite. (Cottage respite is available overnight or over a weekend. Takes place in the community or in the home of a host family. It can be taken for two to three days at a time).

Place-based

The areas with the lowest rate of residential aged care places per 1,000 population aged over 70 years are Kalamunda (37.2), Mundaring (41.5) and Joondalup (46.6).¹⁵ These areas are also projected to have an increasing ageing population by 2025.¹

Home Care Packages

In Perth North PHN, Metro East had about half the number of home care packages (1104) as Metro North (2131). Both

Outcomes of the service needs analysis

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| | | <p>regions had a similar proportion of Level 4 packages (39% and 38%, respectively). Metro North had a higher number of providers (31) than Metro East (27).⁹⁰</p> <p>The number of people awaiting a home care package at their approved level, who have yet to be offered a lower level package was higher in Metro North(1950), more than double the number in Metro East (887).⁹⁰</p> <p><i>After-Hours GP Attendance Residential Aged Care Facilities</i></p> <p>In Perth North PHN, Mundaring, Kalamunda and Swan SA3s had the lowest utilisation of after-hours GP attendances in residential aged care facilities between 2014-15 and 2016-17.⁹³</p> <p>The Perth North Coastal region has a more complex ageing cohort and is also a popular place to retire, compounding the strain on services for older adults in this region. Distances required to travel to access health care services in this region may also pose considerable challenges to the disabled and ageing.⁸⁸ Further research is needed to identify specific service gaps and sub-regions requiring targeted attention to ensure the service needs of the ageing population are met.</p> |
| <p>SN1.4 There is a need for transition programs to support people moving from one service to another and back into the community, particularly people travelling from country regions.</p> | <p><i>Services need to be integrated and collaborative in order to provide person-centred care that meets individual needs.</i></p> | <p>Whole of PHN</p> <p>Qualitative feedback has identified that Western Australia has current inefficiencies in the co-ordination and integration of primary and secondary care services, leading to system-based problems including:⁸⁸</p> <ul style="list-style-type: none"> • Increased waiting times for treatment in secondary care • High number of inappropriate referrals to secondary care • Inefficient use of resources • Poor discharge from secondary to primary care/general practice • Lack of system integration. <p>There is also a high level of population flow in relation to Country WA PHN residents travelling to health services and specialist appointments in Perth North PHN. There is often a lack of integration and collaboration between services in the country and metropolitan regions, and communication back to the patient. This can create isolation, a lack of understanding and inconsistent care.⁹⁴</p> <p>System navigation and care coordination is an issue for all primary health clinicians. Awareness of other service providers and programs are limited and care coordination between multiple clinicians is challenging in time-poor environments.⁹⁵</p> |

Outcomes of the service needs analysis

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| | | <p>The development of Health Pathways enables GPs to manage and refer their patients to the most appropriate local care, working to improve the integration of care across services. As of August 2018, over 423 localised Health Pathways have been developed in a variety of diagnostic categories across Western Australia, and page views by GPs have increased considerably in two years (9,388 in November 2015 to 354,193 in August 2018).⁹⁶</p> <p>Place-based</p> <p>There is limited focus on transition out of services across Perth North PHN. Stakeholder feedback indicates issues for some in transitioning from child to adult diabetes services, from hospital to home services for other people, people experiencing mental health issues, and homeless people in Perth North PHN.⁸⁸ Further research is needed to identify the extent of these transition issues in specific areas across Perth North PHN.</p> |
| <p>SN1.5 Uptake of targeted early intervention primary care could be improved.</p> | <p><i>Targeted early intervention and/or secondary prevention in primary care could prevent the development of chronic conditions and disease.</i></p> | <p>Early treatment is the most effective way to reduce the impact of chronic and comorbid conditions. Early intervention can produce significant long-term health care savings and improve overall quality of life. Cancer screening has been shown to reduce morbidity and mortality by cancer through early detection and treatment. Childhood immunisation is recommended as a safe and effective way of protecting against harmful diseases and reducing overall spread of disease. Jurisdictions are mandated to ensure childhood immunisation rates are at least 90%, with a national ‘Strive for 95%’ target. This target informed the ‘Western Australian Immunisation Strategy 2016-2020’ which outlined a framework for enhancing all aspects of immunisation program service delivery.⁹⁷</p> <p>Whole of PHN</p> <p><i>Cancer screening</i></p> <p>Participation in breast cancer screening, cervical cancer screening, and bowel cancer screening is similar in Perth North PHN (58%; 58%; 43%) compared to Perth South PHN (56%; 54%; 43%) and state rates (57%; 56%; 43%).⁹⁸</p> <p><i>Avoidable mortality by cancer</i></p> <p>There are similar rates of avoidable mortality from cancer in Perth North PHN (25 ASR per 100,000), compared to state (27) and national rates (29).</p> <p><i>Immunisation</i></p> |

Outcomes of the service needs analysis

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| | | <p>The percentage of fully immunised children in Perth North PHN aged five years old (91%) is under the national immunisation target (95%)¹</p> <p><i>Potentially Preventable Hospitalisations (PPHs) for vaccine preventable conditions</i></p> <p>The <i>Potentially Preventable Hospitalisation Hotspots in Western Australia</i> (2017) identified three hotspots for vaccine preventable conditions in Perth North PHN located in SA3 of Mundaring, Stirling and Wanneroo. Vaccine preventable conditions include instances of influenza and pneumonia that were vaccine preventable as well as diseases that could have been prevented through childhood vaccinations. Vaccine preventable hotspots were located in the SA2 of Chidlow, Balga-Mirrabooka and Alexander Heights-Koondoola. Hotspots in Chidlow may be attributed to the presence of Acacia prison located within the SA2.</p> <p>Place-based</p> <p><i>Cancer screening</i></p> <p>There are lower screening rates for all cancers in Swan and Wanneroo compared to Perth North PHN averages; also low rates of screening for bowel cancer in Perth City (41%) and Bayswater-Bassendean (41%), breast cancer in Cottesloe-Clairemont (49%), and cervical cancer in Kalamunda and Bayswater-Bassendean (both 56%).⁹³</p> <p><i>Avoidable mortality by cancer</i></p> <p>Avoidable mortality by cancer was not significant within any SA3s.</p> <p><i>Immunisation</i></p> <p>There are low overall immunisation rates for children aged one to five years in Mundaring (89%), Perth City (90%) and Stirling (90%).</p> <p><i>Potentially preventable hospitalisations for vaccine preventable conditions</i></p> <p>Three hotspots for vaccine preventable conditions in Perth North PHN located in SA3 of Mundaring, Stirling and Wanneroo. Vaccine preventable hotspots were located in the SA2 of Chidlow, Balga-Mirrabooka and Alexander Heights-Koondoola. Hotspots in Chidlow may be attributed to the presence of Acacia prison located within the SA2 Hotspots in Balga-Mirrabooka and Alexander Heights-Koondoola could be attributed to a higher proportion of hepatitis B hospitalisations.²¹</p> |
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| <p>SN1.6 Lack of access to and awareness of appropriate primary care services across Perth North PHN.</p> | <p><i>A lack of access to and awareness of appropriate primary care services, both during and after-hours, further compounds issues of service demand and timely and appropriate care, often resulting in increased reliance on unnecessary ED services.</i></p> | <p>Approximately 80% of non-urgent ED presentations in Western Australia occur during the week day business hours of 8am and 4pm, indicating a large proportion of non-urgent ED presentations could be prevented by accessing primary care services.⁸⁸ After-hours primary medical care provided by GPs, community health centres, co-located general practice (AHGP) clinics and telephone helplines can help meet demand for those seeking medical attention outside of these hours to reduce demand on ED services. However, residents need to have adequate access to (including location and cost) and awareness of during and after- hours primary care services to maximise primary care utilisation and alleviate pressure on secondary and tertiary systems.</p> <p>A 2018 survey of 137 WA health care consumers asked about consumer experiences when accessing after-hours primary care. Half of the respondents had accessed an after-hours primary care service while 46% had not. Of those who accessed a service, 48% described accessing after-hours primary care as easy because they were aware of specific services. Of the 46% who did not access an after-hour primary care service, 16% of consumers did use an emergency department to access after-hours primary care while 13% booked a home visiting GP. When asked what one thing would make the greater difference in improving their ability to get access to health care, some respondents indicated that accessing after-hours care would have a significant impact. One respondent said that they “attend an after-hours clinic because there are more times available that are convenient” (man, aged 45-54).⁸⁵</p> <p>Whole of PHN</p> <p><i>Utilisation of GP after-hours services</i></p> <p>A total of 43% of general practices in Perth North PHN are delivering after-hours services, with utilisation of GP after-hours MBS services for urgent and non-urgent consultations in Perth North PHN (46 per 100 population) higher than Perth South PHN (36) and state utilisation (36), but lower than national rates (49).⁹⁹</p> <p><i>Provision of after-hour services in General Practice</i></p> <p>After-hours primary care refers to periods during the week and on the weekend when GP Clinics are typically closed. After-hours primary care is defined as the hours between:</p> <ul style="list-style-type: none"> • After 6pm Monday to Friday • After 12pm Saturday • All hours Sunday and public holidays.¹⁰⁰ |
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| | | <p>Data sourced from the National Health Service Directory indicates that 129 General Practices provide some level of after-hours primary care in Perth North PHN, either opening after 6pm on weekdays or providing weekend appointments.</p> <p><i>Utilisation of Healthdirect after-hours GP helpline</i></p> <p>Healthdirect Australia is contracted to provide an after-hours telephone-based GP service which complements existing after-hours health services. The after-hours GP helpline is a national service funded by the Australian Government. In 2018, there were 3,291 episodes recorded for the after-hours GP Helpline in Perth North PHN. Only 8.6% of callers were advised to go to the Emergency Department immediately while 60% were advised to administer self-care and visit a GP. There were more female (60%) patients calling the helpline than male (40%) patients.¹⁰¹</p> <p><i>GP Urgent Care Network Pilot</i></p> <p>The General Practice Urgent Care Network Pilot is a partnership between the WA Department of Health and the WA Primary Health Alliance. The Pilot offers urgent care appointments at General Practices using an online booking service through Healthdirect's National Health Services Directory. In Perth North PHN, 60 General Practices are involved in the Pilot.</p> <p>Place-based</p> <p><i>Utilisation of GP after-hours services</i></p> <p>There are low rates of MBS utilisation of GP after-hours services in Mundaring (15 per 100 resident population), Kalamunda (15), Cottesloe-Claremont (17) and Wanneroo (21), with high utilisation in Perth City (91) and Stirling (70).⁹⁹</p> <p><i>Utilisation of Healthdirect after-hours GP helpline</i></p> <p>Stirling (576), Swan (605) and Wanneroo (763) had the highest number of episodes in 2018 while Mundaring (98) and Cottesloe- Claremont (77) had the lowest.¹⁰¹</p> <p><i>GP Urgent Care Network Pilot</i></p> <p>Swan (13) and Wanneroo (13) SA3s had the largest number of General Practices participating in the Pilot. Mundaring (2), Bayswater-Bassendean (3) and Cottesloe-Claremont (3) had the least.</p> |
| SN1.7 Services could be better | Lack of person-centred care coordination for | An estimated 20% of primary care users require service coordination for chronic and complex conditions. ¹⁰² Coordinated, team-based care is central to improving services for people with complex needs. Primary care services are expected to |

Outcomes of the service needs analysis

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| <p>tailored to meet individual needs of people with multiple risk factors/chronic conditions.</p> | <p><i>those with composite risk factors and comorbid chronic conditions.</i></p> | <p>coordinate with one another and with specialist services. This is difficult for small organisations funded largely on a fee-for-service basis. General practices do not have the organisational capacity to develop, coordinate and manage integrated service delivery across a network of providers for people with complex care needs..¹⁰²</p> <p>A 2018 survey of WA health care consumers indicated that general practitioners provided the majority of care coordination for patients. Of 137 respondents, 71 consumers had a health professional help coordinate their care or the care of a person they supported. The care coordination for the majority of patients was provided by their general practitioner (68%). Fifty consumers reported that the care coordination helped them manage their chronic condition or the chronic condition of the person they supported. One respondent, who received treatment for a chronic condition, said that they “really appreciate” their “family doctor and have done so for the past 18 years” (woman, aged 55-64).⁸⁵</p> <p>Place-based</p> <p>Consultation with the local Joondalup, Midland, Swan and Wanneroo community identified issues with providing culturally secure services for Aboriginal people living with comorbid alcohol, drug and mental health issues.¹⁰³ Service providers in these areas also reported difficulty in meeting needs of clients that presented with complex and comorbid issues, and the difficulty in facilitating access to the right care without clients needing to wait for extended periods of time to receive help.¹⁰³</p> |
| <p>SN1.8 There is a need to promote best-practice management of chronic conditions in primary care.</p> | <p><i>Poor management of patients with chronic conditions can lead to serious complication, loss of quality of life, and increased burden on tertiary care through potentially preventable hospitalisations.</i></p> | <p>Appropriate and best-practice management of chronic conditions in primary care is important. GP chronic disease management plans provide the structure for the multidisciplinary team required for effective multidisciplinary care; however, it is estimated that only one third of patients with chronic disease in Australia receive a GP management plan, with less than 20% of plans reviewed regularly.¹⁰⁴</p> <p>Barriers to the delivery of best practice chronic disease management include:¹⁰⁴</p> <ul style="list-style-type: none"> • Complexity of communication within the care team • Time spent putting together management plans which are up-to-date, evidence-based and personalised for the patient • Keeping track of the responsibilities of everyone on the care team and ensuring that duty of care and responsibilities are properly discharged • Lack of time and resources required to provide patient self-management support |

Outcomes of the service needs analysis

- Administrative overheads and red tape associated with meeting documentation and paperwork requirements.

Whole of PHN

Utilisation of MBS GP chronic disease services

There are similar rates of utilisation of MBS GP chronic disease services in Perth North PHN (28 per 100 resident population) compared to Perth South PHN (29), Country WA PHN (28), state (28) and national rates (27)⁹⁹

Potentially preventable hospitalisations (PPHs) for chronic conditions

Fourteen PPH hotspots for chronic conditions were identified in Perth North PHN. These include diabetes complications, COPD, angina, congestive heart failure and iron deficiency anaemia.¹⁹

Place-based

Utilisation of MBS GP chronic disease services

There is a high rate of utilisation for MBS GP chronic disease services in Wanneroo (40 per 100 resident population), Joondalup (36) and Swan (35), with low utilisation in Mundaring (14), Stirling (18) and Perth City (19).⁹⁹

Potentially preventable hospitalisations (PPHs) for chronic conditions

A hotspot is an area that shows a rate of hospitalisation of at least 1.5 times over the state average for a three-year period to 2015-16. The following hotspots were identified for chronic conditions in Perth North PHN:¹⁹

- Bassendean-Eden Hill-Ashfield, Maylands, Hazelmere-South Guildford, Middle Swan-Herne Hill (SA2) diabetes complications
- Balga-Mirrabooka (SA2) diabetes complications and COPD
- Bullsbrook and Midland-Guilford (SA2) COPD
- Stratton-Jane Brook and Clarkson (SA2) COPD and angina
- Lockridge-Kiara (SA2) iron deficiency
- Alexander Heights-Koondoola (SA2) congestive heart failure.

Outcomes of the service needs analysis

SN1.9 There are several sub-regions with a higher proportion of adults facing health care barriers related to cost, transport and connectivity.

Services need to be affordable and accessible, particularly to meet the health care needs of those in vulnerable and disadvantaged groups.

A 2018 survey of WA health care consumers asked what the major barriers were to accessing primary health services. The main barriers reported were cost, being too busy and not giving health enough priority, and waiting weeks or months for available appointments. In response to having to wait for appointments, the ideal waiting periods for respondents varied. One respondent said that “being able to get an appointment with my preferred GP in a day or two” (gender not identified, 55-64) would improve their ability to access health care. Another respondent said that not having to “wait more than a week for a GP appointment” (man, aged 65-74) would help in accessing health care. When asked if anything else had made it difficult in the past 12 months to get the right care, some respondents expressed their concern with the quality of the treatment they were receiving, including having their concerns dismissed and the fear of stigma and discrimination. One respondent, who received treatment for two chronic conditions, said that the “fear of judgment” (woman, aged 25-34) impacted their ability to get the right care. Another respondent said that “professionals who are willing to give your case more attention instead of being dismissive” (woman, aged 35-44) would make the greatest difference in accessing health care.⁸⁵

Whole of PHN

Barriers to accessing health care

Adults living in Perth North PHN are likely to face barriers to accessing health care at similar rates to Perth South PHN, Barriers to accessing health care in Perth North PHN may include cost (1.3 ASR per 100), no motor vehicle access (5.0%) and lack of home Internet access (10.5%).¹

Waiting times

Almost one in four people who saw a GP in Perth North PHN felt they waited longer than acceptable to get an appointment (24%), similar to the national average (23%).¹⁰⁵

Place-based

Barriers to accessing health care

In Perth City, Stirling, Swan and Bayswater-Bassendean⁴⁷:

- Between 10% to 14% of residences do not have an Internet connection
- Between 3% to 11% of residences have no motor vehicle
- Between 1.3 to 1.7 ASR per 100 adults reported cost as main barrier to accessing health care.

| Outcomes of the service needs analysis | | |
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| | | <p><i>Waiting times</i></p> <p>Barriers to receiving adequate care in the Midland and Swan area included accessibility, transport issues and unsuitable service opening hours.¹⁰³</p> |
| <p>SN1.10 Patients experience difficulty navigating the complex health care system, impacting engagement in appropriate and timely care.</p> | <p><i>Patients need to understand how to access the right care at the right place at the right time through effective communications and relationships with primary care providers.</i></p> | <p>A 2018 survey of 137 WA health care consumers asked what the major barriers were to accessing primary health services. When asked if anything else had made it difficult in the past twelve months to get the right care, some respondents said that navigating the health system had made it difficult to access health care. One respondent said “knowing where to go and being able to direct what I needed” (woman, aged 55-64) would make the greatest difference.⁸⁵</p> <p>Place-based</p> <p>Community consultation with the local Joondalup, Midland, Swan and Wanneroo community related to drug, alcohol and mental health services in the area identified a key barrier to receiving help was not knowing where to go, difficulty for both the provider and the client in knowing what local services were available, how to access them, and how to navigate the complex system.¹⁰³</p> <p>Further research is needed across Perth North PHN to identify how to support patients to navigate and access the appropriate care in an efficient and timely manner.</p> |
| <p>SN1.11 Low uptake of digital health technologies, including telehealth and My Health Record.</p> | <p><i>Digital technologies support the efficiency and effectiveness of the health system and can increase patient access to more primary care services</i></p> | <p>Digital health includes a broad range of innovative technologies for the purposes of providing care and sharing information to enhance patient outcomes. Telehealth can deliver health services and facilitate communication between specialists and patients, whilst electronic medical records such as the national My Health Record can facilitate communication and coordinated care across multiple practitioners. In 2018, every Australian will get a ‘My Health Record’ unless they choose to opt out. Information available through My Health Record can include, a patients a patient’s health summary, medication prescribing and dispensing history, pathology reports, diagnostic imaging reports and discharge summaries.</p> <p>The uptake of digital health technologies has been inconsistent across Western Australia and has yet to be normalised as part of primary care practice. Qualitative feedback indicated that readily accessible and affordable clinical software for primary care clinicians would significantly improve interactions with My Health Record and other digital technologies.¹⁰⁶</p> |

Outcomes of the service needs analysis

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| | | <p>A 2018 survey of WA healthcare consumers responded to questions on accessing health care and health care providers through technology. Only 37 respondents were comfortable utilising technology for an initial consultation; 73 respondents were comfortable utilising technology for follow-up appointments and 82 respondents were comfortable utilising technology to monitor ongoing conditions; but only 11 respondents currently utilised technology to engage with a health service remotely on a regular basis.⁸⁵</p> <p>Whole of PHN</p> <p><i>Telehealth</i></p> <p>There are similar low rates of MBS utilisation for telehealth services in Perth North PHN compared to Perth South PHN and state rates (0.3 per 100 resident population), and lower than Country WA PHN (0.5) and national rates (0.4).⁹⁹</p> |
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Primary Mental Health Care (including Suicide Prevention)

| Outcomes of the service needs analysis | | |
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| Identified Need | Key Issue | Description of Evidence |
| SN2.1 Models of care focused on early intervention to enable effective self-management and prevent exacerbation of existing mental health conditions, or development of suicidal ideation. | <i>There are sub-regions in Perth North PHN with relatively high levels of psychological distress and/or mental and behavioural disorders.</i> | <p><i>Psychological distress</i></p> <p>The Kessler 10 (K10) scale is a 10-item questionnaire that provides a global measure of psychological distress based on questions about anxiety and depressive symptoms over a 30-day period. Based on data from the WA Health and Wellbeing Surveillance System (HWSS)¹⁰⁷, the prevalence of high and very high psychological distress among adults aged 16 years and over in Perth North PHN (8.1%) was not significantly higher than the state rate (8.2%). There were no sub-regions in Perth North PHN with significantly high rates compared to either PHN or state rates.</p> <p>As part of National Mental Health Week 2018, headspace released the following data on the prevalence of psychological distress among young Australians.¹⁰⁸</p> <ul style="list-style-type: none"> • About 32% of youth (12-25-year-olds) in Australia reported high or very high levels of psychological distress – more than three times the rate in 2007 (9%). • Western Australia had the second highest rate (33%), after Victoria (35%). • Rates of psychological distress were significantly higher for young women (38%) compared to young men (26%). • The highest rates were reported for 18-21-year-olds (38%). <p>Young people are particularly vulnerable to mental health issues during transitional periods including leaving school and entering the workforce, moving out of home and relationship breakups.¹⁰⁸</p> <p><i>Mental and behavioural disorders</i></p> <p>Based on data from the WA Health and Wellbeing Surveillance System (HWSS)¹⁰⁷, the prevalence of anxiety and depression among adults aged 16 years and over in Perth North PHN (9.1% and 8.3%, respectively) was not significantly higher than state rates (8.6% and 8.4%, respectively). There were no sub-regions in Perth North PHN with significantly high rates compared to either PHN or state rates.</p> |

Outcomes of the service needs analysis

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| <p>SN2.2 Shortage of early intervention services, particularly in suburban growth corridors.</p> | <p>Limited early intervention services available across the PHN for people with mental and behavioural issues, and suicide risk.</p> | <p>The Integrated Atlas of Mental Health¹⁰⁹ shows that in Perth North PHN, mental health services are generally concentrated in inner areas, with relatively limited service provision in suburban growth corridors, such as the north-western corridor within Wanneroo SA3. Although Perth City SA3 has a relatively high supply of services, there are limited services in the neighbouring Bayswater – Bassendean SA3, an area with high rates of psychological distress, mental and behavioural disorders, and suicide risk.</p> <p><i>Early intervention, child and youth services</i></p> <p>WAPHA funds headspace centres in Joondalup, Osborne Park, and Midland. The service is designed to provide early access for young people and their families to receive the help they need for problems affecting their wellbeing. To address the needs of young people with, or at risk of, severe and complex mental illnesses, trauma-informed youth mental health clinicians have been appointed within these centres. The centres also provide the hYEPP program, delivering specialist treatment to young people experiencing, or at risk of developing psychosis.</p> <p>The following is a summary of other WAPHA-funded services across Perth North PHN.</p> <ul style="list-style-type: none"> • The Trauma Transformation Initiative (TTI) provides support to survivors of child sexual abuse and seeks to raise awareness in the general community about childhood trauma. • DBTeen is an evidence-based multi-family treatment program to address severe emotional dysregulation among 14-18-year-olds using the principles of Dialectical Behaviour Therapy (DBT). Target areas are City of Swan and City of Wanneroo. • In Stirling and Joondalup LGAs, the Group Psychological Therapies program supports young people with, or at risk of, severe mental illness. • The Family Therapy Program in Northbridge, Joondalup and Midland assists people to manage systemic family issues that are contributing to mental health problems within the family, such as domestic violence, problematic Alcohol and Other Drug (AOD) use, grief, disability, trauma and parenting challenges. |

Outcomes of the service needs analysis

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| <p>SN2.3 Capacity of the health workforce to recognise and respond to mental health presentations.</p> | <p><i>Inadequate supply of primary care services mean people with health care needs are not able to access the right care at the right time in order to effectively manage their health.</i></p> | <p>Whole PHN</p> <p><i>Workforce supply</i></p> <p>Perth North PHN had a higher number of full-time equivalent psychologists and psychiatrists but a lower number of general practitioners (GPs) per 10,000 residents compared to WA overall in 2017.⁸⁷ Perth North PHN had the highest number of GPs as well as the highest percentage of non-vocationally registered (non-VR) GPs in Western Australia.</p> <p><i>MBS utilisation</i></p> <p>In 2017-18, about 8.0% of the population in Perth North PHN utilised GP mental health treatment plans compared to 8.5% of the population across Australia.¹¹⁰ Across metropolitan PHNs as well as Australia overall, utilisation of clinical psychologists was lower than other types of psychologists. However, Perth North PHN had a relatively high utilisation of clinical psychologists (2.9%) compared to other types of psychologists (2.1%) and this rate was higher than metropolitan PHN (2.3%) and national (2.1%) clinical psychology utilisation rates.</p> <p>Place-based</p> <p><i>Workforce supply</i></p> <p>In Perth North PHN, the lowest supply of psychologists was in Wanneroo, Kalamunda and Bayswater - Bassendean SA3s (< 4 FTE per 10,000 residents).⁸⁷ Mundaring and Stirling SA3s had the lowest supply of GPs in Perth North PHN (< 8 FTE per 10,000 residents). Moreover, Mundaring SA3 had the highest percentage of non-vocationally registered (non-VR) GPs (33%). There was a very low or no supply of psychiatrists practising in Bayswater – Bassendean, Mundaring, Wanneroo or Kalamunda SA3s as at 2017. In contrast, Perth City and Cottesloe-Claremont SA3 had the largest supply of psychologists, GPs and psychiatrists per 10,000 residents in Perth North PHN. Some of these high rates can be attributed to Graylands Hospital (Mental Health Service and inpatient unit) located within the Cottesloe-Claremont SA3 and Royal Perth Hospital located within the Perth SA3.</p> <p><i>MBS utilisation</i></p> |
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Outcomes of the service needs analysis

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| | | <p>The following relates to the percentage of the population that utilised MBS-subsidised mental health-related services in 2017-18.¹¹⁰</p> <ul style="list-style-type: none"> • The lowest utilisation rates of GP mental health treatment plans were in Cottesloe – Claremont (6.3%), Stirling (6.7%), and Bayswater – Bassendean (7.1%). In contrast, Wanneroo SA3 had the highest rate (10.1%), which was well above metropolitan PHN (8.4%) and national (8.5%) rates. • In every SA3 except Swan and Wanneroo, utilisation of clinical psychologists was higher than other types of psychologists. • Cottesloe – Claremont SA3 had the highest utilisation of clinical psychologists and psychiatrists, which may be partly attributed to Graylands Hospital (mental health service and inpatient unit) located within this sub-region and/or the capacity for out of pocket payments. |
| <p>SN2.4 Prescription rates are an indicator of mental health service utilisation.</p> | <p><i>Current mental health interventions have high reliance on pharmaceutical interventions.</i></p> | <p>[This section has been redacted for data confidentiality reasons]</p> |
| <p>SN2.5 Reduce over-reliance on the acute care sector.</p> | <p><i>Non-urgent mental health-related ED presentations may be a reflection of poor management of mental health conditions in primary health care.</i></p> | <p>Whole PHN</p> <p>A report by the UWA Collaborative for Healthcare Analysis and Statistical Modelling to the CHASM Governance Committee and the Aboriginal Health Research Translation Group¹¹¹ determined that increased proximity to primary care was strongly associated with lower rates of mental health-related ED presentations among young non-Aboriginal adults (25-34 years) residing in metropolitan areas. Therefore, measures that improve access to community mental health services are likely to be effective in reducing rates of ED presentations. Refer to the Aboriginal Health section below for a discussion of this population’s utilisation of the acute care sector.</p> <p>Place-based</p> |

| Outcomes of the service needs analysis | | |
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| | | <p>The report to CHASM¹¹¹ identified Butler – Merriwa - Ridgewood SA2 in Wanneroo SA3 as a potential priority area for community mental health-based interventions in Perth North PHN based on a relatively large population of non-Aboriginal adults aged 15-34 years and a relatively high population-weighted mean distance to primary care. Please note that these are preliminary results only. At the time of writing, the report to CHASM was being updated with additional data and will undergo further methodological review.</p> |
| <p>SN2.6 General practitioners should be the “first port of call” for patients experiencing mental ill health.</p> | <p><i>People with mental health conditions are not linked in with GPs or primary mental health services, including after-hours care.</i></p> | <p>Whole PHN</p> <p>In 2012, the Stokes Review identified that in Western Australia, delays in access to treatment were causing mental health, alcohol and drug problems to worsen, leading to the need for higher cost treatment.¹¹²</p> <p><i>After-hours care</i></p> <p>Mental health services generally operate during business hours only (some private psychology services have after-hours services, often with a surcharge). This means that people who have difficulty accessing services during business hours due to work, study or other responsibilities will have limited access to primary mental health care. For youth aged 12-25 years, headspace offers a free online counselling service called ‘ehespace’, which operates after-hours. After-hours GP services are readily available across Perth North PHN but there is a shortage of mental health-specific services.</p> <p>Place-based</p> <p>Co-design workshops¹¹³ identified that transport limitations, including lack of infrastructure and cost, were a significant barrier to accessing mental health services for people residing in the Midland, Kalamunda and Mundaring areas.</p> |

| Outcomes of the service needs analysis | | |
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| SN2.7 Culturally-secure mental health services. | <i>Services should be accessible by Aboriginal people and people from culturally and linguistically diverse backgrounds - cultural security of service delivery could be improved.</i> | [This section has been redacted for data confidentiality reasons] |
| SN2.8 Services meeting the needs of, and accessible for, socioeconomically disadvantaged groups. | <i>Lack of appropriately targeted, affordable services for socioeconomically disadvantaged groups.</i> | <p>Private mental health services are readily available throughout Perth North PHN. However, many of these services have significant out-of-pocket costs, despite the availability of Medicare subsidies.</p> <p><i>Mild to moderate mental health conditions</i></p> <p>The Practitioner Online Referral Treatment Service (PORTS) provides free, GP-referred mental health services via telephone and/or online to financially disadvantaged people aged at least 16 years who have symptoms of anxiety, depression or harmful alcohol and other drug use. If appropriate, GPs may refer patients to face-to-face services supplied by ORS Psychology in Perth. Services are delivered over 2-8 weeks.</p> <p>PORTS services are suitable for patients with mild to moderate mental health conditions that respond to short term, low intensity interventions. We note that PORTS does not cater to those who require longer term or ongoing interventions (> 8 weeks).</p> <p>Child and Adolescent Brief Intervention Services (CABIS) are free short term, face-to-face psychological treatment services for youth with mild to moderate mental health concerns. However, like PORTS, these services do not cater to those who require longer term interventions.</p> <p><i>Severe and complex mental health conditions</i></p> <p>State-based care services are generally the main provider of care for patients with severe and/or complex mental health needs. For patients whose condition is mostly being managed in primary care, MHConnex provides free care coordination services in the Perth metropolitan area.</p> |

Outcomes of the service needs analysis

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| <p>SN2.9 Services meeting the needs of, and accessible for, the aged population.</p> | <p><i>Lack of appropriately targeted services for the aged.</i></p> | <p>To date, there have been few studies examining the mental health of older adults. A report by SANE Australia¹¹⁴ found that most studies focussed on dementia and physical health problems and that there was a lack of attention given to mental health conditions in the elderly. There is also a shortage of mental health services for older adults, especially those living in supported accommodation.¹¹⁴ The report indicated that there is a need for targeted mental health services for the elderly and for easily accessible information about these services for both patients and carers.</p> <p>In Western Australia, older adults (aged 65 years and over) were significantly more likely to have used a primary, hospital based or allied health service than younger adults (aged 16 to 64 years), but were significantly less likely to have used mental health services.¹¹⁵</p> <p>For details about psychological therapies for older adults living in residential aged care facilities (RACFs), please refer to HN2.9 Mental health in residential aged care facilities.</p> <p>The following is a summary of outpatient mental health services targeted to older adults in Perth North PHN, including information from the Integrated Atlas of Mental Health.¹⁰⁹ These are generally mobile services – there is only one non-mobile service, located in Sir Charles Gairdner Hospital.</p> <p><i>Acute care</i></p> <ul style="list-style-type: none"> • Selby Older Adult Mental Health Service is the only team providing mobile, acute outpatient services for older adults in the Lower West catchment from Shenton Park. • The Older Adult Psychiatric Liaison Team provides acute care within Sir Charles Gairdner Hospital. <p><i>Non-acute care</i></p> <ul style="list-style-type: none"> • There are five mobile, non-acute care services for older adults based in Shenton Park, Joondalup, Stirling, Mount Lawley and Midland. • There are no non-mobile, non-acute care services for older adults. <p>Currently, there are no older adult mental health services located in Kalamunda and Mundaring SA3s, which are areas with a relatively high proportion of people aged 65 years and over (> 16%).</p> |
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Outcomes of the service needs analysis

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| <p>SN2.10 Reduce stigma and discrimination.</p> | <p><i>Stigma and discrimination affect mental health service utilisation and increase the likelihood of adverse health and social outcomes.</i></p> | <p>Reducing the stigma of a mental health condition is one of the key priorities in the Fifth National Mental Health and Suicide Prevention Plan.¹¹⁶ Stigma and discrimination, including that from health service providers, discourages people from disclosing a mental health condition and accessing mental health services in a timely way. This in turn may exacerbate psychological distress and increase the likelihood of adverse outcomes, particularly for groups that are already at risk such as Aboriginal people and people who identify as LGBTI.</p> <p>Qualitative feedback from consumer surveys conducted by WA Primary Health Alliance indicated that stigma was a significant barrier to seeking help. Respondents noted that fear of judgement and shame about their mental health condition made it difficult for them to access treatment in the past 12 months. Fear of consequences such as medication side effects, involuntary admission and losing or not gaining employment prevented some respondents from fully disclosing their mental health condition to their GP.⁸⁵</p> <p>As part of the Fifth National Mental Health and Suicide Prevention Plan, people with lived experience, including peer support workers, will play an important role in reducing stigma and discrimination through grassroots-based advocacy in their community.¹¹⁶</p> |
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Alcohol and Other Drug Treatment Needs

| Outcomes of the service needs analysis | | |
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| Identified Need | Key Issue | Description of Evidence |
| SN3.1 Alcohol and other drug treatment focused on early intervention. | Locations with high alcohol and other drug-related hospitalisations and ED presentations may indicate a need for early intervention. | [This section has been redacted for data confidentiality reasons] |
| SN3.2 Services that meet the needs of children and adolescents with alcohol and other drug problems. | Most current services do not cater for children/adolescents. | <p>Whole of PHN</p> <p><i>Child alcohol and other drug-related services</i></p> <p>The Integrated Atlas of Mental Health and Alcohol and Other Drugs¹⁰⁹ indicates that of the 72 alcohol and other drug-specific services identified in Perth North PHN, 58 (81%) were for adults, with the remainder for children and adolescents. There are no services listed in the Mental Health Atlas (2016) for older adults.¹⁰⁹ A WA Primary Health Alliance survey of health consumers revealed that some young adults felt intimidated by alcohol and other drug services, which tended to be dominated by older, longer-term users. This could indicate a need for more services for youth and young adults.⁸⁵</p> |
| SN3.3 Services that help people earlier in the care continuum, before the health effects of alcohol and other drug use escalate in severity. | Rebalance investment from high cost, low volume care to higher volume care earlier in the care continuum. | <p>Whole of PHN</p> <p><i>Alcohol and other drug-related services</i></p> <p>In Perth North PHN, most of the alcohol and other drug treatment episodes delivered in 2016 to 2017 were high cost, low volume including counselling (59%), withdrawal management (7.7%), and rehabilitation (4.5%).⁶¹ 8.2% of treatment episodes involved information and education,⁶¹ which are generally low cost, high volume.</p> |
| SN3.4 Recognise and respond to harmful alcohol | GP screening and brief intervention for substance | <p>Whole of PHN</p> <p><i>Alcohol and other drug treatment episodes</i></p> |

Outcomes of the service needs analysis

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| <p>and other drug use in general practice.</p> | <p><i>use disorders could be improved.</i></p> | <p>Alcohol screening and brief interventions (ASBIs), which include opportunistic screening and assessment of patients about alcohol and other drug use, assist general practitioners to identify patients at risk of alcohol and other drug-related harm. Recommended approaches include quantity-frequency estimates (how much how often) and structured questionnaires such as AUDIT-C.¹¹⁷ Where indicated, these are followed up with a brief intervention or comprehensive assessment, depending on severity. Although ASBIs are a relatively low cost and effective intervention, they are rarely successfully implemented in general practice.¹¹⁸ GPs also have a role to play in encouraging pregnant women to follow the National Health and Medical Research Council (NHMRC) guidelines and not drink alcohol during pregnancy.</p> <p>There are no current MBS items that relate specifically to assessing or treating alcohol and other drug misuse within general practice. This makes it difficult to assess how often GPs are currently treating patients for these issues.</p> <p>In Perth North PHN, 21% of closed treatment episodes at publicly funded alcohol and other drug services in the 2016 to 2017 period were referred by another health service.⁶¹ Health service referrals may be as viewed as evidence that other health services are recognising alcohol and other drug issues in patients and are aware of alcohol and other drug services for referral.⁶¹</p> |
| <p>SN3.5 Minimise the health risks associated with intravenous drug use.</p> | <p><i>Clean syringe programs mitigate the risk of contracting a blood borne virus.</i></p> <p><i>Hepatitis C can be cured but uptake of treatment could be improved.</i></p> | <p>Intravenous drug users are at a higher risk of contracting hepatitis C, which has serious health consequences (see HN3.8). Direct-acting antivirals (DAAs) have been available on the PBS since March 2016 and, in contrast to earlier treatments, have few or no side-effects.¹¹⁹ Between March 2016 and June 2017, an estimated 16% of people living with a chronic hepatitis C infection accessed DAA treatment in Western Australia.¹²⁰ This was lower than the national rate at 19%.¹²⁰ A paper looking at the uptake of hepatitis DAA treatment in Australia found that treatment uptake was variable, and lower in socioeconomically disadvantaged areas and areas with a higher proportion of people born overseas.¹²¹</p> |
| <p>SN3.6 Services that meet the needs of people with alcohol and other drug problems comorbid with mental illness.</p> | <p><i>Lack of connectivity between alcohol and other drug and mental health services.</i></p> | <p>As discussed in HN3.7, harmful alcohol and other drug use and mental health conditions often co-occur and around one-third of people with an alcohol and other drug use disorder also have a mental illness.⁶⁴ There is also evidence that a co-occurring mental health condition makes a person more likely to seek treatment, meaning that co-morbidities are even more common in an alcohol and other drug treatment setting.^{64,122-124} The National Health and Medical Research Council (NHMRC) has produced comprehensive</p> |

Outcomes of the service needs analysis

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| | | <p>guidelines for managing co-occurring alcohol and other drug and mental health conditions in an alcohol and other drug setting.⁶⁴</p> <p>In WA Primary Health Alliance’s baseline Needs Assessment (2016) community consultation in all regions identified concerns about the lack of connectivity between alcohol and other drug and mental health services. Also noted were the difficulties experienced by people with comorbid conditions accessing coordinated care and support. This has also been a consistent theme in the latest Needs Assessment consultation with WA Primary Health Alliance regional and metropolitan staff.</p> <p>Place-Based</p> <p>Given that harmful alcohol and other drug use is common among people with a mental health conditions (see HN3.7), these percentages are low. This may indicate alcohol and other drug issues are not being identified or that patients with mental health and alcohol and other drug issues are not seeking treatment at mental health services.</p> |
| <p>SN3.7 Access and uptake of services to help people with alcohol and other drug dependency.</p> | <p>Shortage of addiction medicine workforce with a critical shortfall forecast for 2021.</p> <p>Low utilisation of addiction medicine services.</p> | <p>The WA Medical Workforce 2013 to 2021 report indicated that addiction medicine consultants are currently in low supply (< 80% of demand) and that there are critical shortfalls forecast for 2021 (< 70% of demand) due to low trainee throughput and expected retirements.¹²⁵ There is an undersupply in metropolitan and rural locations, with substantial demand unmet in rural locations.¹²⁵</p> <p>MBS data for 2017 to 2018 indicates that WA has a low utilisation of addiction medicine MBS items, with only 928 services, compared to 7,597 services in NSW, 2,939 in Victoria and 1,964 in South Australia (a state with a smaller population than WA).</p> <p>In WA, the largest group of patients utilizing addiction medicine specialists in 2017 to 2018 was 35 to 44-year-olds (30.2%), followed by 45 to 54-year-olds (25.1%). Males outnumbered females in every age group except 55-64 years.</p> <p>Place-based</p> <p>As at 2016, there were only seven addiction medicine specialists practising in Perth North PHN. Five of these were located in Perth City SA3 (Perth City SA2, Subiaco–Shenton Park SA2, and Wembley–West</p> |

Outcomes of the service needs analysis

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| | | Leederville–Glendalough SA2) with the remainder in Swan SA3 (Midland–Guildford SA2) and Joondalup SA3 (Joondalup–Edgewater SA2). |
| SN3.8 Services that recognise the need to treat alcohol and other drug problems and co-morbidities. | <i>Care coordination and patient pathways between alcohol and other drug, mental health and other health services could be improved to better support people living with multi-morbidities.</i> | <p>Co- and multiple morbidities involving alcohol and other drug use are discussed in HN3.6</p> <p>As discussed in HN3.7, drug and alcohol use disorders and mental health disorders often co-occur. In 2008, the Australian Government Department of Health and Ageing has published a guide on the comorbidity of mental health conditions and harmful alcohol and other drug use for primary care clinicians. This guide discusses each mental illness and lists the clinical issues associated with comorbidity with harmful alcohol and other drug use (broken down into the major drug types).¹²⁶</p> <p>In the baseline WA Primary Health Alliance Needs Assessment, the lack of cohesion among services was the common theme across metropolitan and regional areas.¹²⁷</p> |

Aboriginal Health (including Aboriginal chronic disease)

| Outcomes of the service needs analysis | | |
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| Identified Need | Key Issue | Description of Evidence |
| SN4.1 Lack of culturally secure services for Aboriginal people, particularly in sub-regions with higher density Aboriginal populations. | <i>All services should be accessible and culturally secure for Aboriginal people.</i> | <p>The Aboriginal concept of health is not the same as in Western society, and a holistic and integrated approach to Aboriginal health is required to address social determinants and better health outcomes.¹²⁸ It is important for health care providers to understand the Aboriginal concept of health and provide targeted services that are culturally acceptable and secure for Aboriginal people.</p> <p>Whole of PHN</p> <p>Qualitative feedback has indicated the following areas of need in Perth North PHN:⁸⁸</p> <ul style="list-style-type: none"> • Lack of culturally secure services for Aboriginal people • Low trust of non-Aboriginal services that are not culturally sensitive • Low numbers of Aboriginal people employed in the health workforce • Lack of development and demonstrated commitment to Aboriginal employment. <p>Specific areas of Aboriginal health service need in Perth North PHN include:⁸⁸</p> <ul style="list-style-type: none"> • Mental health – limited culturally appropriate services and low Aboriginal mental health practitioner workforce • Alcohol and other drugs – no specific support services available delivered in the community • Prison health – increased numbers of Aboriginal health workers needed within the prisons to provide a culturally appropriate and secure service • Aboriginal aged care – limited services available for older Aboriginal people (55 years and above). <p>Barriers to accessing health care are typically higher among Aboriginal people and vulnerable populations, For example, nearly one in five homes occupied by the Aboriginal population in Greater Perth do not have access to the Internet (18%).⁷⁷</p> |

| Outcomes of the service needs analysis | | |
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| | | <p>Place-based</p> <p>Recent consultation with the local Midland and Swan Aboriginal community identified a particular lack of culturally secure alcohol, drug and health services, in addition to issues with ease of access and receiving appropriate cultural understanding and support from local service provider needs.¹²⁹ Further research is needed across Perth North PHN to identify issues related to providing culturally secure services to meet the needs of the Aboriginal community.</p> |
| SN4.2 There is a need for targeted early intervention in primary care. | <p>Targeted early intervention and/or secondary prevention in primary care could prevent the development of chronic conditions and disease.</p> | <p>Early treatment is the most effective way to reduce the impact of chronic and comorbid conditions. Early intervention can produce significant long-term health care savings and improve overall quality of life. Childhood immunisation is recommended as a safe and effective way of protecting against harmful diseases and reducing overall spread of disease. Jurisdictions are mandated to ensure childhood immunisation rates are at least 90%, with a national 'Strive for 95%' target. This informed the 'Western Australian Immunisation Strategy 2013-2015' which outlined a framework for enhancing all aspects of immunisation program service delivery.⁹⁷</p> <p>Whole of PHN</p> <p><i>Aboriginal Health Assessment</i></p> <p>Perth North PHN (426) had a higher rate of General Practice Aboriginal Health Assessments recorded compared to Perth South PHN (265) and Country WA PHN (375).</p> <p><i>Immunisation</i></p> <p>The rate of immunisation for Aboriginal children (94%) in Perth North PHN is close to the national target but lower than the state (96% and national rates (96%).¹³⁰</p> |
| SN4.3 There is a need to improve access to and awareness of appropriate primary care services. | <p>A lack of access to and awareness of appropriate primary care services, both during and after-hours, further compounds issues of service demand and timely and</p> | <p>Whole of PHN</p> <p><i>Utilisation of Healthdirect after-hours GP helpline</i></p> <p>Healthdirect Australia is contracted to provide an after-hours telephone-based GP service which complements existing after-hours health services. The after-hours GP helpline is a national service funded</p> |

| Outcomes of the service needs analysis | | |
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| | <i>appropriate care, often resulting in increased reliance on unnecessary ED services.</i> | by the Australian Government. In 2018, there were 3,291 episodes recorded for the after-hours GP Helpline in Perth North PHN with 4.1% of patients identifying as Aboriginal and/or Torres Strait Islander. |
| SN4.4 Poor access to existing services by Aboriginal people, and people from culturally and linguistically diverse backgrounds. Cultural security of service delivery can be improved. | <i>Culturally secure mental health services for Aboriginal people, and CALD population (i.e. use of appropriate communication tools such as language, culture, print-size etc.).</i> | Interviews with stakeholders indicated restricted access to culturally secure services for Aboriginal people living with chronic conditions, including mental health conditions. ⁹⁴ Some of the issues identified include: <ul style="list-style-type: none"> • lack of referral by GPs to culturally-appropriate allied health providers • cultural and language barriers • the need to travel to Perth for some types of treatment • lack of access to transport, and • lack of awareness of services by the community and providers. |
| SN4.5 Lack of Aboriginal mental health services in sub-regions with higher density of Aboriginal population. | <i>Culturally secure mental health services for Aboriginal people, and CALD population (i.e. use of appropriate communication tools such as language, culture, print-size etc.).</i> | At a state-wide level, the Specialist Aboriginal Mental Health Service (SAMHS) provides services from its office in Mount Claremont. Within Perth North PHN, the Derbarl Yerrigan Health Service delivers non-acute mobile outpatient services for Aboriginal from their Mirrabooka and Midland locations as well as non-acute non-mobile services from East Perth. ¹⁰⁹ Also, Women's Health and Family Services run an Aboriginal grandparent and family support program from Northbridge. There are no Aboriginal-specific mental health services in the Mundaring SA3, which has the highest proportion of Aboriginal people in the Perth North PHN. Stakeholder feedback indicates a service need for Aboriginal people residing in the north west corridor (Wanneroo SA3) who must travel to Mirrabooka to access services. |
| SN4.6 Lack of appropriately targeted services for the socioeconomically disadvantaged groups. | <i>Services meeting the needs of, and accessible for socioeconomically disadvantaged, and aged population groups.</i> | Please refer to SN2.8 for a discussion of mental health services for socioeconomically disadvantaged groups, including Aboriginal people. |

Outcomes of the service needs analysis

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| SN4.7 Models of care focused on early intervention. | <i>Locations with high alcohol and other drug-related hospitalisations and ED presentations indicate a need for early intervention.</i> | Whole of PHN ED presentations and public hospitalisations directly related to alcohol and other drug use may indicate that services to manage alcohol and other drug misuse and dependence were not available or accessible at an earlier stage. |
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SECTION 5 - CHECKLIST

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

| Requirement | ✓ |
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| Governance structures have been put in place to oversee and lead the Needs Assessment process. | ✓ |
| Opportunities for collaboration and partnership in the development of the Needs Assessment have been identified. | ✓ |
| The availability of key information has been verified. | ✓ |
| Stakeholders have been defined and identified (including other PHNs, service providers and stakeholders that may fall outside the PHN region); Community Advisory Committees and Clinical Councils have been involved; and Consultation processes are effective. | ✓ |
| The PHN has the human and physical resources and skills required to undertake the Needs Assessment. Where there are deficits, steps have been taken to address these. | ✓ |
| Formal processes and timeframes (such as a Project Plan) are in place for undertaking the Needs Assessment. | ✓ |
| All parties are clear about the purpose of the Needs Assessment, its use in informing the development of the PHN Activity Work Plan and for the department to use for program planning and policy development. | ✓ |
| The PHN is able to provide further evidence to the Department if requested to demonstrate how it has addressed each of the steps in the Needs Assessment. | ✓ |
| Geographical regions within the PHN used in the Needs Assessment are clearly defined and consistent with established and commonly accepted boundaries. | ✓ |
| Quality assurance of data to be used and statistical methods has been undertaken. | ✓ |
| Identification of service types is consistent with broader use – for example, definition of allied health professions. | ✓ |
| Techniques for service mapping, triangulation and prioritisation are fit for purpose. | ✓ |
| The results of the Needs Assessment have been communicated to participants and key stakeholders throughout the process, and there is a process for seeking confirmation or registering and acknowledging dissenting views. | ✓ |
| There are mechanisms for evaluation (for example, methodology, governance, replicability, experience of participants, and approach to prioritisation). | ✓ |

GLOSSARY

Aboriginal

The term Indigenous is used to refer to Australian Aboriginal and Torres Strait Islander people. According to the most widely adopted definition of Aboriginal or Torres Strait Islander (the 'Commonwealth working definition'): "An Aboriginal or Torres Strait Islander is

- a person of Aboriginal or Torres Strait Islander descent;
- who identifies as being of Aboriginal or Torres Strait Islander origin; and
- who is accepted as such by the community with which the person associates".

This definition was developed during the period 1967 to 1978 and is now widely accepted by Commonwealth and other government agencies. To acknowledge the separate Indigenous peoples of Australia, the term 'Aboriginal and Torres Strait Islander people' is preferred in WAPHA publications. However, the terms 'Indigenous' or 'Aboriginal' are used interchangeably when referring to Indigenous status or when it assists readability.

After hours

This refers to the period outside 8am to 8pm on weekdays (excluding public holidays) and 8am to 1pm on Saturdays.

Age-standardised rate

A method of adjusting the crude rate to eliminate the effect of differences in population age structures when comparing crude rates for different periods of time, different geographic areas and/or different population sub-groups (e.g. between one year and the next and/or States and Territories, Indigenous and non-Indigenous populations). Adjustments are usually undertaken for each of the comparison populations against a standard population (rather than adjusting one comparison population to resemble another).

Avoidable mortality

Refers to deaths from certain conditions that are considered avoidable given timely and effective health care. Avoidable mortality measures premature deaths (for those aged 0–74 years) for specific conditions defined internationally and nationally as potentially avoidable given access to effective health care.

Chronic diseases

A diverse group of diseases, such as cardiovascular disease, asthma, diabetes and arthritis, which tend to be long-lasting and persistent in their symptoms or development.

Co-morbidities/multi-morbidities

The presence of one or more illnesses (or diseases) in a person, in addition to a primary disease or disorder. For example, chronic lung disease and diabetes.

Lower urgency emergency department presentations

An emergency department presentation where the patient: (1) had a triage category of 4 (semi-urgent) or 5 (non-urgent); (2) did not arrive by ambulance, or police or correctional vehicle; and (3) was not admitted to the hospital, not referred to another hospital, or did not die.

Potentially preventable hospitalisations (PPH)

A set of conditions for which hospitalisation could have been prevented by timely and appropriate provision of primary or community-based healthcare.

Prevalence

The proportion of people in a population found to have a condition at a certain point in time. It is arrived at by comparing the number of people found with a condition to the number of people studied. Prevalence is usually expressed as a fraction or percentage.

Primary care

A component of primary healthcare. Primary care provides front-line personal health services to individuals and is the first point of contact with healthcare provided in the community, most commonly with a general practitioner. It generally does not require an external referral at the point of entry. Within the context of WAPHA, primary care includes pharmacy and other allied health professionals. Primary care has only a limited influence on broader social, economic and environmental factors. Note that while a referral is not needed to access a specialist alcohol and drug service, they are considered to be secondary care providers.

SEIFA

The SEIFA Index of Disadvantage can be used to determine the relative level of disadvantage of different areas based on a range of statistics gathered through census surveys. The indicators reflecting social disadvantage include low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations. A higher SEIFA score indicates an area with a lower relative level of disadvantage, while a lower score signifies an area with a higher level of disadvantage.

Social determinants of health

Many of the key drivers of poor health reside in our everyday living and working conditions—the circumstances in which people grow, live, work and age. These social determinants include factors such as income, education, employment and social support. Social determinants can strengthen or undermine the health of individuals and communities. For example, in general, people from poorer social or economic circumstances are at greater risk of poor health than people who are more advantaged.

Statistically significant

An indication from a statistical test that an observed difference or association may be significant or 'real' because it is unlikely to be due just to chance.

Vocationally-registered (VR) general practitioner

These are general practitioners (GPs) who are registered as Fellows of the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM) or who are on the General Practice Vocational Register. Vocationally-registered (VR) GPs have access to special Medicare item numbers and higher Medicare rebates.

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