

PHN NEEDS ASSESSMENT

WESTERN SYDNEY PRIMARY HEALTH NETWORK

2019 - 2022



An Australian Government Initiative

Submitted to the Department of Health
29th November 2018



WentWest acknowledges the First Nations people of Australia as the Traditional Custodians of the land on which we work and live. We pay respect to Elders past, present and future and extend that respect to all Aboriginal or Torres Strait Islander people within western Sydney.

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NARRATIVE

Primary Health Networks (PHNs) have been preparing needs assessments (NA) since their establishment in 2015. The primary goal of the NA is to establish the health and wellbeing needs of their individual communities, and develop tailored strategies to address them. The development of the NA is a cyclical process, which includes ongoing review and collection of data, and stakeholder and community consultation to identify any new or emerging needs.

This NA brings together the three primary needs assessments: core, mental health and suicide prevention, and alcohol and other drugs.

The focus of this NA is on highlighting the specific health and wellbeing needs of the western Sydney community, and identifying the priority areas that will guide planning and commissioning over the next three years.

During the data scan, a number of data gaps were identified that, if filled, would assist with the identification of geographic hotspots and allow for targeted planning and commissioning. Gaps included:

- Immunisation data: HPV at SA3 level, CALD, refugees, asylum seekers, Aboriginal and Torres Strait Islander at SA3 level.
- Consistent collection of substance use among CALD populations.
- AOD use at regional level and for young people.
- Geographical distribution of LGBTIQ+ population
- Cancer screening rates by vulnerable populations (currently only available for breast screening).



NARRATIVE

The development of the NA was guided by five key steps:

- 1** A **review** of previous NAs, Activity Work Plans, and other relevant internal reports.
- 2** A **data scan** to update data, and identify any new or emerging issues. Sources included Australian Bureau of Statistics (ABS), Public Health Information Development Unit (PHIDU), Australian Early Development Census (AEDC), Australian Institute of Health and Welfare (AIHW), Australian Immunisation Register (AIR), and HealthStats NSW.
- 3** An **assessment** of all collated data to **synthesis and triangulate** identified needs to ensure consistency across multiple data sources.
- 4** A **prioritisation** process was applied to identify a shortlist of priority areas for WSPHN. This process included the application of eight evidence-based criteria: Scale of the issue, Benchmarking against national/state data and other similar regions, Impact of the issue, Degree of health inequities, Linkages with known determinants of health, Alignment with priorities, targets and opinion, Unmet need, and Feasibility.
- 5** The **identification of final priority areas**, including a review process and endorsement from key WentWest personnel.



Priority areas

PHN PROGRAM PRIORITY AREAS

- ⊕ Aboriginal and Torres Strait Islander health
- ⊕ Mental Health
- ⊕ Population Health
- ⊕ Workforce
- ⊕ Digital health
- ⊕ Aged care
- ⊕ Alcohol and other drugs (AOD)

WSPHN POPULATION GROUPS

- ⊕ Maternal, child and family
- ⊕ Young people
- ⊕ Older people
- ⊕ At-risk and vulnerable population groups

WSPHN HEALTH ISSUES

- ⊕ Chronic disease (asthma and COPD, cancer screening, and diabetes)
- ⊕ Communicable diseases (vaccine-preventable and viral hepatitis)
- ⊕ Mental health
- ⊕ Alcohol and other drugs

WSPHN SYSTEM LEVEL ISSUES

- ⊕ Health literacy and health literacy responsiveness
- ⊕ After hours services
- ⊕ Integration and coordination
- ⊕ Digital health
- ⊕ Health workforce

ABOUT WESTERN SYDNEY PHN

BACKGROUND

Primary Health Networks (PHNs) are a federal government health initiative, established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes and improving coordination of care to ensure patients receive the right care in the right place, at the right time.

The Australian Government has identified seven priority areas to guide the work of PHNs. These are: mental health, Aboriginal and Torres Strait Islander health, population health, digital health, health workforce, aged care, and alcohol and other drugs.

WESTERN SYDNEY PHN

Since 2002 WentWest has been part of the western Sydney community, delivering support and education to primary care and working with key partners to progress the region's health system.

As the Western Sydney Primary Health Network, WentWest is focused on addressing both regional and national health priorities. Together with health professionals, partners from both the primary health and hospital sector, consumers and the broader community, WentWest seeks to identify gaps and commission solutions for better health outcomes.



ABOUT WESTERN SYDNEY PHN

OUR ROLE

As a PHN we have three main roles:

- 1** To commission health services to meet the identified and prioritised needs of people in our region, and address identified gaps in primary health care.
- 2** Through practice support, we work closely with general practitioners (GPs) and other health professionals to build health workforce capacity and the delivery of high quality care.
- 3** Work collaboratively within our region to integrate health services at the local level to create a better experience for patients, encourage better use of health resources, and eliminate service duplication.

OUR FOCUS

Western Sydney PHN's activities are underpinned by the **Quadruple Aim of Primary Care**. The four aims to achieve system reform and enhancement are:

- 1 Patient experience of care**
Reduced waiting times, improved access, and patient and family needs met.
- 2 Quality and population health**
Improved health outcomes, equity of access, and reduced disease burden.
- 3 Sustainable cost**
Cost reduction in service delivery, reduced avoidable/unnecessary hospital admissions, return on innovation costs invested, and ratio of funding for primary: acute care.
- 4 Improved provider satisfaction**
Sustainability and meaning of work, increased clinician and staff satisfaction, teamwork, leadership, and quality improvement culture.



Population 2016

WSPHN Total population - 948,593

12,755 Aboriginal peoples

371 Torres Strait Islander peoples
252 people identifying as both

- Western Sydney is home to one of the largest urban Aboriginal and Torres Strait Islander populations in Australia.
- More than 13,300 people (1.5% of the population) identify as Aboriginal or Torres Strait Islander.¹
- Most SA3s have much lower proportions of Aboriginal and Torres Strait Islander peoples, with rates less than 1% of the total population. However, the Aboriginal and Torres Strait Islander community in Mount Druitt SA3 is substantially larger, making up 4.7% of the population (5,305 people), followed by Blacktown SA3 at 2.1%.²

Population 2011-2036

Western Sydney is projected to have the largest population growth in NSW between 2011 and 2036. This accounts to an extra 636,450 people.

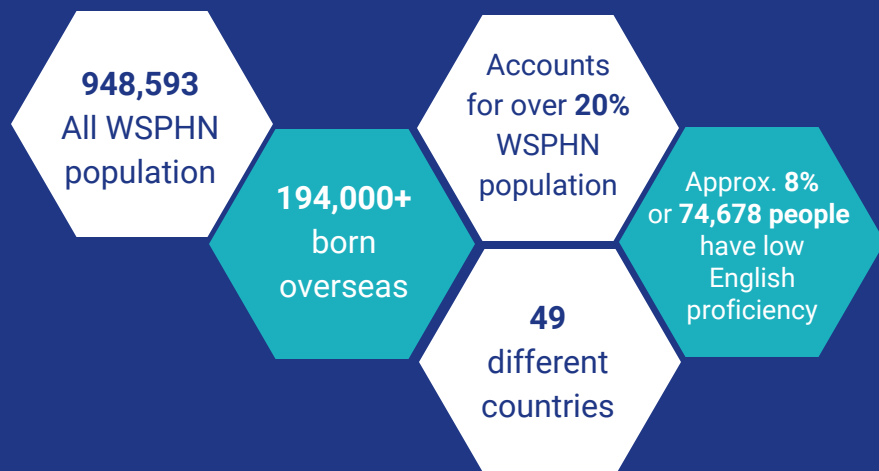
Parramatta LGA is expected to see the largest growth, with over 200,000 more people, which is a 105.2% increase.³



References

1. Public Health Information Development Unit (2018). Social health atlas of Australia: Data by Primary Health Network. October 2018.
2. Australian Bureau of Statistics, data by region, 2011-16, population and people, Australia, State and Territory, Statistical Area Levels 2-4, Greater Capital City Statistical Area, 2011-2016.
3. Australian Bureau of Statistics 2017 tables generated 12 January 2018 using Estimated Resident Population (ERP) by Statistical Area Level 3 (SA3) (Australian Statistical Geography Standard (ASGS) 2016), 2012 to 2016, data cube: Excel spreadsheet. http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Demographic_Data

Culturally & linguistically diverse community



Language

There are a large number of SA2s in the WSPHN region where English is not spoken at home. Less than 19% of residents speak English only at home in Parramatta-Rosehill (18.9%), Lidcombe (18.9%), Auburn-South (18.3%), Auburn-Central (12.8%) and Auburn-North (9.1%).

Country of birth - Top 5

- 1 India - 25,761 
- 2 China - 23,242 
- 3 Philippines - 21,917 
- 4 Lebanon - 10,587 
- 5 South Korea - 8,882 

Low English proficiency- Top 5

- 1 Merrylands - Guildford SA3 - 19,033
- 2 Auburn SA3 - 17,816
- 3 Parramatta SA3 - 11,651
- 4 Blacktown SA3 - 8,137
- 5 Baulkham Hills SA3 - 6,796

References

Australian Bureau of Statistics 2017, tables generated 20 December 2017 using PURP by SA3 (Australian Statistical Geography Standard (ASGS) 2016), 2016 Census, table builder: Excel spreadsheet

Note: Low English proficiency refers to those who do not speak English well or do not speak English at all

POPULATION HEALTH

LIFESTYLE RISK FACTORS

SOCIAL DETERMINANTS

CHRONIC DISEASE

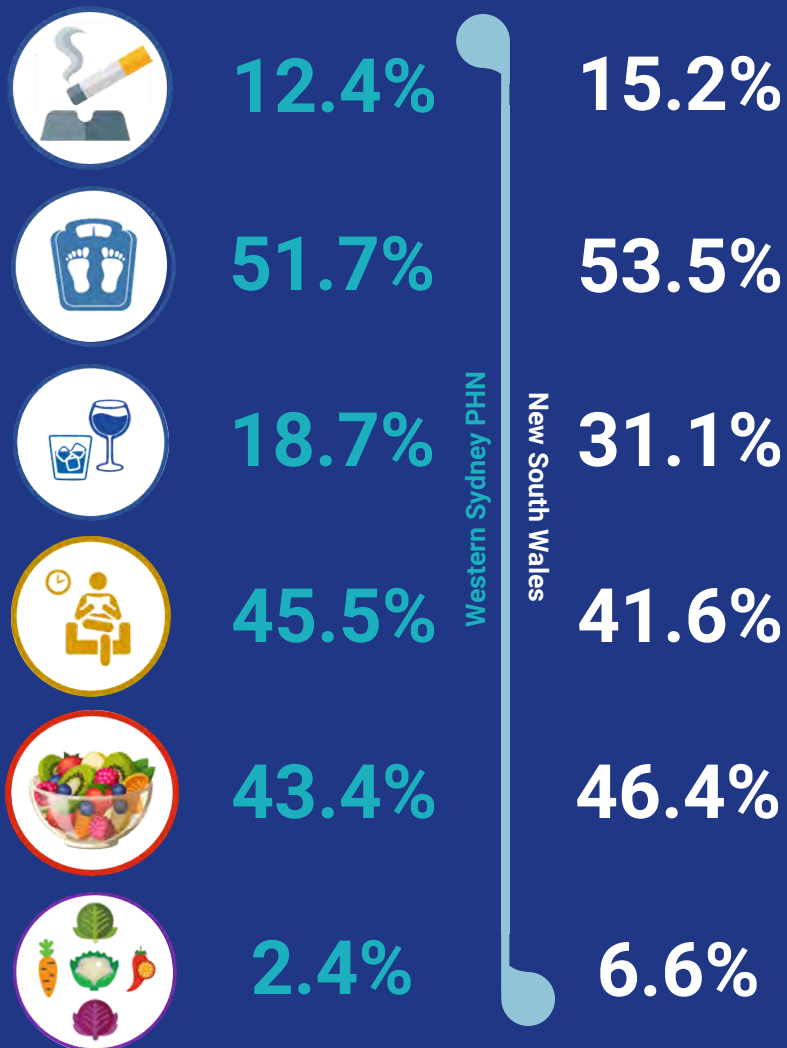
- ⊕ Asthma and COPD
- ⊕ Cancer screening
- ⊕ Diabetes
- ⊕ Chronic disease management

COMMUNICABLE DISEASES

- ⊕ Vaccine preventable diseases
- ⊕ Viral hepatitis



Lifestyle risk factors



SUMMARY

Lifestyle risk factors are modifiable attributes, characteristics or exposures that increase the likelihood of a person developing a disease or health disorder. These can include tobacco use, high body mass index (BMI), alcohol use, physical inactivity and inadequate consumption of fruit and vegetables.¹

- **Smoking** in adults has been gradually declining across the country, including in the WSPHN (24.1% in 2002 to 12.4% in 2017). This trend is consistent in NSW (22.5% in 2002 down to 15.2% in 2017).²
- In 2017, WSPHN has the 3rd lowest percentage (51.7%) of **people who were overweight or obese** compared with NSW (53.5%).² Despite the lower percentage, this still accounts for over half of the adult population in western Sydney at risk of poorer health outcomes.²
- **Alcohol consumption** at levels posing long-term risk to health amongst people aged 16 and over is lower in WSPHN (18.7%) compared with NSW (31.1%).²
- In 2017, 45.5% of people aged 16 and over in WSPHN had **insufficient physical activity** levels, compared with 41.6% in NSW.²
- In 2017, the percentage of WSPHN people aged 16 and over **consuming the daily recommended serves of vegetables** was considerably lower than many other PHNs in NSW (WSPHN 2.4%, NSW 6.6%). Daily **consumption of fruit** is also lower in WSPHN (43.4%), compared with NSW (46.4%).²

References

1. Australian Institute of Health and Welfare. Risk factors to health. 2017. <https://www.aihw.gov.au/reports/biomedical-risk-factors/risk-factors-to-health/contents/risk-factors-and-disease-burden>
2. HealthStats NSW 2017 - NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Obesity: http://www.healthstats.nsw.gov.au/Indicator/beh_bmi_age/beh_bmi_comparison, Fruit and veg consumption: http://www.healthstats.nsw.gov.au/Indicator/beh_veg_statage/beh_veg_statage Smoking: http://www.healthstats.nsw.gov.au/Indicator/beh_smo_age/beh_smo_comparison, Smoking attributable hospitalisations: http://www.healthstats.nsw.gov.au/Indicator/beh_smoafhos/beh_smoafhos_phn_trend Alcohol attributable hospitalisations: http://www.healthstats.nsw.gov.au/Indicator/beh_alcafhos

SUMMARY

According to the World Health Organisation, social inequalities and disadvantage are the main reason for unfair and avoidable differences in health outcomes and life expectancy across groups in society. Factors such as socio-economic position, conditions of employment, power and social support—known collectively as the social determinants of health—act together to strengthen or undermine the health of individuals and communities.

The latest data tells us that residents in the WSPHN region experience greater socio-economic disadvantage compared to the general NSW population, except for those living in The Hills LGA.

Some western Sydney residents are living in an obesogenic environment...



28% of neighbourhoods in western Sydney had a 3:1 ratio of takeaway shops to greengrocers and supermarkets.

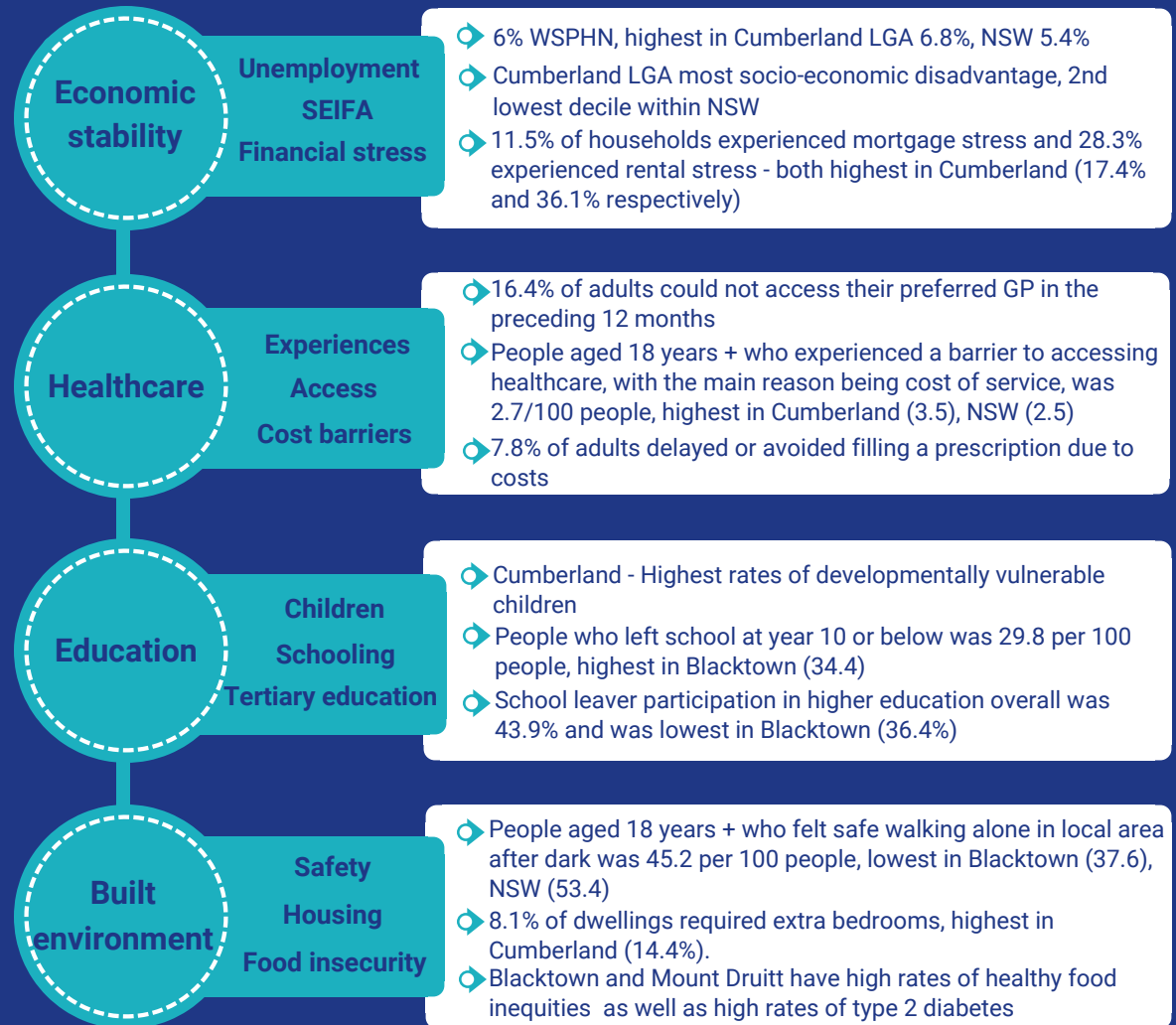


12% of neighbourhoods in western Sydney had a 3:1 ratio of alcohol outlets to greengrocers and supermarkets.



Suburbs that have high rates of healthy food inequities also have high rates of type 2 diabetes (Blacktown and Mt Druitt).

Social determinants



References

1. Australian Bureau of Statistics (2018). Socio-Economic Indexes of Australia (SIEFA), 2016. Canberra.
2. Public Health Information Unit. Social Health Atlas of Australia: Data by Primary Health Networks (incl. Local Government Areas). October 2018.
3. Australian Institute of Health and Welfare (2018). Patient Experiences in Australia: Reporting years, 2013-14, 2014-15, 2015-16, and 2016-17. Canberra.
4. Astell-Burt, T., & Feng, X. (2015). Geographic inequity in healthy food environment and type 2 diabetes: Can we please turn off the tap? Medical Journal of Australia, 6, 246-248.

Asthma and COPD

KEY FACTS

- In 2011, asthma was among the top three causes of total disease burden for children aged 5-14 years.³
- In 2016, COPD was the fifth leading underlying cause of death in Australia, and 70% of deaths were among people aged 75 years and over.³
- Asthma and COPD are among the eight most common chronic conditions experienced by Australians.³
- In 2011, COPD contributed the highest percentage (43%) of total burden of all respiratory conditions, followed by asthma (29%).³

SUMMARY

Chronic Obstructive Pulmonary Disease (COPD) is an umbrella term for a group of progressive lung conditions including emphysema, chronic bronchitis, and chronic asthma. People with **asthma** have sensitive airways in their lungs which react to triggers, causing a 'flare-up'.

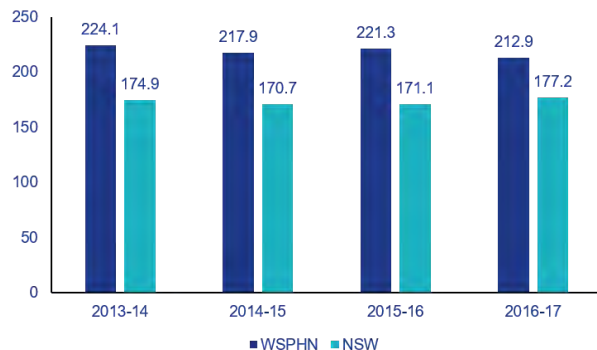
Whilst COPD and asthma cannot be cured, they can be well controlled by following an individualised, daily management plan. People can live for many years with COPD and still enjoy a good quality of life. Poorly managed COPD and asthma can contribute to potentially preventable hospitalisations.^{1,2}

PRIORITY AREAS

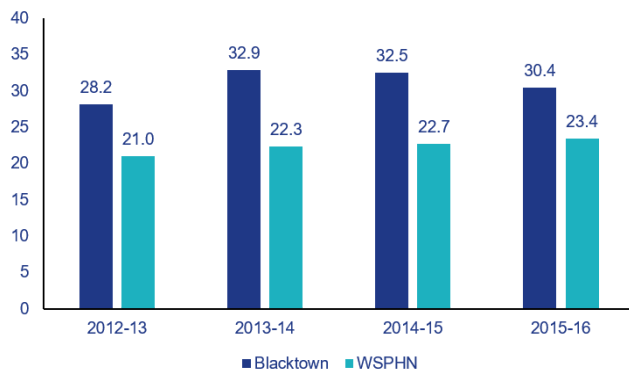
Improving asthma and COPD management is a priority for western Sydney, particularly:

- Better management of asthma and COPD through the use of evidence-based treatment guidelines and incorporating appropriate use of case conferencing.
- Reducing avoidable asthma hospitalisations.

Asthma and COPD



Asthma hospitalisations, all ages, Western Sydney PHN and NSW, 2013-14 to 2016-17
Rate per 100,000 population



COPD deaths, all ages, Blacktown and Western Sydney PHN, 2012-13 to 2015-16
Rate per 100,000 population

KEY FACTS CONTINUED

- WSPHN experienced consistently higher rates of asthma hospitalisations (212.9 per 100,000 population) compared with NSW (177.2 per 100,000 population) in 2016-17. However, asthma prevalence in people aged 16 and over was lower in WSPHN (7.8%) compared with NSW (10.9) in 2017.⁴
- Asthma death rates are also higher in WSPHN (2.2 per 100,000) than NSW (1.6 per 100,000) rates for the period 2015-16. This may suggest poorer management of the condition in western Sydney.⁴
- COPD death rates are lower in WSPHN compared with NSW rates, however they have been higher in Blacktown LGA compared with NSW for every period between 2001-02 and 2015-16.⁴



PHN PROGRAM PERFORMANCE INDICATORS

P9

Rate of GP team care arrangements/case conferences

P12

Rate of potentially preventable hospitalisations

References

- National Asthma Council Australia. What is Asthma? <https://www.nationalasthma.org.au/understanding-asthma/what-is-asthma>
- Lung Foundation Australia. Overview Chronic Obstructive Pulmonary Disease. <https://lungfoundation.com.au/patients-carers/living-with-a-lung-disease/copd/overview/>
- Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW
- NSW HealthStats. Asthma and COPD: http://www.healthstats.nsw.gov.au/Indicator/res_copddth/res_copddth_lga_trend

Cancer screening

KEY FACTS

- **Participation rates in national cancer screening programs**, including breast, bowel and cervical screening, are lower in the western Sydney region compared with NSW and national rates.^{1,2}
- Rates are even lower in some SA3s in the region. In Mount Druitt SA3 cancer screening rates for all three programs are consistently lower than other SA3s in the region, NSW and national rates.^{1,2}
- **Bowel cancer screening rates** in WSPHN have increased from 32.7% in the 2014-15 to 34.3% in 2015-16. However, they are far lower than the national average (40.9%), and are lowest of all NSW PHNs.^{1,2}
- The lowest bowel screening participation rates in WSPHN SA2s were: Lethbridge Park–Tregear (25.5%), Bidwill-Hebersham–Emerton (25.6%), Glendenning Dean Park (26.1%), Mount Druitt–Whalan (26.6%), and Parramatta–Rosehill (27.5%).^{1,2}

SUMMARY

Cancer screening programs aim to reduce illness and death resulting from cancer through an organised approach to screening. Screening is effective at detecting cancers in people with no symptoms. Australia has three cancer screening programs:

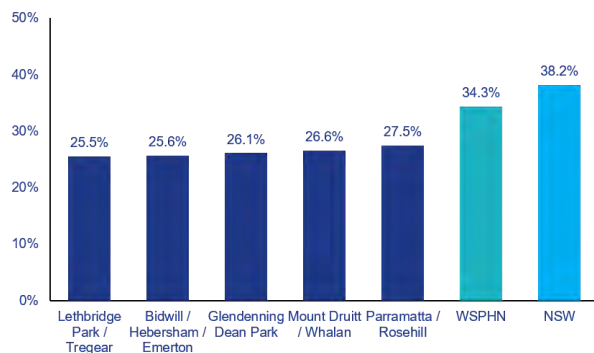
- **BreastScreen Australia**
(women aged 50-74 years, screening every two years)
- **National Cervical Screening Program**
(women aged 25-74, screening every five years)
- **National Bowel Cancer Screening Program**
(women and men aged 50-74 years, every two years)

PRIORITY AREAS

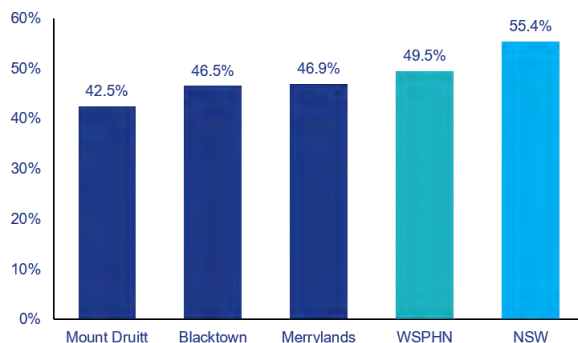
- Improving cancer screening rates is a priority for all of the WSPHN region, with targeted activities for: Mount Druitt, Cervical screening, Breast screening, and Bowel screening.
- Increase awareness of cancer screening among priority groups, such as CALD people and Aboriginal and Torres Strait Islanders.
- Support primary care to provide opportunistic cervical screening and up-skill GPs and Practice Nurses to promote uptake.
- Provide support to GPs on identification and management of the population who has never screened or who are lapsed.
- Work with stakeholders who have an impact on health to influence the community to participate in screening.

Cancer screening

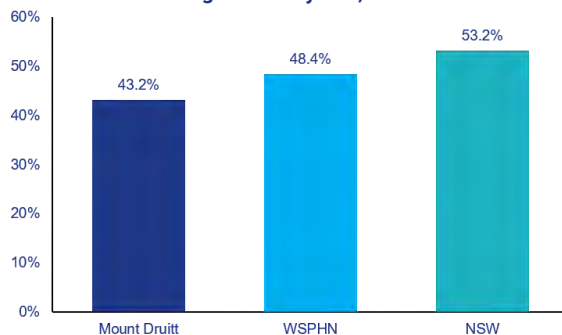
Participation in the National Bowel Cancer Screening Program, people aged 50-74 years, 2015-16



Participation in the National Cervical Cancer Screening Program, women aged 20-69 years, 2015-16



Participation in the National Breast Cancer Screening Program, women aged 50-69 years, 2015-16



KEY FACTS CONTINUED

- **Cervical cancer screening rates** in WSPHN in 2015-16 (49.5%) are lower compared with NSW (55.4%) for women aged 20-69. Residents in SA3s Blacktown (46.5%), Merrylands (46.9%) and Mount Druitt (42.5%) had lower participation rates compared to both the state and national (55.4%) rates.^{1,2}



- In 2015-16, **Breast screening rates** for women aged 50-69, were lower in WSPHN (48.4%) compared to NSW (53.2%). The SA3 Mt Druitt had a much lower participation rate at 43.2%.^{1,2}

PHN PROGRAM PERFORMANCE INDICATOR

PH2

Cancer screening rates for cervical, bowel and breast cancer

References

1. My Healthy Communities. Web update: Participation in national cancer screening programs in 2015-2016. Australian Institute of Health and Welfare. Data by PHN and SA3 areas. Released 19 April 2018. <https://www.myhealthycommunities.gov.au/our-reports/cancer-screening/april-2018/web-update>
2. AIHW. Australian Institute of Health and Welfare analysis of National Bowel Cancer Screening Program register data, state and territory BreastScreen register data, and state and territory cervical screening register data. Participation in Australian cancer screening programs in 2015-16. Released 27 October 2017 <https://www.aihw.gov.au/reports/cancer-screening/cancer-screening-in-australia-by-small-geographic/data>

Diabetes

KEY FACTS



In western Sydney it is estimated that:

- 129,000 (15%) have diabetes;
- 25,900 (3%) have significant additional diseases, such as vascular problems (high co-morbidity)
- 103,200 (12%) have diabetes with low co-morbidity
- 85% of these residents will have type 2 diabetes (109,650 people).³



Additionally, there are up to 301,000 people (35% of the population) at 'high risk' of type 2 diabetes with pre-diabetes or high blood glucose.³



The area of Blacktown and Mount Druitt has an even greater proportion of residents with diabetes. Screening at the Emergency Department (ED) in 2017 showed rates of 17% of people with diabetes and 29% having pre-diabetes.³



In 2016-17, hospitalisations due to type 2 diabetes were higher in WSPHN (90.7 per 100,000) than NSW (88.7).⁴



In 2017, rates of diabetes or high blood glucose, for people aged 16 years and over in WSPHN was 11.5% and 10.1% in NSW. These rates have been increasing over time for both WSPHN and NSW.



Rates of diabetes (pre-existing or gestational) have increased substantially between 2007 and 2016 in WSPHN (5.9% to 15.3%) and NSW (4.9% to 13.5%).³

SUMMARY

Diabetes is a serious complex condition where the body is unable to maintain healthy levels of glucose in the blood. The condition affects the entire body, and when poorly managed can lead to other health complications. The four types of diabetes are: pre-diabetes, type 1, type 2 and gestational diabetes.¹

The impact of diabetes varies among population groups, with rates being 3–6 times as high among Aboriginal and Torres Strait Islander people as among non-Indigenous Australians. Generally, the prevalence of diabetes increases with increasing socioeconomic disadvantage.²

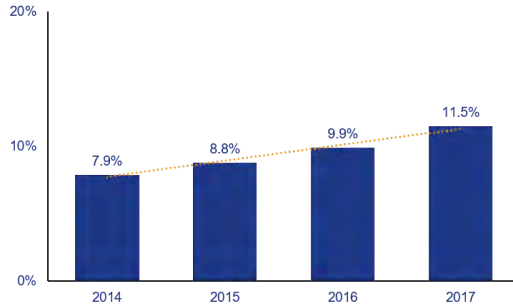
PRIORITY AREAS

A coordinated and whole of system approach to diabetes prevention and management, including:

- Working in partnership with Western Sydney LHD, consumers, and health professionals as a member of the Sydney Diabetes Alliance to reduce the health and social burden of the condition.
- Supporting general practice and primary care to detect and treat diabetes, through education and training and primary and secondary prevention activities, such as joint specialist case conferencing and integrated care.

Diabetes

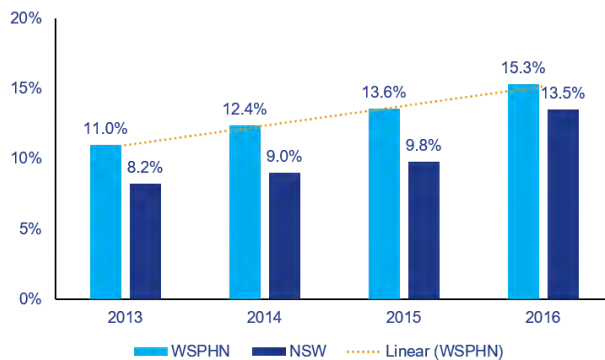
Diabetes or high blood glucose, people aged 16 years and over, Western Sydney PHN, 2014 to 2017



Diabetes hospitalisations by type 2 diabetes, 2016-17. Rate per 100,000 population



Maternal condition, percent of diabetes (pre-existing or gestational), WSPHN and NSW, 2013 to 2016



KEY FACTS CONTINUED

Factors such as age, family history and place of birth can contribute to an increased risk of developing diabetes and some groups are at even greater risk. Many of these groups are strongly represented amongst western Sydney residents, including:

- **Aboriginal and Torres Strait Islander peoples:** Type 2 diabetes is more common and has an earlier onset in this population.
- **People from Asia and Pacific Islands heritage:** Have higher rates of diabetes and develop diabetes at a lower weight and BMI.
- **People with mental health problems:** 41.6% of adults with diabetes reported having medium, high or very high levels of psychological distress.
- **Women in their Childbearing Years:** The percentage of gestational diabetes in western Sydney is higher than for NSW. Western Sydney has a higher birth rate, with three out of our five LGAs having higher fertility rates than the rest of NSW.³

PHN PROGRAM PERFORMANCE INDICATORS

- P9 Rate of GP team care arrangements/case conferences
- P12 Rate of potentially preventable hospitalisations

References

1. Diabetes Australia. What is Diabetes? [Accessed October 2018] <https://www.diabetesaustralia.com.au/what-is-diabetes>
2. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW
3. Western Sydney Diabetes. Taking the heat out of our diabetes hotspot. Western Sydney PHN, PwC, Diabetes NSW & ACT, Western Sydney LHD, NSW Government. 2017 https://www.westernsydneydiabetes.com.au/themes/default/basemedia/content/files/WSD_TakingHeat_DiabetesHotspot.pdf
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Chronic disease management

KEY FACTS

- WSPHN has consistently higher rates of potentially preventable hospitalisations for chronic conditions than the NSW rate (2016-17 – WSPHN 1056.8/100,000 and NSW 963.4/100,000).¹
- Consumer consultations identified that people with complex conditions frequently feel rushed and unheard during GP appointments, leading to inappropriate care, incorrect diagnosis and prescriptions, poor treatment advice, and poor or limited support.²
- Results from the Health Literacy Questionnaire, and a survey of mental health and AOD healthcare providers in Western Sydney about health literacy responsiveness identified: People managing more than 3 chronic conditions have lower levels of health literacy, and Health Literacy responsiveness was perceived as the lowest amongst government organisations delivering mental health and AOD services and support (e.g. hospitals), and highest in the non-government sector (e.g. community organisations).²

SUMMARY

A chronic medical condition is one that has been (or is likely to be) present for six months or longer, for example, asthma, heart disease, or diabetes. Good chronic disease management is continuous and provides consistent care, is planned and proactive, supports self-management, and is intended to keep people as well as possible.

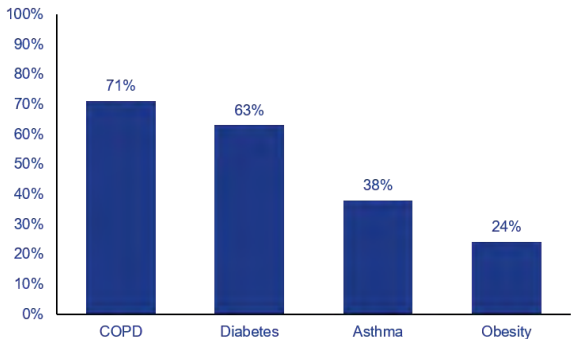
PRIORITY AREAS

Improving chronic disease management, with a specific focus on:

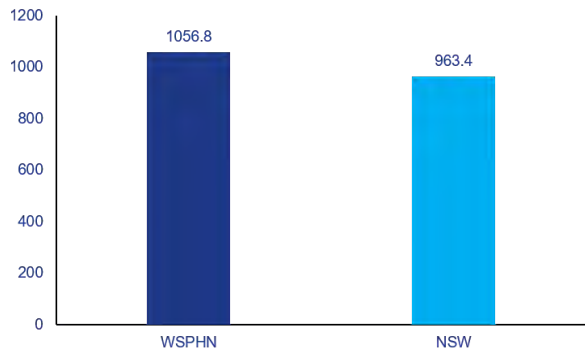
- Improving GPs' capacity and capability to manage patients with chronic and complex conditions.
- Supporting and encouraging the use of team-based and patient-centered care models.
- Establishing localised care and referral pathways for a variety of conditions.
- Increasing healthy lifestyle choices in vulnerable communities.

Chronic disease management

Percentage of Australian adults receiving appropriate health care, 2009-2010 (selected chronic conditions)



Potentially preventable hospitalisations for chronic conditions, 2016-17 (rate per 100,000 population)



KEY FACTS CONTINUED

- Research in western Sydney has found that people with mental health conditions also experienced chronic conditions such as ‘arthritis, osteoporosis, cardiovascular conditions, cancer, diabetes and other conditions’. In addition, this research found that only 67% of the sample who reported having a mental illness rate their health positively, compared to 82% of the total sample.³
- Patient care provided by health care providers can vary. Some variation can be expected and reflects appropriate responses to differing patient needs and requirements. However, when differences in care do not reflect such factors and is not based on best practice guidelines, it represents unwarranted variation in care.⁴
- More than 4 million Australians suffer from chronic pain or pain that lasts longer than three months. A better understanding and better pain management for people suffering persistent pain is needed in western Sydney.⁵

PHN PROGRAM PERFORMANCE INDICATORS

- | | |
|---|---|
| P4 Support provided to general practices and other health care providers | P9 Rate of GP team care arrangements/ case conferences |
| P6 Rate of general practices receiving payment for after hours services | P12 Rate of potentially preventable hospitalisations |

References

1. HealthStats. Potentially preventable hospitalisations. Accessed October 2018. http://www.healthstats.nsw.gov.au/IndicatorGroup/IndicatorviewList?&code=bod_acs&topic=&name=Potentially%20preventable%20hospitalisationsTopic
2. The Science of Knowing. WentWest Consumer Needs Assessment Project Report. 2018
3. Brooke M. Consumers and after hours health care in western Sydney: Summary of research insights. Outcomes Services;2016.
4. Australian Institute of Health and Welfare, 2017. The second Australian Atlas of Healthcare Variation (2017). Sydney.
5. Dr Coralie Wales, Chronic Pain Australia President, WSLHD

Immunisation

KEY FACTS

- Current immunisation rates in WSPHN were below the 95% coverage targets for one, two and five year age groups.¹
- Children in WSPHN have lower immunisation rates than NSW and Australia overall.¹
- Immunisation rates for Aboriginal and Torres Strait Islander children are higher in WSPHN compared with NSW and national rates at two and five years.¹
- The rate of girls aged 15 years who received all three doses of HPV vaccine (fully immunised) in the WSPHN region has increased between 2013-14 and 2015-16 (69.4% to 83.4%), and was higher than the national rate in 2015-16.²
- The rate of boys aged 15 years who received all three doses of HPV vaccine (fully immunised) in the WSPHN region has increased between 2014-15 and 2015-16 (60.3% to 70.4%), but was lower than both the state and national rates in 2015-16.²

SUMMARY

Immunisation is a safe and effective way of reducing the spread of vaccine-preventable diseases in the community and protecting against potentially serious health problems. Although the majority of Australian children are immunised, it is important to maintain high immunisation to reduce the risk of outbreaks of serious diseases.

The National Immunisation Schedule includes vaccines for diseases such as Hepatitis A and B, Diphtheria, Tetanus, Pertussis, Pneumococcal, Rotavirus, Polio, Meningococcal, Measles, Mumps, Rubella, and Human Papillomavirus (HPV).

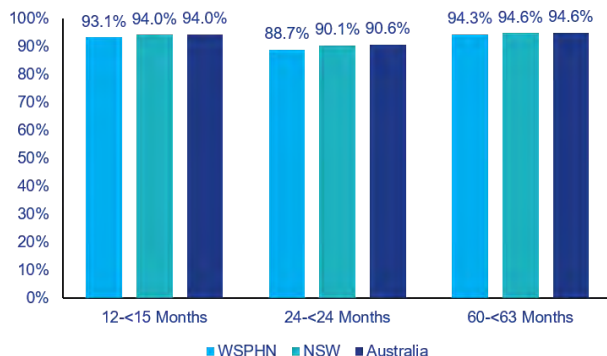
PRIORITY AREAS

Achieving and maintaining 95% immunisation coverage rates at 5 years is a key performance indicator for all PHNs. Improving immunisation rates is a priority for all of the WSPHN region, with targeted activities for:

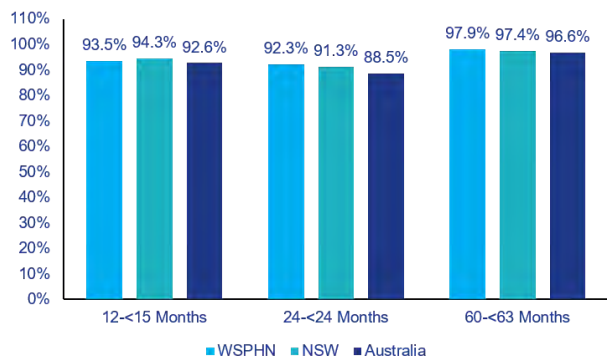
- Hotspots in Parramatta and Auburn LGAs.
- Continued focus on maintaining good coverage amongst Aboriginal and Torres Strait Islander children.

Immunisation

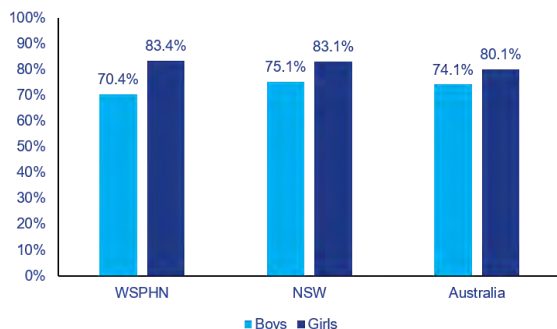
Immunisation rates as of Sep 2018, percent of children fully immunised within each age group ¹



Aboriginal and Torres Strait Islander children fully immunised, as at 30 September 2018 ¹



Percentage of boys and girls aged 15 years in 2015-16 who were fully immunised against HPV (all three doses) ³



KEY FACTS

There are locations (SA3s) within the region with substantially lower immunisation rates than WSPHN, NSW and national rates. SA3s where the rate is 4% or more below the Australian national target of 95% have been identified below. ¹

12-<15 months

Merrylands-Guildford 89.9%

24-<27 months

Auburn 85.4%
Mount Drutt 85.9%
Merrylands-Guildford 86.8%

60-<63 months

Merrylands-Guildford 90.3%



Immunisation rates for Aboriginal and Torres Strait Islander children is not available at the SA3 level, so it's difficult to discern if there are particular geographic hotspots in the region.

Research suggests that immunisation uptake among refugees is sub-optimal and there are gaps relating to immunisation initiatives and policies for refugees. Immunisation rates for CALD, refugee, and asylum seeker populations are not currently available. However, low childhood vaccination rates in the region correlate to areas where there are larger populations of CALD, refugee, and asylum seeker communities (Auburn, Merrylands-Guildford). ^{3,4}

PHN PROGRAM PERFORMANCE INDICATOR

PH1

Rate of children fully immunised at 5 years

References

1. Department of Health. Australian Immunisation Register - Coverage Report Australia, NSW, PHN, and SA3 All children, Aboriginal and Torres Strait Islander children. <https://beta.health.gov.au/resources/publications/2018-phn-childhood-immunisation-coverage-data>
2. Australian Institute of Health and Welfare (2017). HPV immunisation rates 2012-13 to 2015-16.
3. Mahimbo, A., et al., (2017). Immunisation for refugees in Australia: A policy review and analysis across all states and territories. ANZJPH, 41(6), 635-640
4. Mahimbo, A., et al., (2017). Challenges in immunisation service delivery for refugees in Australia: A health system perspective. Vaccine, 35, 5148-5155.

Viral hepatitis

KEY FACTS

- Western Sydney had 13,089 people living with Chronic Hepatitis B in 2016 (1.37% of the population), which is higher than NSW (1.08%) and Australia (0.98%).¹
- Western Sydney have approximately double the national average number of people living with CHB per specialist.¹
- Auburn (2.42%) had a substantially higher prevalence of CHB than the PHN average of 1.37%. In addition, the prevalence of CHB in western Sydney was generally higher in those areas closer to the metropolitan centre (the areas of Carlingford (1.89%), Merrylands-Guildford (1.68%), and Parramatta (1.21%)) than those situated in the northern part of the PHN.¹
- An estimated 38% of people living with CHB across the country are undiagnosed.¹
- The majority of people living with CHB in Australia (61%) were born overseas (Asia-Pacific 41%). Of the 41%, 17% were from China and 8% from Vietnam.¹
- Hepatitis B immunisation coverage has improved overall and in most PHNs, and with nearly half of all PHNs having achieved the 95% National Strategy target in 2016, although coverage was lower among Aboriginal and Torres Strait Islander children.¹
- A 2016 study of local GPs identified that they prefer having specialist input for the assessment and management of CHB. This poses a barrier for patients to receive timely treatment. WSLHD stakeholders have reported there is a significant waiting list to access hospital gastroenterology clinics.³

SUMMARY

Hepatitis B is now the most common blood-borne virus in Australia, estimated to affect over 230,000 people. Although highly effective treatments are available, and effective management and care results in improved patient outcomes, levels of uptake for testing, treatment and monitoring remain low. A large majority of affected Australians do not receive regular care for their chronic hepatitis B infection (CHB).¹

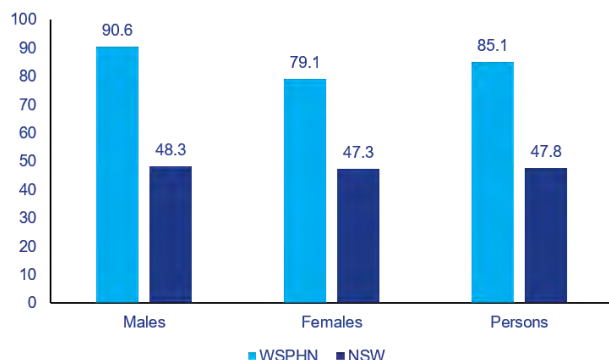
Treatment for hepatitis C has undergone a revolution in recent years, with highly effective, short-duration, and well tolerated curative treatments now available and subsidised in Australia for all adults living with hepatitis C. Initial uptake of these treatments has been strong, however it is important to track the delivery of these treatments and assess variation in the levels of uptake across Australia.²

PRIORITY AREAS







- Improving GPs' knowledge, capacity and confidence to provide assessment, prescription and management to patients with CHB and hepatitis C.
- Support to GPs to complete opportunistic screening and promoting uptake and compliance of antiviral treatment.
- Reduce hepatitis B and C infections, disease burden and improve the health outcomes of people living with viral hepatitis.
- Community engagement and health promotion to reduce stigma and increase community action on viral hepatitis.
- Increasing awareness, vaccination, testing and treatment among priority groups: Chinese, Arabic, Vietnamese and Korean speaking communities, and Aboriginal and Torres Strait Islander peoples.
- Geographic hotspots: Merrylands-Guildford, Mt Druitt, Auburn and Parramatta SA3s.

Viral hepatitis

Hepatitis B notifications for people aged 15-44 years, by WSPHN, NSW 2015
Notifications per 100,000 population



People most at risk or most affected by hepatitis C are:

-  People living with hepatitis C
-  People who inject drugs, especially new inmates
-  People in or recently in custodial settings
-  Aboriginal people
-  People from CALD backgrounds
-  Young people who are at risk of injecting

KEY FACTS CONTINUED

- There are treatments that can cure hepatitis C in 70-80% of cases, but only about 2% of people with hepatitis C start treatment in any year. Factors that influence the uptake of current treatments include: their tolerability and duration, lack of awareness about their availability and effectiveness, as well as barriers to accessing treatment services in some areas. In addition, the promise of better treatments on the horizon has led many to delay starting therapy.⁴
- In 2014-15, an estimated 1 in 50 (1.9%) adult Australians were living with chronic hepatitis C.⁴
- 31% of Australian prison entrants tested positive for hepatitis C in 2015.⁴
- Between 2000 and 2015, chronic hepatitis C infection was the second most common diagnosis among deaths attributed to notifiable diseases.⁴
- In 2016-17, hepatitis C medicines accounted for the most government spending on medications.⁴
- Data from the NSW Hepatitis B and C Strategies indicates that over 7,000 people in WSLHD are living with hepatitis C, but only 19% have initiated treatment. Data also showed that 72% of hepatitis C treatment is dispensed by specialists compared with 28% from GPs, suggesting similar issues to hepatitis B treatment.⁵

PHN PROGRAM PERFORMANCE INDICATOR

P4

Support provided to general practices and other health care providers

References

1. MacLachlan J, Thomas L, Cowie B, and Allard N. Hepatitis B Mapping Project: Estimates of geographic diversity in chronic hepatitis B prevalence, diagnosis, monitoring and treatment - National Report 2016. Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). Darlinghurst. 2018
2. MacLachlan J, Thomas L, Cowie B, and Allard N. Hepatitis C Mapping Project: Estimates of geographic diversity in chronic hepatitis C prevalence, diagnosis, monitoring and treatment - National Report 2016. Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). Darlinghurst. 2018
3. Najjar, N et al (2016) A survey of Sydney General Practitioners management of Chronic Hepatitis B, Medical Journal of Australia. 2016;204(2):74e1-e4
4. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW
5. NSW Government. NSW Hepatitis B and C Strategies 2014-2020 ,2017 Annual Data report. <https://www.health.nsw.gov.au/hepatitis/Documents/2017-annual-data-report.pdf>

MATERNAL, CHILD AND FAMILY

- ⊕ Pregnancy and newborn period
- ⊕ Childhood risk factors
- ⊕ Childhood development
- ⊕ Domestic violence



Pregnancy and newborn period

KEY FACTS

- In 2017, Blacktown LGA had the highest number of births in the WSPHN region, and the largest number of mothers under the age of 19 years (65% of all mothers under the age of 19 years were from Blacktown LGA).²
- Between 2014-16, the rate of low birth weight babies for all women in WSPHN was comparable to other PHNs at 4.9%. However, areas with higher socioeconomic disadvantage, such as Mt Druitt SA3 (6%) and Blacktown SA3 (5.5%) had the highest rates in the region.³
- Between 2014 to 2016, the rate of women smoking during pregnancy in the WSPHN region (6.8%) was amongst the lowest in the country (Australia 10.4%). However, Blacktown SA3 (9.2%) and Mt Druitt SA3 (18.3%) had the highest rates, with the rate in Mt Druitt being close to three times higher.³
- During 2014 to 2016, 55.2% of all women who gave birth in the WSPHN region had at least one antenatal visit in the first trimester. However, the rates in SA3 areas such as Blacktown (35.5%), Mt Druitt (31.2%), and Auburn (21.5%) were much lower.³

SUMMARY

Teenage mothers may face various adverse health and socioeconomic outcomes. Newborns born to adolescent mothers are also more likely to have low birth weight, with a risk of long-term adverse health outcomes.

An infant's weight at birth is a key indicator of health and a determinant of an infant's chance of survival. Low birth weight babies may also be more vulnerable to illness in childhood and adulthood. A risk factor for low birth weight is smoking during pregnancy.

Antenatal visits in the first trimester of pregnancy (before 14 weeks' gestational age) is associated with improved child and maternal health outcomes, and fewer interventions in the later stages of pregnancy.¹

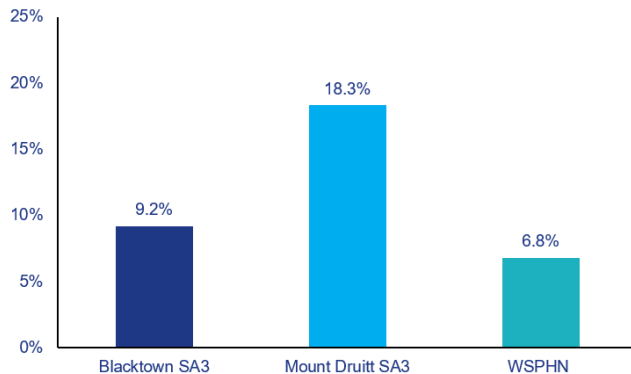
PRIORITY AREAS

Vulnerable young mothers and their children, with a specific focus on:

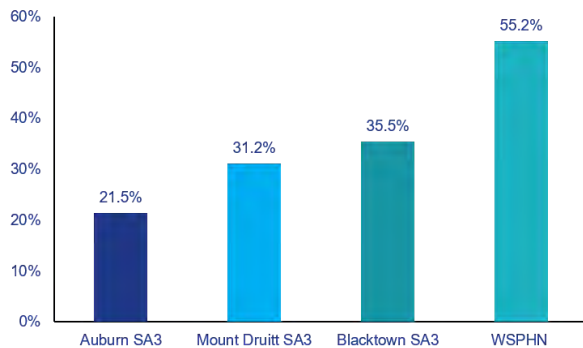
- Improving wrap-around support for vulnerable young mothers and their children.
- Improving antenatal shared care coverage and health outcomes.
- Targeted activities in geographic hotspots: Mount Druitt, Blacktown and Auburn SA3s.

Pregnancy and newborn period

Rate of women who smoked during pregnancy, Western Sydney PHN, 2014 to 2016



Women who had at least one antenatal visit in the first trimester, Western Sydney PHN, 2014 to 2016



KEY FACTS CONTINUED

- Rates of antenatal care is low among Aboriginal women in the western Sydney region, and a large gap exists compared to non-Aboriginal women. In 2016, 78.6% of Aboriginal women in western Sydney had their first antenatal visit prior to 20 weeks of pregnancy, compared to 87.3% for non-Aboriginal women.^{1,2}
- In 2016, the incidence of low birth weight babies for Aboriginal women in western Sydney (11.0%) have reduced since 2015 (13.9%), and are similar to that of NSW overall (10.8%). However, the rate remains substantially higher among Aboriginal women in western Sydney compared to non-Indigenous women (6.8%).⁴
- The proportion of Aboriginal mothers in western Sydney who smoke during pregnancy remains higher than that of Aboriginal mothers in NSW overall (47.7% compared to 41.3%). Aboriginal mothers in western Sydney are significantly more likely to smoke during pregnancy compared to non-Aboriginal mothers (47.7% compared to 5.8%).⁴
- Perinatal mental health (PMH) issues, such as depression and anxiety can occur during pregnancy and after birth. Research suggests that postnatal depressive symptoms affect a significant number of Australian women, and population estimates of postnatal anxiety symptoms may be as high as 20%. Women who have already experienced mental health concerns may be at higher risk of PMH issues. Without appropriate treatment and support, PMH issues may have long-term adverse impacts for both mother and child.^{5,6}

PHN PROGRAM PERFORMANCE INDICATORS

P2

Health system improvement and innovation

P4

Support provided to general practices and other health care providers

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.
3. Australian Institute of Health and Welfare 2018. Child and maternal health indicators 2016. October 2018. Canberra.
4. NSW Perinatal Data Collection (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.
5. Grant, K. A., et al., (2008). Maternal anxiety during the transition to parenthood: A prospective study. Journal of Affective Disorders, 108, 101–111.
6. Buist, A., et al., (2008). Postnatal mental health of women giving birth in Australia 2002-2004: Findings from the beyondblue national postnatal

Childhood risk factors

KEY FACTS



24.8%

of secondary school students aged 12-17 years were overweight and obese, western Sydney, 2014 ³



41.6%

of children aged 5-15 years had sedentary behaviours, western Sydney, 2016-17 ³



6.9%

of children aged 2-15 years, consumed the daily recommended amounts of vegetables, western Sydney, 2016-17 ⁴



61.5%

of children aged 2-15 years, consumed the daily recommended amounts of fruit, western Sydney, 2016-17 ⁴

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. The Mapping food Environments Australian Localities (MEAL) Project (2014). Epidemiological Profile WSLHD Residents
3. NSW School Students Health Behaviours Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.
4. NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.

SUMMARY

Good nutrition and regular physical activity in childhood are an important factor to overall positive health and wellbeing. Lack of physical activity, poor nutrition and diets high in sugar are associated with poor health outcomes, such as an increased risk of chronic diseases (e.g. type 2 diabetes, cardiovascular disease, and some types of cancer).¹

Regional socioeconomic inequalities may contribute to limited access to fresh and nutritious foods in socioeconomic disadvantaged areas, which combined with poor nutritional knowledge, may contribute to poor dietary habits and health inequalities.²

PRIORITY AREAS

- Commission services addressing local population health issues, including preventive health initiatives, such as healthy lifestyle projects and peer support programs
- Work with stakeholders who have an impact on health to influence their approach to population health.
- Provide support to general practices and other health care providers on identification and management of population health risk factors.

Childhood development

KEY FACTS

- In 2015, the rate of children developmentally vulnerable on **one or more domains** was slightly higher in the WSPHN region (22.7%) compared to NSW overall (20.2%).
- There is substantial variability within the region, and there have been significant increases from 2012 to 2015 in **15 suburbs** across the region where rates are substantially higher than that of WSPHN and NSW overall (e.g. Blackett, Whalan, Dharruk).
- The rate of children who are developmentally vulnerable on **two or more domains** is slightly higher in WSPHN (11.2%), compared to NSW overall (9.6%).
- There are large variations in the region, with **16 suburbs** across the region having rates that are far higher (range 13% - 34%) and have had significant increases from 2012 (e.g. Whalan, North Parramatta, Parklea).²
- Consumer consultation identified a range of issues they face supporting their children with developmental delays and/or disabilities, including: difficulties transitioning to the NDIS, program and funding gaps as a result of the NDIS (e.g. case coordination and alternative therapies), and poor visibility of available services.³

SUMMARY

The early years of a child's life have a profound impact on their future cognitive, social, emotional and physical development. Adverse or traumatic events have the potential to significantly alter the future wellbeing of individuals. The skills and abilities acquired in early childhood are fundamental to a person's success and wellbeing later in life.

Developmental delay is the term used when a young child is slower to develop physical, emotional, social and communication skills than is expected in children of that age. There is evidence that providing support and services for infants and young children with early developmental delays and their families can alter the child's longer term developmental trajectory, and reduce the risk of secondary health and psychosocial conditions.¹

PRIORITY AREAS

Developmentally vulnerable children and their families with a specific focus on:

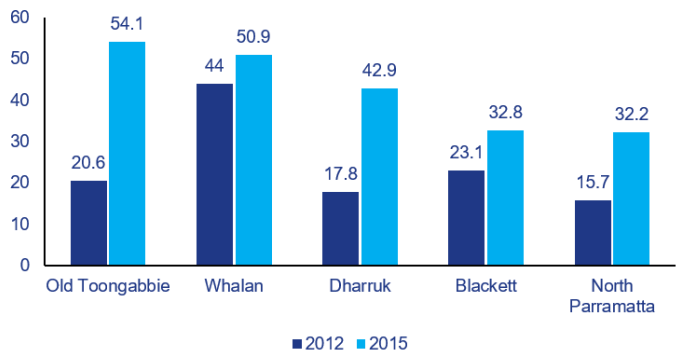
- Geographic hotspots in Old Toongabbie, Whalan, Dharruk, Blackett, North Parramatta, South Wentworthville, Parklea, and Kings Langley.
- Expansion of the Thrive@5 program into geographic hotspots.

Childhood development

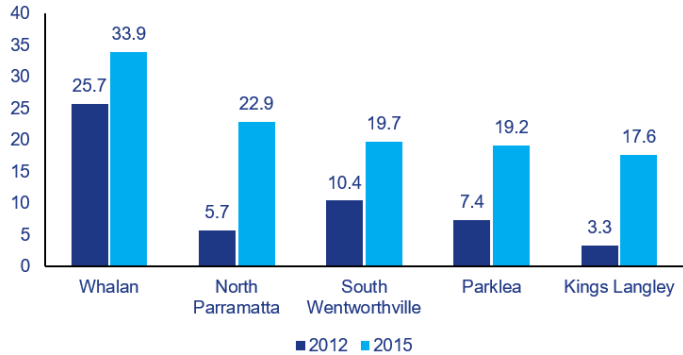
KEY FACTS CONTINUED

Top 5 suburbs with the highest vulnerability rates in the region and that have had significant increases from 2012 to 2015

Percent of children vulnerable on one or more domains²



Percent of children vulnerable on two or more domains²



- The Australian Early Development Census (AEDC) is a nationwide data collection of early childhood development at the time children commence their first year of full-time school.
- The Instrument collects data relating to five key areas of early childhood development referred to as 'domains', these include: Physical health and wellbeing, Social competence, Emotional maturity, Language and cognitive skills, Communication skills and General knowledge. The AEDC domains have been shown to predict later health, wellbeing and academic success.
- There are suburbs in WSPHN that have seen a statistically significant increase in the percentage of children who are vulnerable on one or more, and on two or domains from 2012 to 2015.²
- Western Sydney does not have a community paediatrician. Areas such as South Eastern Sydney and South Western Sydney have access to a community paediatrician.

PHN PROGRAM PERFORMANCE INDICATORS

- P1 PHN activities address prioritised needs
- P2 Health system improvement and innovation
- P4 Support provided to general practices and other health care providers

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. Australian Early Development Census. Data Explorer. Collated data for the WSPHN region. October 2018.
3. The Science of Knowing. WentWest Consumer Needs Assessment Project Report 2018

Domestic violence

KEY FACTS

- The rate of domestic violence related assaults in Blacktown LGA are the highest in the WSPHN region, and much higher compared to NSW overall (586.9 compared to 370 per 100,000).¹
- The Mount Druitt area has been identified as a hotspot for domestic violence related police referrals.²
- Statistics also demonstrate the significant impacts of domestic violence on women and children, including:
 - Intimate partner violence is a leading contributor to illness, disability and premature death for women aged 18-44.³
 - Children of mothers experiencing domestic violence have higher rates of social and emotional problems than other children.⁴
 - Indigenous women are 32 times more likely to be hospitalised due to family violence than non-Indigenous women.⁵
 - Domestic and family violence is the leading cause of homelessness for women and their children.⁶

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. Australian Bureau of Statistics (2017). Personal Safety, Australia, 2016. Canberra.
3. Ayre et al. (2016). Examination of the burden of disease of intimate partner violence against women in 2011. Sydney: ANROWS.
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6. AIHW. (2017). Specialist Homelessness Services 2016–17. Canberra: AIHW.

SUMMARY

Domestic violence has significant adverse health and wellbeing impacts on victims, and broader implications for society as a whole. For women aged 15-44 years, domestic violence is among the leading preventable contributors to illness, disability, and death.¹

In the 2016 Personal Safety Survey, an estimated 187,800 women experienced violence and were pregnant at some point in their relationship, of which 18% reported experiencing violence from their partner during pregnancy.²

PRIORITY AREAS

Ensuring people experiencing domestic violence have access to commissioned services for identified vulnerable sub-populations, including:

- Psychological therapies delivered by mental health professionals (PHN Program Performance Indicator - MH2).

AGED CARE

- ⊕ Dementia
- ⊕ Falls among older people
- ⊕ Palliative care and end of life planning
- ⊕ System level issues



Dementia

KEY FACTS

- In 2011, dementia is more prevalent among older people, and was the second leading cause of total burden of disease for people aged 65 years and over.¹
- It is estimated that 12,788 people are living with dementia in western Sydney. This is projected to increase by more than 200% by 2050. The State Electoral Division of Parramatta, Auburn, Granville is estimated to have the highest numbers of people living with dementia.³
- In 2016-17, the rate of hospitalisations for dementia as principle diagnosis or as a comorbidity for people aged 65 years and over in the WSPHN region was 1378.5 per 100,000 people.⁴
- 58.5% of people using permanent residential aged care in Western Sydney on 30 June 2017 had a diagnosis of dementia.⁵

SUMMARY

Dementia is a term that covers a range of conditions related to gradual brain function impairment commonly associated with memory loss. It is estimated that the prevalence of dementia in Australia was 376,000 people in 2018, and could increase to 550,000 by the year 2030.¹

Dementia is the second leading cause of death of Australians contributing to 5.4% of all deaths in males and 10.6% of all deaths in females each year.²

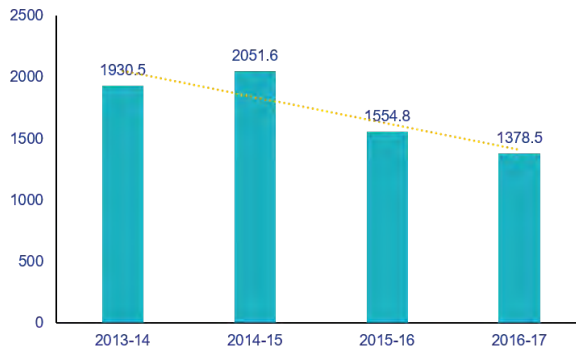
PRIORITY AREAS

Working in partnership with the WSLHD through the Western Sydney Integrated Senior's Health (WISH) committee to:

- Identify at-risk older persons in the region
- Improve management of dementia, including patients with behavioural and psychological symptoms of dementia
- Support GPs to identify at-risk older persons
- Improve medication use in the community and RACFs
- Reduce preventable hospitalisations
- Improve integrated care (i.e. geriatric medicine and chronic and complex stream in community health).

Dementia

Dementia as a principal diagnosis or as a comorbidity, hospitalisations persons aged 65 and over, WSPHN, Rate per 100,000, 2013-14 to 2016-17



"You're treated differently once a diagnosis of dementia is made... There is a stigma about dementia... perception that you should stop doing complex tasks"

WentWest Consumer Needs Assessment participant
Female, living with dementia ⁶

KEY FACTS CONTINUED

➤ People living with dementia and their carers provided insights into their challenges and what needs to change in the region, including:

- There are long delays in recognising, seeking and receiving a dementia diagnosis amongst family and from GPs.
- There is a stigma associated with dementia in healthcare and social contexts. Sufferers can be treated differently by healthcare professionals and friends once a diagnosis is made.
- They highly regard social support programs and see them as essential services for both respite, managing their dementia, and enabling social interactions with people with similar experiences.⁶

PHN PROGRAM PERFORMANCE INDICATORS

P4 Support provided to general practices and other health care providers

AC1 Rate of MBS services provided by primary care providers in RACFs

P12 Rate of potentially preventable hospitalisations

AC2 Rate of people aged 75 and over with a GP health assessment

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. Dementia Australia. Dementia Statistics. Accessed November 2018. <https://www.dementia.org.au/statistics>
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6. The Science of Knowing. WentWest Consumer Needs Assessment Project Final Report 2018.

Falls among older people

KEY FACTS

- In 2015, the rate of people in WSPHN over the age of 65 years who experienced a fall in the previous year was 20.8%. In 2016-17, a total of 3,635 people over the age of 65 years were hospitalised for fall-related injuries.²
- It is estimated that 19% of patients are not transported to hospital, but re-present to hospital with another fall. It has been identified that there is a lack of understanding of the outcomes of non-transported 'Falls' patients. Studies have shown that these patients have the highest re-attendance and 30-day mortality rates, there is currently no system for prospectively and regularly monitoring these patients.
- Stakeholder consultations suggest that follow-up care for older people who have experienced a fall is not optimal, and often re-present with further falls.

SUMMARY

Falls among older people continue to be a public health concern, and injuries from falls can lead to functional decline. Older Australians are at an increased risk of falls, which increases the risk of osteoporosis, and bone and joint pain.¹ Consultations with ambulance services in the WSPHN region have highlighted falls among older people as a major issue.

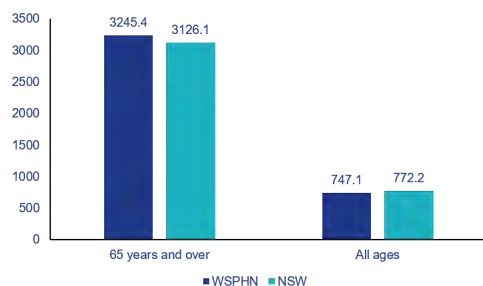
PRIORITY AREAS

Working in partnership with the WSLHD through the Western Sydney Integrated Senior's Health (WISH) committee to:

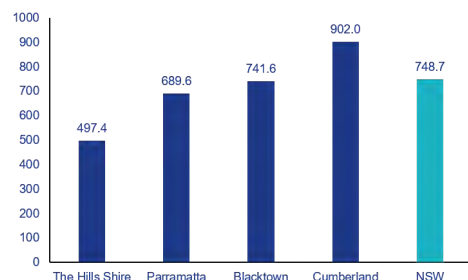
- Identify at-risk older persons in the region
- Support GPs to identify at-risk older persons
- Improve medication use in the community and RACFs
- Reduce preventable hospitalisations
- Improve integrated care (i.e. geriatric medicine and chronic and complex stream in community health).

Falls among older people

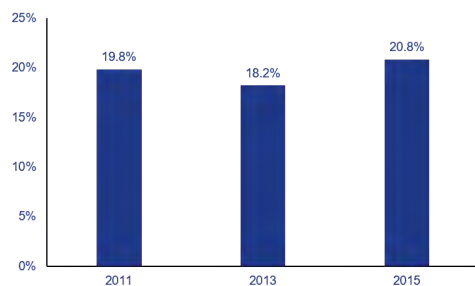
Fall-related injury hospitalisations, Hospital stay: Total, WSPHN, NSW 2016-17, Rate per 100,000 population



Fall-related injury hospitalisations, persons of all ages, WSPHN LGAs, NSW, 2015-17
Spatially adjusted rate per 100,000 population



Percent of falls in the previous year in WSPHN, persons aged 65 years and over, 2015



KEY FACTS CONTINUED



Consultation data from NSW Ambulance and the WSLHD indicate that older people who have had a fall are not receiving appropriate follow-up care in the community and re-present with falls. They identified a lack of care pathways and services are fragmented due to long waiting lists and unclear entry data.³

PHN PROGRAM PERFORMANCE INDICATORS

P4

Support provided to general practices and other health care providers

AC1

Rate of MBS services provided by primary care providers in RACFs

P12

Rate of potentially preventable hospitalisations

AC2

Rate of people aged 75 and over with a GP health assessment

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.
3. NSW Ambulance Falls Patients: Evaluation of 2014 Activity. Ambulance Service of NSW, 2016.

Palliative care and end of life planning

KEY FACTS



A recent discussion paper on delivering integrated quality care at end of life identified a range of issues, gaps, and needs in the region, Including:

- Gaps in patient and family understanding about the role of palliative care.
- Need for greater appreciation of differing cultural practices and norms among CALD and Aboriginal and Torres Strait Islander groups.
- Seeing younger patients from some cultural groups dying with delayed diagnosis and exotic diagnoses (e.g. refugees).
- System disconnects in care planning, information transfer and care delivery between acute, sub-acute and primary care settings most significantly affect those patients with chronic and complex conditions who require multiple services to coordinate efforts.
- Other system disconnect examples: transfers from home or aged care to ED when patient is dying in the moment, transfers from aged care as an avoidance strategy for managing difficult end of life decisions and care.¹

SUMMARY

Ensuring that every person receives quality end of life care, including specialist palliative care where required, as they approach the end of their life remains one of the major challenges to health systems in developed nations around the world.

Specialist Palliative Care - Services provided by clinicians who have advanced training in palliative care. The role includes: providing direct care to patients with complex palliative care needs, and providing consultation services to support, advise and educate non-specialist clinicians who are providing palliative care.¹

End of Life Care - Includes physical, spiritual and psychosocial assessment, care and treatment delivered by health professionals and ancillary staff. It also includes support of families and carers, and care of the patient's body after their death. End of life is when a person is likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days).¹

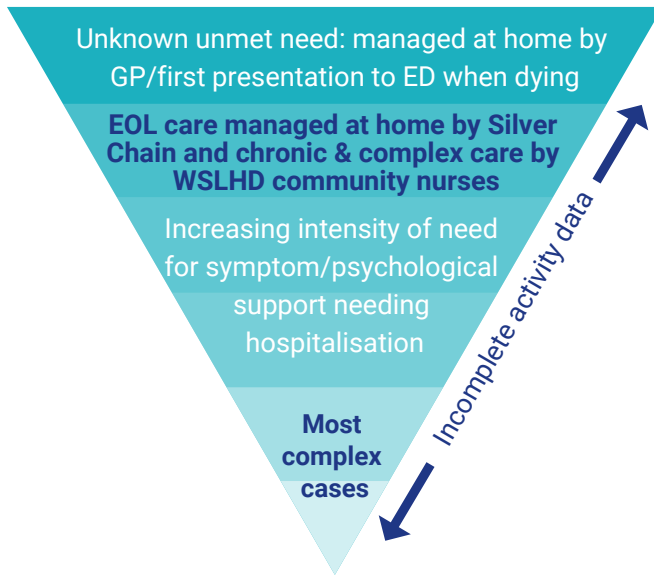
PRIORITY AREAS

Working in partnership with the WSLHD and primary care providers to:

- Increase GPs' capacity and capability to support end of life planning.
- Address appropriately skilled workforce shortage issues.
- Support improved integration and coordination of palliative care and end of life planning services and healthcare.

Palliative care and end of life planning

Pyramid of need: Population-based distribution of patients' need for palliative and support care in WSLHD.¹



A recent study identified an ambiguous, or sometimes uneasy relationship between providers delivering palliative and end of life care in western Sydney.¹

KEY FACTS CONTINUED

- The discussion paper also identified barriers to GPs' involvement in end of life care. Factors such as the reimbursement model being counter-productive for iterative, sometimes lengthy end of life care planning conversations; limited time and/or expertise in busy practices; and difficulties in liaison with treating specialists to know what prognostic information has been provided to the patient who is approaching end of life. GPs have also reported difficulties navigating the WSLHD's palliative care services where each facility has its own way of working; the role of the various LHD palliative care senior staff may not always be clear from the outside; and there is no single 'triage' point for guiding referrals or requests.¹
- Stakeholder consultations have suggested that more education on Advanced Care Plans and palliative care is required for RACF staff, practice nurses and GPs, including the uptake of HealthPathways.²
- There are workforce concerns around the sustainability of a skilled palliative care nursing workforce locally. It is an ageing workforce with 35% of the workforce being 55 years+ of age. There are staff shortages, fewer RNs in the inpatient skill mix, and difficulty recruiting experienced specialist palliative care nurses.¹

PHN PROGRAM PERFORMANCE INDICATORS

P4	Support provided to general practices and other health care providers	AC1	Rate of MBS services provided by primary care providers in RACFs
P12	Rate of potentially preventable hospitalisations	AC2	Rate of people aged 75 and over with a GP health assessment

References

1. LettsConsulting, Delivering Integrated Quality Care at End of Life: Discussion Paper Palliative and End of Life Care Planning for the Future Western Sydney Local Health District 2018.
2. Consultation data collected during stakeholder engagement activities with WentWest personnel.

System level issues

KEY FACTS

- Clinical data indicate that screening and care planning for older people may be sub-optimal, with only 20% of people over that age 75 years receiving an over 75's Health Assessment.²
- There is a lack of appropriate care pathways for older people in the WSPHN region, and pathways and services are fragmented, due in part, to long waiting lists, particularly for people who experience sudden deterioration requiring rapid access to interventions.²
- General practitioners and RACF staff in the region have reported transfer of patient information between acute and primary care as being substandard, which can impact on appropriate care, such as medication prescriptions.²
- Consultations with managers of aged care facilities in the WSPHN region indicate significant aged workforce challenges, such as retaining appropriately skilled and trained staff, high staff turnover, increasing complexity of residents, and poor English proficiency amongst some agency staff.²
- High demand for GPs in RACFs, with anecdotal reports suggesting provision of timely and quality care is variable.²
- The Aged Care Funding Instrument showed that among people in permanent residential aged care in Australia on 30 June 2017:
 - 85% had at least one diagnosed mental health or behavioural condition
 - 52% had dementia
 - 47% had a diagnosis of depression.⁴

SUMMARY

As the population ages and life expectancy increases, Australians will experience more chronic health conditions and associated disabilities. This represents a key challenge for the primary health care system, including increasing demand on residential aged care facilities (RACF), integration and coordination of services, variation in care, and workforce issues.¹

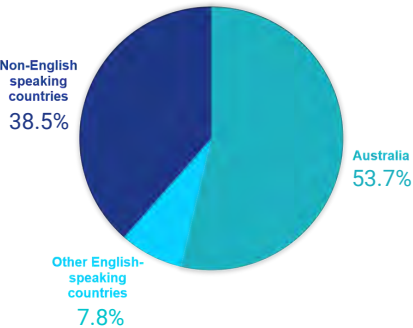
There are 57 RACFs, 91 home care services, and 78 home support services available in the western Sydney region.

PRIORITY AREAS

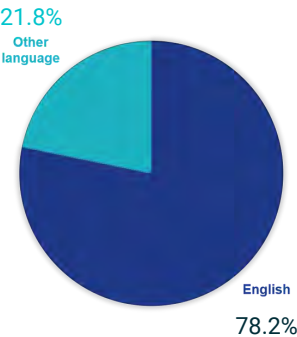
- Increased screening and care planning for older people in the primary care setting to identify health needs early.
- Reducing ED presentations by RACF residents, and preventable hospitalisations.
- Improving communication between primary, tertiary and community care.
- Build capacity and support the workforce to deliver timely, coordinated, effective and appropriate care to older people.
- Support adoption of integrated models of care for vulnerable older populations.
- Increased access to acute, non-complex treatment for RACF residents and elderly in the community.

System level issues

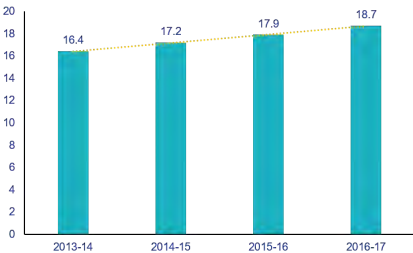
Country of birth of people using permanent residential aged care in western Sydney aged care on 30 June 2017.



Preferred language of people using permanent residential aged care in western Sydney aged care on 30 June 2017.



GP attendances in aged-care homes, per person, WSPHN, 2013-14 to 2016-17



KEY FACTS CONTINUED

- Vulnerable older people who have dementia, lack support networks or have communication difficulties have great difficulty accessing services through My Aged Care.
- GPs in RACFs report difficulty accessing quality diagnostics, such as x-rays, ultrasound, specialist input and after hours coverage. WSPHN GPs expressed the need to utilise telehealth to facilitate better care.⁵
- GPs identified numerous measures required to improve access and quality of medical care in RACFs as urgent or extremely urgent, including:
 - Availability of suitably trained and experienced nurses and other health professionals
 - Increased funding for medical practitioners
 - Improved access to palliative care services
 - Improved access to mental health services in RACFs
 - Reduced polypharmacy to lower the risk of adverse health events in older people
 - Improved access to specialist care, such as geriatrician, palliative care, psychiatric, renal, cardiac, and diabetic.⁵
- Higher proportions of permanent residents who speak a language other than English and born in non-English speaking countries in western Sydney RACFs compared with NSW and Australia.⁶

PHN PROGRAM PERFORMANCE INDICATORS

- AC1 Rate of MBS services provided by primary care providers in RACFs
- P4 Support provided to general practices and other health care providers (Aged care)
- AC2 Rate of people aged 75 and over with a GP health assessment

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. PEN Clinical Audit Tool data – Health Intelligence Unit. 2017
3. Consultation data collected during stakeholder engagement activities with WentWest personnel.
4. AIHW. GEN Aged Care Data. Accessed November 2018. <https://www.gen-agedcaredata.gov.au/My-aged-care-region>
5. Australian Medical Association. 2017 AMA Aged Care Survey Report. <https://ama.com.au/article/2017-ama-aged-care-survey>
6. Australian Institute of Health and Welfare. My Aged Care Region statistics. <https://www.gen-agedcaredata.gov.au/My-aged-care-region>.
7. Australian Institute of Health and Welfare (2018). Medicare Benefits Schedule statistics, 2010-11 to 2016-17. Canberra.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

- ⊕ Health and wellbeing
- ⊕ Chronic disease
- ⊕ Social and emotional wellbeing
- ⊕ Alcohol and other drugs
- ⊕ Maternal, child and family
- ⊕ Cancer screening



Health and wellbeing

Why does the gap still exist?

There are a number of areas that have a significant impact on the health and wellbeing of Aboriginal and Torres Strait Islander peoples:



Historical and political factors: Before colonisation, both Aboriginal and Torres Strait Islander people lived a semi-nomadic lifestyle. The transition from living as active hunter-gatherers to a mostly inactive lifestyle with a Westernised diet has had serious effects on their health. Colonisation also led to the introduction of certain policies, which contributed to past and continuing experiences of: racism, discrimination, the forced removal of children, and loss of identity, culture and land.¹



Social determinants: Indigenous Australians, on average, have lower levels of education, employment, income, and poorer quality housing than non-Indigenous Australians.²



Health risk factors: Indigenous Australians, on average, have higher rates of smoking and risky alcohol consumption, exercise less, and have a greater risk of high blood pressure than non-Indigenous Australians.²



Access to appropriate health services: Indigenous Australians are more likely to report difficulty in accessing affordable health services that are nearby than non-Indigenous Australians, and accessing culturally appropriate services. The WSPHN region has one Aboriginal health service - Greater Western Aboriginal Health Service (GWAHS).²

SUMMARY

Aboriginal and Torres Strait Islander peoples conceptualise health holistically. This includes physical, social, emotional, cultural, spiritual and ecological wellbeing, for individuals and for the community. Despite improvements in health outcomes in some areas, Aboriginal and Torres Strait Islander peoples experience widespread socioeconomic disadvantage and health inequality.¹

Aboriginal and Torres Strait Islander peoples have a shorter life expectancy than non-Indigenous Australians and are at least twice as likely to rate their health as fair or poor.²



References

1. Australian Indigenous HealthInfoNet (2018) Summary of Australian Aboriginal and Torres Strait Islander health status, 2017. Retrieved [October 2018] from <https://healthinfonet.ecu.edu.au/learn/health-facts/summary-aboriginal-torres-strait-islander-health>
2. Australian Institute of Health and Welfare 2018. Australia's health 2018: in brief. Cat. no. AUS 222. Canberra: AIHW

Maternal, child and family

KEY FACTS

- Rates of antenatal care is low among Aboriginal women in the western Sydney region, and a large gap exists compared to non-Aboriginal women.²
- In 2016, 38.8% of Aboriginal women in western Sydney had their first antenatal visit prior to 14 weeks of pregnancy, compared to 55.8% for non-Aboriginal women.¹
- In 2016, 78.6% of Aboriginal women in western Sydney had their first antenatal visit prior to 20 weeks of pregnancy, compared to 87.3% for non-Aboriginal women.¹
- In 2016, the incidence of low birth weight babies for Aboriginal women in western Sydney (11.0%) reduced since 2015 (13.9%), and are similar to that of NSW overall (10.8%). However, the rate remains substantially higher among Aboriginal women in western Sydney compared to non-Indigenous women (6.8%).²
- In NSW, the overall proportion of Aboriginal mothers smoking during pregnancy has decreased from 49.9% in 2012 to 41.3% in 2016.² However, the proportion of Aboriginal mothers in western Sydney who smoke during pregnancy remains higher than that of Aboriginal mothers in NSW overall (47.7% compared to 41.3%). Aboriginal mothers in western Sydney are significantly more likely to smoke during pregnancy compared to non-Aboriginal mothers (47.7% compared to 5.8%).²

SUMMARY

Maternal behaviours and birth outcomes can impact a child's future health and wellbeing, including participation in antenatal care, abstaining from smoking during pregnancy, and the infant's birth weight. Antenatal care visits in the first trimester of pregnancy (before 14 weeks' gestational age) is associated with improved child and maternal health outcomes, and fewer interventions in the later stages of pregnancy.¹

Smoking during pregnancy is associated with a range of poor child health outcomes, including low birth weight and increased risk of perinatal death.¹

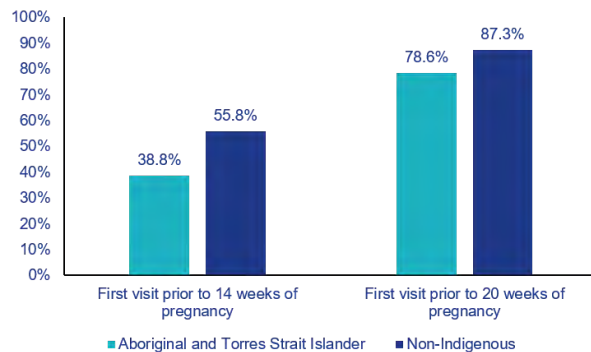
An infant's weight at birth is a key indicator of health and a determinant of an infant's chance of survival (low birth weight is categorised as <2,500 grams).¹

PRIORITY AREAS

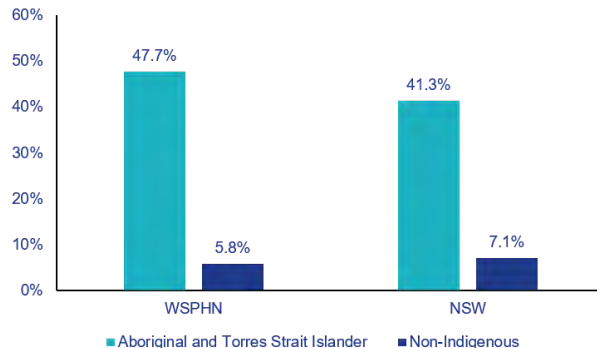
- Support integrated responses to maternal health and parenting

Maternal, child and family

Rates of antenatal care among Aboriginal women, western Sydney, 2016



Smoking during pregnancy among Aboriginal and non-Aboriginal mothers, Western Sydney PHN, NSW, 2016



KEY FACTS CONTINUED

- In 2014-15, 23% of people supported by specialist homelessness services identified as Aboriginal or Torres Strait Islander, including more than 1 in 4 children aged 0-10.
- Immunisation rates for Aboriginal and Torres Strait Islander children are higher in WSPHN compared with NSW and national rates at two and five years.
- Aboriginal mothers and babies are under-reported on the Perinatal Data Collection. The estimated percentage of Aboriginal or Torres Strait Islander mothers in WSLHD that were reported to the Perinatal Data Collection was 83.8% in 2016. This is the lowest rate compared with all other NSW LHDs and Australia (90.5%).³
- In 2016-17, 13,749 (46.0 per 1,000) Aboriginal and Torres Strait Islander children were the subject of a child protection substantiation—almost 7 times the rate of non-Indigenous children (6.8 per 1,000). In NSW, the rate was 57.2 per 1,000 Indigenous children in 2015-16 compared with 7.4 for non-Indigenous children.^{4,5}

PHN PROGRAM PERFORMANCE INDICATORS



P1 PHN activities address prioritised needs



IH5 ITC improves the cultural competency of mainstream primary health care services



P2 Health system improvement and innovation



PH1 Rate of children fully immunised at 5 years

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. NSW Perinatal Data Collection (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.
3. Centre for Epidemiology and Evidence. New South Wales Mothers and Babies 2016. Sydney: NSW Ministry of Health, 2017.
4. Australian Institute of Health and Welfare 2018. Child protection Australia 2016-17. Child welfare series no. 68. Cat. no. CWS 63. Canberra: AIHW.
5. Australian Institute of Family Studies. Child protection and Aboriginal and Torres Strait Islander children. CFCA Resource Sheet— August 2017

Chronic disease

KEY FACTS

- Life expectancy in NSW between 2011-15 for Indigenous Australians was significantly lower compared to non-Indigenous Australians for both males (72.1 compared to 80.9) and females (75.8 compared to 85.1).¹
- Chronic disease within the western Sydney community has been highlighted as an area of concern, with high rates of chronic diseases such as cardiovascular disease, diabetes, chronic obstructive pulmonary disease (COPD), as well as higher rates of chronic disease related hospitalisations and mortality.³
- In 2016-17, COPD and diabetes complications were among the top five conditions for potentially preventable hospitalisations in NSW for Aboriginal and Torres Strait Islander peoples.⁴

SUMMARY

Despite concerted efforts, health disparities between Indigenous and non-Indigenous Australians continue to exist and are a key factor in the much lower life expectancy rates among Indigenous Australians.¹

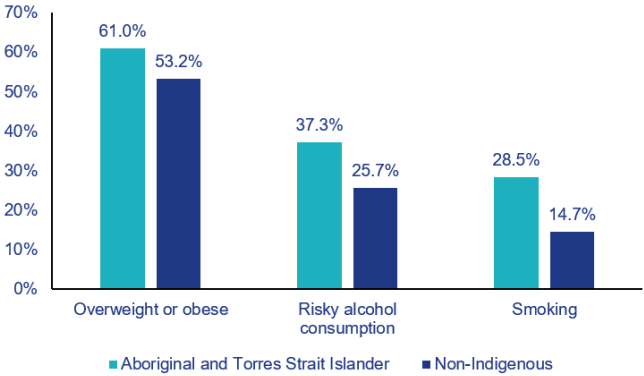
Chronic disease accounts for two-thirds of all premature deaths among Aboriginal and Torres Strait Islander people. There are large disparities in chronic disease prevalence between Indigenous and non-Indigenous Australians. Aboriginal and Torres Strait Islander people experience far worse health outcomes than non-Indigenous people, with earlier onset of chronic disease.²

PRIORITY AREAS

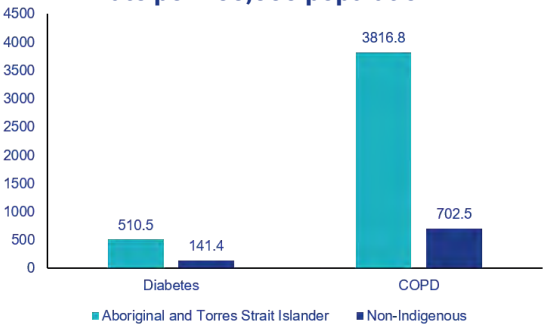
- Encourage provision and uptake of MBS item 715 health assessments
- Increase use of GP team care arrangements/case conferences
- Delivery of Integrated Team Care (ITC) services, including care coordination, supplementary and clinical services
- Improving the cultural competency of mainstream primary healthcare services
- Encouraging GPs to support their patients to self-identify
- Improving health literacy on positive lifestyle choices

Chronic disease

Risk factors by Aboriginality, adults aged 16 years and over, NSW, 2017



Hospitalisations for diabetes and COPD by Aboriginality, 2016-17, NSW
Rate per 100,000 population



Prevalence of diabetes or high blood glucose by Aboriginality, persons aged 16 years and over, NSW, 2017



KEY FACTS CONTINUED

There are a range of behavioural risk factors associated with chronic diseases, including overweight and obesity, high level of alcohol consumption, and smoking.⁴

State level data in 2017 indicate that:

- 61% of Aboriginal and Torres Strait Islander people were overweight or obese compared to 53% of non-Indigenous Australians.
- 37% of Aboriginal and Torres Strait Islander people consumed alcohol at levels posing immediate risk to health compared to 26% of non-Indigenous Australians.
- 29% of Aboriginal and Torres Strait Islander adults currently smoked compared to 15% of non-Indigenous Australians.⁵

PHN PROGRAM PERFORMANCE INDICATORS

P9

Rate of GP team care arrangements/ case conferences

IH5

ITC improves the cultural competency of mainstream primary health care services

IH1

Numbers of ITC services commissioned

IH7

ITC processes support Aboriginal and Torres Strait Islander people enrolled in the program to access coordinated care

References

1. Australian Institute of Health and Welfare 2017. Trends in Indigenous mortality and life expectancy, 2001–2015: evidence from the Enhanced Mortality Database. Cat. no. IHW 174. Canberra: AIHW.
2. ABS (2014). Chronic disease results for Aboriginal and Torres Strait Islander and non-Indigenous Australians: Feature article.
3. Public Health Information Development Unit (2018). Aboriginal and Torres Strait Islander Social health atlas of Australia: Data by Indigenous Area. August 2018.
4. NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. 51. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
5. NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.

Cancer screening

KEY FACTS

- National cervical screening participation rates for Aboriginal and Torres Strait Islander women are not available, as Indigenous status information is not collected on pathology forms in all jurisdictions, but there is evidence that this population group is under-screened.²
- Incidence of cervical cancer in Aboriginal and Torres Strait Islander women is more than twice that of non-Indigenous women, and mortality nearly 4 times the non-Indigenous rate.²
- There are limitations in the data available to estimate Indigenous Australians' participation in the NBCSP. Using 2016 Census proportions, the 2015–2016 participation rate for Indigenous Australians aged 50–74 was estimated to be 19.5%; this compares with an estimated participation rate for non-Indigenous Australians of 42.7%.²

SUMMARY

Indigenous Australians participate in BreastScreen Australia and the National Bowel Cancer Screening Program (NBCSP) at a lower rate than non-Indigenous Australians. Information is not available on Indigenous participation in the National Cervical Screening Program, although there is evidence that Indigenous Australians also participate in cervical screening at a lower rate.¹

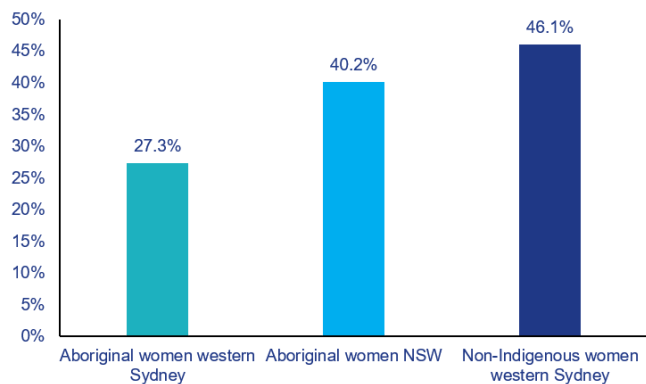
Due to the lower participation rates in these screening programs, they are more likely to have late stage cancer by the time they are diagnosed – when the cancer is much more difficult to treat successfully.¹

PRIORITY AREAS

- Improving cancer screening rates among Aboriginal and Torres Strait Islander peoples, particularly:
Women aged 20-69 years in Mount Druitt (cervical screen), Women aged 50-74 years (BreastScreen), Men and women aged over 50 years (Bowel screen).
- Support primary care to provide opportunistic cervical screening and up-skill GP's and Practice Nurses to promote uptake.
- Provide support to GPs on identification and management of the population who has never screened or who are lapsed.
- Work with stakeholders who have an impact on health to influence the community to participate in screening

Cancer screening

Breast screening rates among Aboriginal and Non-Aboriginal women aged 50-69 years in western Sydney and NSW, 2014-15



KEY FACTS CONTINUED

- In 2015-16, participation in Australian breast screening among women aged 50-74 years was significantly lower in Aboriginal and Torres Strait Islander women (37%) compared to non-Indigenous women (55%).⁴
- In 2014-15, breast screening rates among Aboriginal women in western Sydney were significantly lower (27.3%) than for Aboriginal women in NSW (40.2%), and compared to non-Indigenous women in western Sydney (46.1%), and NSW overall (51.6%).⁵

PHN PROGRAM PERFORMANCE INDICATORS

PH2

Cancer screening rates for cervical, bowel and breast cancer

References

1. Australian Institute of Health and Welfare 2018. Cancer in Aboriginal & Torres Strait Islander people of Australia. Web Report Cat. no: CAN 109. Canberra: AIHW.
2. Australian Institute of Health and Welfare 2018. Cervical screening in Australia 2018. Cat. no. CAN 111. Canberra: AIHW.
3. Australian Institute of Health and Welfare 2018. National Bowel Cancer Screening Program: monitoring report 2018. Cat. no. CAN 112. Canberra: AIHW.
4. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
5. Cancer Institute NSW. Cancer control in NSW, Annual performance report 2016. Cancer Institute NSW, Sydney. February 2017.

Social and emotional wellbeing

KEY FACTS

- In 2017, rates of people 16 years and over experiencing high or very high psychological distress were higher among Aboriginal and Torres Strait Islander people in NSW when compared to non-Indigenous (23.3 compared to 14.9), and have increased from 2013 (16.3) to 2015 (21.7).²
- Headspace in Mount Druitt has the highest proportion of Aboriginal and Torres Strait Islander clients of all headspace centres in western Sydney at 14.2% compared to the regional average at 5.8% (Parramatta, Castle Hill sites). This is also higher than the national rate.³
- Research consistently indicates that a high proportion of people experiencing homelessness also experience mental illness. Aboriginal and Torres Strait Islander peoples are overrepresented in the homeless population. In 2014-15, 23% of people supported by specialist homelessness services identified as Aboriginal or Torres Strait Islander, including more than 1 in 4 children aged 0-10 years.⁴
- Overall, the homelessness rate in the WSPHN is comparable with the state average. However, levels of homelessness are substantially higher in SA3s with high Aboriginal and Torres Strait Islander populations and higher levels of socioeconomic disadvantage (Auburn, Mount Druitt, Merrylands-Guildford).⁵

SUMMARY

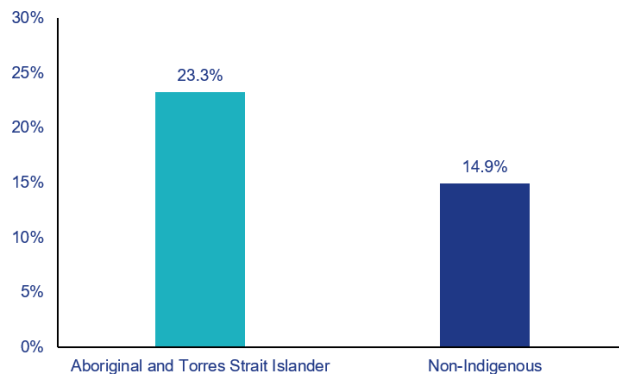
For Aboriginal and Torres Strait Islander peoples, social and emotional wellbeing is preferred over the term 'mental health'. Social and emotional wellbeing describes the social, emotional, spiritual, and cultural wellbeing of a person. The term recognises that connection to land, culture, spirituality, family, and community are important to people and can impact on their wellbeing. It also recognises that a person's social and emotional wellbeing is influenced by policies and past events.¹

PRIORITY AREAS

- Support young Aboriginal and Torres Strait Islander people to maintain their culture, language and heritage, and reconnect with elders.
- Access to care coordination for Aboriginal and Torres Strait Islander peoples with severe and complex mental health conditions.

Social and emotional wellbeing

High or very high psychological distress by Aboriginality, persons aged 16 years and over, NSW, 2017



KEY FACTS CONTINUED

- ABS data indicates that suicide rates are consistently much greater among Aboriginal and Torres Strait Islander Australians than non-Indigenous Australians. In the 5 years from 2013-2017, Aboriginal and Torres Strait Islander children aged 5-17 years in NSW had suicide death rates nearly three times those of non-Indigenous children (5.2 per 100,000 compared to 1.8 per 100,000) (based on preliminary data).^{6,7}
- There is a need for social and emotional wellbeing services, particularly in relation to substance misuse. Consultations within the region suggests that a focus on holistic social and emotional wellbeing is needed. This is needed due to the various adverse socioeconomic outcomes experienced by Aboriginal and Torres Strait Islander people in the WSPHN region, including higher unemployment levels, lower educational attainment, and poorer health outcomes.⁸

PHN PROGRAM PERFORMANCE INDICATORS

MH2

Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals

IH4

Proportion of PHN commissioned mental health services delivered to the regional Aboriginal and Torres Strait Islander population that were culturally appropriate

MH6

Clinical outcomes for the regional population receiving services – low intensity psychological interventions

IH5

ITC improves the cultural competency of mainstream primary health care services

References

1. Australian Indigenous HealthInfoNet. Social and emotional wellbeing. <https://healthinonet.ecu.edu.au/learn/health-topics/social-and-emotional-wellbeing/>
2. HealthStats website - NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed October 2018.
3. Headspace. 2017. Headspace centres: Western Sydney PHN: Financial Year 2017/18 (Quarter one – 1 Jul to 30 Sep 2017).
4. Homelessness Australia. Homelessness and Aboriginal and Torres Strait Islanders Fact Sheet. ACT: Homelessness Australia; 2016.
5. Census of Population and Housing: Estimating homelessness, 2011. 2012. Table 2 Homeless operational groups and other marginal housing, New South Wales – by Statistical Area Level 3 – 2011.
6. Australian Institute of Health and Welfare 2018. Alcohol and other drug treatment services in Australia. Canberra: AIHW.
7. Australian Bureau of Statistics (2018). Causes of death, Australia, 2017. Canberra.
8. Community consultation; Close the gap team; Allied health provider focus groups; Engagement with a range of Non-Government organisations and Semi-structured interviews with Aboriginal and Torres Strait Islander health service providers and community organisations.

Alcohol and other drugs

KEY FACTS

- NSW data indicate that in 2017, alcohol consumption at levels posing long-term health risks were higher among Aboriginal and Torres Strait Islander people (41.3%) compared to non-Aboriginal people (30.7%).²
- General practice data indicates that of 6,272 people who identified as Aboriginal attending general practice in WSPHN, 13% identified as drinkers and 1.2% identified as drug users. Of these, 24.5% of drinkers indicated they had a mental health problem and 61.6% of drug users indicated a mental health issue.³
- NSW data indicates that in 2016-17, 11% Aboriginal and Torres Strait Islander people were seeking treatment for someone else's drug use.⁴



SUMMARY

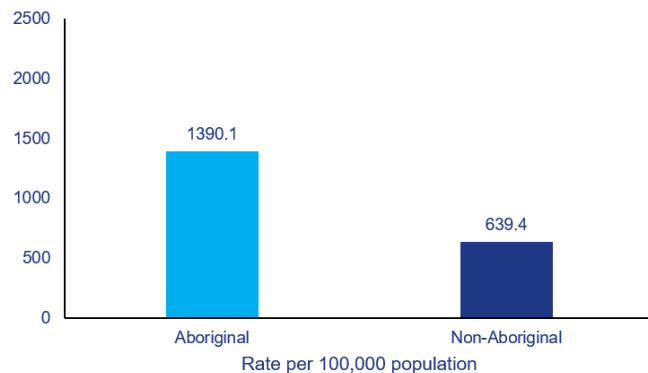
The 2014-15 National Aboriginal and Torres Strait Islander Social Survey showed that Aboriginal and Torres Strait Islander people are smoking less, engaging less in risky single occasion drinking, and abstain from both alcohol use and binge drinking at higher proportions than non-Indigenous Australians. However, smoking rates and binge drinking rates are higher in the Indigenous population. The number of people reporting having used illicit substances in the last 12 months has also risen.¹

PRIORITY AREAS

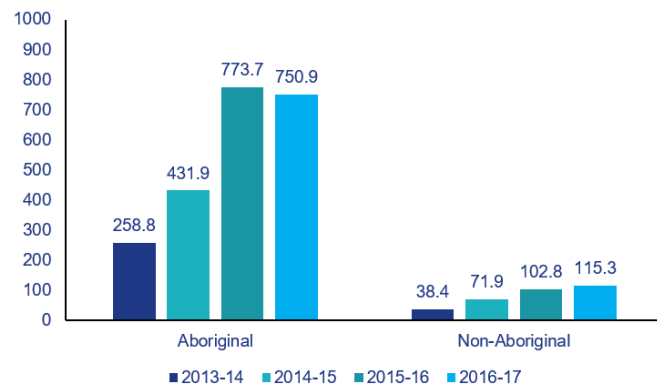
- Enhanced rehabilitation capacity for identified priority groups, including:
 - Young Aboriginal and Torres Strait Islander peoples, with a specific focus on youth-focused early intervention, brief intervention, post treatment support and relapse prevention
 - Adult Aboriginal and Torres Strait Islander peoples, with a specific focus on brief intervention, day program relapse prevention, case management, care planning and coordination
- Improved withdrawal service referral pathways
- Culturally appropriate service development

Alcohol and other drugs

Alcohol attributable hospitalisations by Aboriginality, NSW 2014-15



Methamphetamine-related hospitalisations by Aboriginality, persons aged 16 years and over, NSW 2013-14 to 2016-17



KEY FACTS CONTINUED

- Alcohol attributable hospitalisations among Aboriginal people in NSW decreased in 2014-15 from that of previous years. However, rates per 100,000 people were more than double among Aboriginal people (1390.1) compared to non-Indigenous Australians (639.4).²
- Methamphetamine-related hospitalisations among Aboriginal people in NSW has significantly increased over the last four years. Rates per 100,000 people have almost tripled since 2013-14 (258.8) to 2016-17 (750.9).²

PHN PROGRAM PERFORMANCE INDICATORS

- IH3 Evidence that all AOD commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people
- AOD1 Rate of drug and alcohol commissioned providers actively delivering services

References

1. Australian Bureau of Statistics, 4714.0 - National Aboriginal and Torres Strait Islander Social Survey, 2014-15. Canberra 2017.
2. HealthStats Website: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed October 2018.
3. Patent Assistance Tool (PAT) – WSPHN PAT database.
4. Australian Institute of Health and Welfare 2018. Alcohol and other drug treatment services in Australia: 2016-17. Canberra: AIHW.

OTHER VULNERABLE AND AT-RISK POPULATIONS

- ⊕ Culturally and linguistically diverse (CALD) communities
- ⊕ People experiencing homelessness
- ⊕ People identifying as LGBTIQ+
- ⊕ Veterans
- ⊕ People in prison



CALD communities

KEY FACTS

- Consultations with the Western Sydney Refugee Health Coalition indicates that refugees in the region experience various chronic and complex health issues, older refugees often arrive with poorly managed health conditions, and a substantial proportion of children arrive with physical disabilities and developmental issues that are often undiagnosed.⁴
- A study of over 17,000 women from Sydney investigating determinants of antenatal and postnatal depression found that risk factors for antenatal and postnatal depressive symptoms include: physical intimate partner violence, belonging to CALD populations, and low socioeconomic status.⁵
- Breast screening participation rates among CALD women in NSW has increased since 2012-13, but remains substantially lower when compared to women overall (46.1% compared to 51.6% in 2014-15).⁶
- The Australian Psychological Society indicates that substance misuse is a common consequence of the psychological impacts of the refugee experience, however there is almost no data that provides insights into the prevalence within local communities.⁷

SUMMARY

In 2016, the WSPHN region had a higher proportion of people born in predominately non-English speaking countries (39.4%) compared to NSW overall (21%), with proportions higher still in some LGAs, such as Cumberland (49.7%), and Parramatta (45.2%).¹

From 2015-17, more than 2,000 people were granted humanitarian visas in the WSPHN region, with the majority of people being settled in Blacktown (32%) and Parramatta (29%). Refugee demographics and their needs have changed with the current cohort coming from the Syrian conflict.²

Research shows that people from CALD backgrounds face numerous barriers to accessing timely and appropriate health care. Some CALD populations, such as refugees and asylum seekers, may also have higher rates of trauma and mental health concerns.³

PRIORITY AREAS

- Improving access to culturally appropriate health services, such as access to interpreters.
- Increasing GPs knowledge and awareness of services and support available in western Sydney for refugee and asylum seeker populations.
- Increasing the health literacy of migrant communities who have been living in Australia for more than 5 years.
- Increasing the health literacy responsiveness of health services.

CALD communities

Migrant communities in western Sydney have reported:

- Poor or limited access to interpreters (GP, allied health and hospital settings)
- Limited access to culturally appropriate meals in hospitals and residential aged care facilities
- Difficulties navigating the health system, including misunderstandings about appropriate use of hospital EDs
- Limited access to bi-lingual GPs and hospital staff (admin and clinical staff)

Research has also highlighted low levels of health literacy amongst western Sydney migrants who have been living in Australia for more than five years



KEY FACTS CONTINUED

- Research conducted in Blacktown found that CALD populations with, or supporting people with dementia, face similar barriers and challenges as other Australians, but that these barriers are exacerbated due to language and cultural barriers, particularly around accessing services.⁸
- Consumer focus groups held in the region indicated that awareness of after hours options was limited among CALD populations, with general trends including: a view that ED was the first and only option after hours, low awareness of GP home visiting services and telephone health services.⁹
- Data is limited on the prevalence of substance use disorders in communities where English is not the primary language. The Drug and Alcohol Multicultural Education Centre (DAMEC) estimates that about 6% of all drug and alcohol specialist service presentations relate to this group, however they are significantly underrepresented on a population basis in treatment services. DAMEC reports a paucity of effective models for engaging CALD people, and there is only one CALD substance misuse specialist service in NSW.¹⁰

PHN PROGRAM PERFORMANCE INDICATORS

P4	Support provided to general practices and other health care providers	W2	PHN support for drug and alcohol commissioned health professionals	O11	Cultural awareness training
MH2	Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals	W3	PHN Commissioning Framework	PH2	Cancer screening

References

1. Public Health Information Unit. Social Health Atlas of Australia: Data by Primary Health Networks (incl. Local Government Areas). October 2018.
2. Australian Government, Department of Social Services. Local Government Area of Permanent Settlers (All Streams) with a Date of Settlement* between 01 October 2015 to 04 October 2016. Accessed 23 October 2017.
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4. Stakeholder Consultations with Western Sydney Refugee Coalition. 2017.
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6. Cancer Institute NSW. Cancer control in NSW, Annual performance report 2016. Sydney. February 2017.
7. Department of Health and Ageing Report – Review of the Multicultural Mental Health Australia (MMHA) Project, November 2009.
8. Hamilton, O., & Lawton, A. (2015). Dementia Care for Culturally and Linguistically Diverse (CALD) communities in Blacktown Local Government Area. WESTIR Ltd.
9. Brooke, M, 2016. Consumers and after-hours health care in Western Sydney: Summary of Research Insights. Report prepared for WentWest. March 2016.
10. Drug and Alcohol Multicultural Education Centre (DAMEC). 2017.

People experiencing homelessness

KEY FACTS

- Approximately 6,000 people in the WSPHN region were experiencing homelessness in 2016. Over half of these were in the SA3s of Auburn (29% or 1,726 people), and Merrylands-Guildford (25% or 1,518 people).⁴
- A meta-analysis of studies from western countries assessed the pooled prevalence estimate of alcohol dependence at 37.9% of the homeless population. Similarly, the pooled prevalence estimate of drug dependence was 24.4% of the homeless population. Both of these rates are many magnitudes higher than for the general population.²
- When extrapolating to the homeless people within the WSPHN region in 2016, this equates to approximately 2,300 homeless people with alcohol dependence and 1,500 with drug dependence.

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. Fazel, S. et al., (2008). The prevalence of mental disorders among the homeless in Western countries: Systematic review and meta-regression analysis. PLOS Medicine.
3. Homelessness Australia. States of being: Exploring the links between homelessness, mental illness and psychological distress. An evidence-based policy paper. ACT: Homelessness Australia; 2011.
4. Australian Bureau of Statistics (2016). Census of population and housing: Estimating homelessness, 2016.

SUMMARY

Access to appropriate and affordable housing can reduce adverse outcomes, such as social exclusion, and poor health and wellbeing outcomes. Domestic violence, a shortage of affordable housing, unemployment, mental illness, family breakdown and drug and alcohol abuse all contribute to the level of homelessness in Australia.^{1,2}

The homelessness rate rose by 27% in NSW between the 2011 and 2016 Census. People who experience homelessness experience poorer health outcomes, including high rates of mental illness and substance misuse. Providing adequate support to people experiencing homelessness is a significant public health challenge.³

PRIORITY AREAS

Ensuring people experiencing homelessness have increased access to primary healthcare services and other support services available in western Sydney, including:

- Psychological therapies delivered by mental health professionals (PHN Program Performance Indicator - MH2).
- A range of alcohol and other drug treatment services delivered by service providers (PHN Program Performance Indicator AOD2).

LGBTIQA+ community

KEY FACTS

- In Australia, people who identify as homosexual or bisexual reported higher levels of psychological distress compared to heterosexual people (28% compared to 11%).²
- Research conducted in Australia suggests that LGBTIQA+ people may be at higher risk of suicidal behaviours.³
- People who identify as LGBTIQA+ are more likely to drink alcohol at levels that place them at immediate harm and lifetime risk when compared to heterosexual people.⁴
- People who identify as LGBTIQA+ are significantly more likely to use illicit drugs compared to heterosexual people, including ecstasy, methamphetamines, cannabis, and cocaine.⁵

SUMMARY

People who identify as gay, lesbian, bisexual, transgender, intersex, queer, asexual and other diverse sexual orientations and gender identities (LGBTIQA+) may be more vulnerable to adverse social, economic, and health outcomes (e.g. discrimination, mental health concerns).

Research suggests that people who identify as LGBTIQA+ are more likely to experience health disparities in the areas of mental health, sexual health, and substance misuse. These health outcomes are directly related to experiences of stigma, prejudice, discrimination and abuse on the basis of identifying as LGBTIQA+.¹

PRIORITY AREAS

- Improving access to and visibility of LGBTIQA+ friendly health services.
- Increasing the capacity of primary healthcare professionals to deliver LGBTIQA+ friendly services.
- Increased access to support services available in western Sydney, including psychological therapies delivered by mental health professionals (PHN Program Performance Indicator - MH2), and alcohol and other drug treatment services.

LGBTIQA+ community

"It is always a decision whether or not to disclose my sexuality to a new doctor, I feel much more confident if they have the Rainbow Tick or even just a few posters about inclusiveness/same sex couples or issues, but these images are not the norm in doctors' offices in western Sydney like they are in the inner west"

**Female, identifies as a member of the LGBTIQA+ community
Participant of the WentWest Consumer Needs Assessment Project**

KEY FACTS CONTINUED



A recent consumer consultation project identified significant barriers for people identifying as LGBTIQA+ accessing health services in western Sydney. The LGBTIQA+ community identified:

- Difficulties finding LGBTIQA+ friendly healthcare services
- Some healthcare services in western Sydney are not inclusive or sensitive to the LGBTIQA+ community's needs
- Some members of the LGBTIQA+ community feel unsafe and unsupported in western Sydney in response to the high 'no' vote in the same-sex marriage survey.⁶

PHN PROGRAM PERFORMANCE INDICATORS

P4

Support provided to general practices and other health care providers

W2

PHN support for drug and alcohol commissioned health professional

MH2

Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals

W3

PHN Commissioning Framework

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. Australian Bureau of Statistics 2008. National Survey of Mental Health and Wellbeing 2007: summary of results. Canberra.
3. Skerrett, D. M, Kölves, K., & De Leo, D. (2015). Are LGBT populations at a higher risk for suicidal behaviours in Australia? Research findings and implications. Journal of Homosexuality 62, 883–901.
4. Department of Health. National Alcohol Strategy 2018-2026 – Consultation Draft.
5. National Drug Strategy 2016.
6. The Science of Knowing. WentWest Consumer Needs Assessment Project Report. 2018

Veterans

KEY FACTS

- ▶ The total number of veterans reported by the Department of Veterans Affairs residing in the WSPHN region is 5,215, with almost a third of these residing in the Blacktown LGA.
- ▶ Males who have served in the ADF are almost twice as likely to experience mental health issues, such as depression (9.4%) when compared with males who have not served (5.7%).²
- ▶ Suicide among men and women who have or are currently serving in the ADF has become an increasing concern. Between 2002-2015, the crude rate of suicide death was significantly higher for men who were or had served in the ADF compared to all non-serving Australian men.¹
- ▶ The transition of care of defence workers from the ADF to the Department of Veteran Affairs has been identified as a barrier to service access and delivery.³

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. Van Hooff M, et al. (2014). The Australian Defence Force Mental Health Prevalence and Wellbeing Study: design and methods. European Journal of Psychotraumatology 5, 1–12.
3. Department of Veteran Affairs, 2015, Social Health Strategy for the Veteran and Ex-Service Community.

SUMMARY

Veteran health has been identified as an emerging need in the WSPHN region by stakeholders, including health professionals and service organisations. For example, men aged 55-64 years who have served in the Australian Defence Force (ADF), have significantly higher rates of arthritis and behavioural problems compared to non-service men.¹

PRIORITY AREAS

Ensuring veterans have access to commissioned services for identified vulnerable sub-populations, including:

- Psychological therapies delivered by mental health professionals (PHN Program Performance Indicator - MH2).
- A range of alcohol and other drug treatment services delivered by service providers (PHN Program Performance Indicator AOD2).

People in prison

KEY FACTS

➤ A 2015 NSW Inmate Health Survey identified poor levels of access to health care prior to incarceration. While the majority of participants reported having accessed healthcare services while in custody, 17.5% of participants reported that they had not done so (5.1%) or had only done so upon entering custody (12.4%).²

➤ The survey also identified that there were a large number of participants who reported drinking at levels considered hazardous. 67.1% of men and 63.3% of women scored above 8 (indicative of hazardous drinking). 13% had been diagnosed with an alcohol use disorder. Almost all participants (85.7%) reported having misused drugs other than alcohol. A slightly higher proportion of men (85.8%) reported this compared to women (84.7%).²

➤ It is estimated that approximately 13% of all NSW prisoners come from within Western Sydney PHN boundaries, and therefore are more likely to return when released. In a given year this equates to 1,988 persons per year with around 55% of those coming from Parramatta LGA.³

SUMMARY

Compared to the general community, people in prison experience higher levels of mental illness, substance misuse, chronic conditions, and disability. In 2016, the NSW adult prison population stood in excess of 12,600. Despite making up approximately 3% of the Australian population, and 2.9% of the NSW population, Aboriginal and Torres Strait Islander people accounted for 24% of the NSW prison population in 2015, an increase of 2.5% since 2009.

The most recent NSW prison health survey identified the top five health problems as: back problems (23.5%), hepatitis C (20.7%), asthma (20.6%), allergies (19.4%), hypertension (15.6%). These rates are much higher in comparison to the wider community.¹

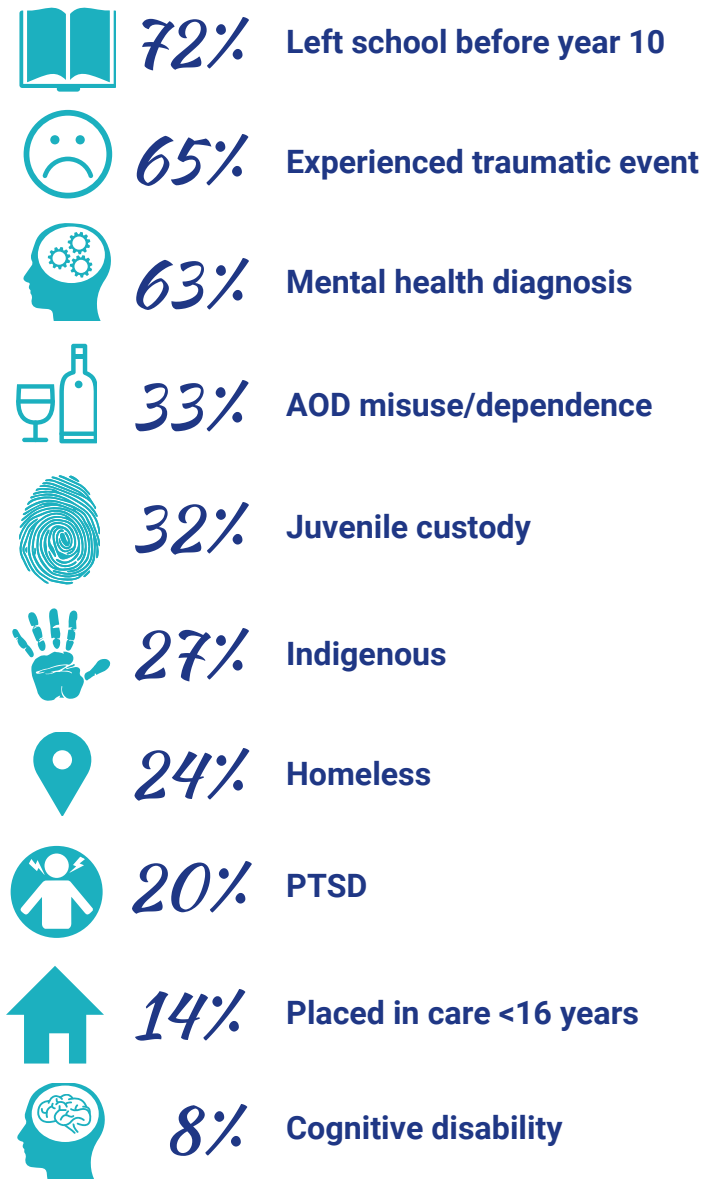
PRIORITY AREAS

Ensuring people recently released from prison have access to commissioned services for identified vulnerable sub-populations, including:

- Psychological therapies delivered by mental health professionals (PHN Program Performance Indicator - MH2).
- Alcohol and other drug treatment services, including transition models from the criminal justice system to AOD treatment.

People in prison



Who goes to prison in NSW?⁵



KEY FACTS CONTINUED

- The prison population is also disproportionately from sub-populations, including Aboriginal and Torres Strait Islander peoples, homeless, have a mental health diagnosis, cognitive disability, experienced a traumatic event, PTSD, substance misuse, placed in care <16 years, left school before year 10, and/or juvenile custody.
- Many experience these factors chronically and simultaneously and have complex support needs. All of the figures to the left are significantly higher than prevalence rates in the community.⁴
- Crime statistics in the WSPHN region based on five-year trends (2013-18) for possession and/or use of drugs, show increases among particular drugs within certain LGAs:
 - **Blacktown:** amphetamine (up 15%)
 - **Cumberland:** cannabis (up 13%), amphetamine (up 5%), other drugs (up 7%)
 - **Parramatta:** other drugs (up 4%).⁵

PHN PROGRAM PERFORMANCE INDICATORS

-  **AOD2** Partnerships established with local key stakeholders for drug and alcohol treatment services
-  **MH2** Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. Justice Health & Forensic Mental Health Network. 2015 Network Patient Health Survey Report. NSW Government. 2017
3. Community Restorative Centre. Retrieved from: <https://www.crcnsw.org.au/get-help/getting-out-of-prison>
4. Sotiri. M. Transition from prison: What works post release. Community Restorative Centre. Presentation at the CMHDARD Symposium June 2018
5. Bureau of Crime Statistics and Research. Incidents of crime recorded by the NSW police force by Local Government Area: number, rates, and trends 2013-2018.

MENTAL HEALTH

- ⊕ Children and young people
- ⊕ Mild to moderate mental illness
- ⊕ Severe and persistent mental illness
- ⊕ Comorbidities
- ⊕ Suicide prevention
- ⊕ Service issues



Children and young people

KEY FACTS

➡ The number of young people in NSW aged between 16-24 years with high or very high psychological distress has increased from 16.8% in 2015 to 22.3% in 2017. Rates are higher among females (21.6% in 2015 to 28.2% in 2017).²

➡ The rate of hospitalisations for intentional self-harm among western Sydney females aged 15-24 years has increased over the last ten years. In 2015-16, the rate was 404 per 100,000, up from 324 per 100,000 in 2014-15. Rates of intentional self-harm among 15-24 year old females in western Sydney is substantially higher than males in the same age group, and compared with overall rates.²

SUMMARY

Research has found that half of all lifetime mental health disorders emerge by age 14 and three quarters by age 24. By intervening early, improving knowledge around mental health and encouraging help-seeking behaviour, it may be possible to not only circumvent the short term detrimental effects of mental health disorders, but also to safeguard young people from longer term, ongoing cycles of dysfunction and disadvantage that may result when mental health disorders remain untreated into adulthood.¹

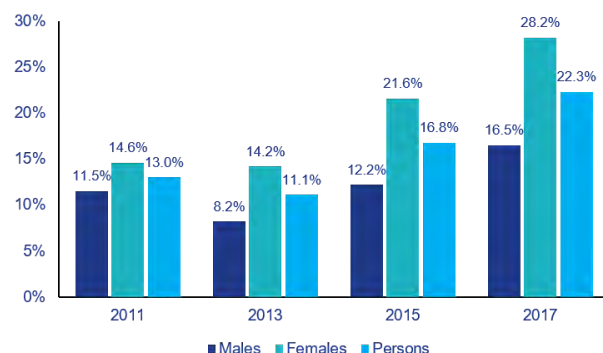
PRIORITY AREAS

Key areas for focus in western Sydney include:

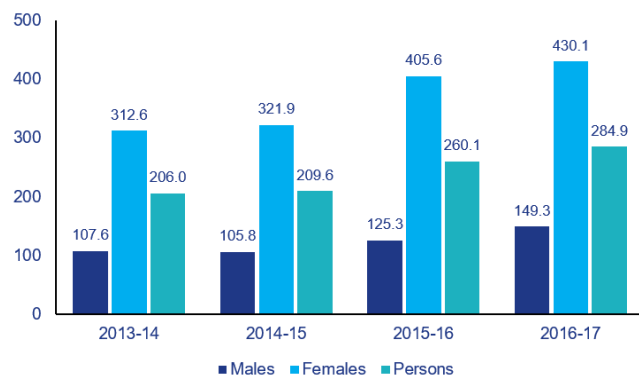
- Females aged 15-24 years
- At-risk and vulnerable young population groups (e.g. Aboriginal and Torres Strait Islander, CALD backgrounds, LGBTIQ+ young people)
- Young people with moderate to severe and persistent mental illness.
- Geographic hotspots: Auburn and Mount Druitt

Children and young people

Percentage of high or very high psychological distress, 16-24 years, All NSW¹



Rates of hospitalisations for intentional self-harm (rate per 100,000), 15-24 years, WSPHN¹



KEY FACTS: HEADSPACE

Data from the region's headspace centres indicates:

- A higher proportion of clients from at-risk populations at the Parramatta centre, including CALD clients (38%) and LGBTIQ+ clients (27%), when compared to the regional averages (25% and 21% respectively).
- The Mount Druitt headspace centre has a considerably higher proportion of Aboriginal and Torres Strait Islander clients (24% compared with 6% regionally) than other centres in the region.
- A higher proportion of clients presenting with 'mild to moderate general symptoms' than the national average (46% compared to 40%).
- More than 20% of clients wait for more than three weeks for an appointment.³
- Consultations have suggested that there is an increasing demand for service to be available afterhours and extended hours

PHN PROGRAM PERFORMANCE INDICATORS

MH1

Rate of regional population receiving PHN commissioned low intensity psychological interventions

MH4

Formalised partnerships with other regional service providers to support integrated regional planning and service delivery

MH2

Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals

MH6

Clinical outcomes for the regional population receiving services – low intensity psychological interventions

References

1. Black Dog Institute. Youth mental health report Youth Survey 2012-16. Mission Australia. https://blackdoginstitute.org.au/docs/default-source/research/evidence-and-policy-section/2017-youth-mental-health-report_mission-australia-and-black-dog-institute.pdf?sfvrsn=6
2. HealthStats Website: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed October 2018.
3. Headspace. 2017. Headspace centres: Western Sydney PHN: Financial Year 2017/18 (Quarter one – 1 Jul to 30 Sep 2017).

Mild and moderate mental illness

KEY FACTS

- Between 2015-17, just over 1 in 4 people (26.1%) in the WSPHN region had a moderate level of psychological distress. This has increased since 2011-13 (19.0%).²
- Consumer consultations indicate a need for increased availability of, and improved access to, services for people experiencing mild to moderate mental health concerns.³ Specifically, a gap has been identified for people experiencing moderate levels of mental illness.
- Between 2012-13 and 2015-16, the number of patients receiving GP mental health treatment plans increased for all SA3 catchments in the Western Sydney PHN region. Parramatta and Rouse Hill – McGraths Hill experienced substantial growth in both patient and service numbers, while Mount Druitt also experienced a large increase in service numbers. It is unclear at this stage whether this represents an increase in need, or increased service utilisation.⁴

SUMMARY

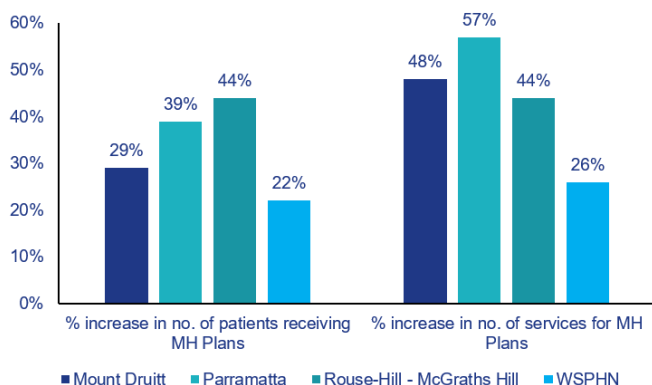
Approximately 20% of Australians experienced mental illness in the previous 12 months, with almost 80% of these classified as either mild or moderate in severity. People with anxiety disorders and substance use disorders are more likely to be classified as mild or moderate than people experiencing affective disorders (e.g. depression).¹

PRIORITY AREAS

- Access and availability of low intensity psychological interventions for people with, or at risk of, mild mental illness.
- Support for people experiencing moderate levels of mental illness, including peer support.
- Improving mental health literacy, assisting consumers to navigate services and supports.
- Integration of online and face to face services that compliment service delivery and continuation of care.

Mild and moderate mental illness

Percentage increase in the number of GP Mental Health Plans and services for GP Mental Health Plans, WSPHN SA3s²



KEY FACTS CONTINUED

➤ Research in the WSPHN region suggests that increased support and access to appropriate services is needed for people experiencing mild to moderate mental illness, and that such support was important to help further complications such as severe mental illness and/or suicidality.³

“When you ring the suicide line, you get a nurse or a doctor, who might give you some advice, tells you to take a few pills and have a cup of tea. Meanwhile, you have the means, you have a plan and need immediate support, but you’re all alone and have no one to be with you and support you. You’re not sick enough for ED, but you can’t wait until an appointment next week. It would be great if there was someone available with lived experience of mental illness to be with you.”

Consumer quote³

PHN PROGRAM PERFORMANCE INDICATORS



MH1

Rate of regional population receiving PHN commissioned low intensity psychological interventions



MH6

Clinical outcomes for the regional population receiving services – low intensity psychological interventions

References

- 1 Slade, T, Johnston, A, Teesson, M, Whiteford, H, Burgess, P, Pirkis, J, Saw, S. (2009) The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra.
- 2 HealthStats Website: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed October 2018.
- 3 Brooke, M. 2016. Consumers and after hours health care in Western Sydney: Summary of Research Insights. Report prepared for WSPHN. March 2016.
- 4 Department of Health (2016a), MBS Items Time Series

Severe and persistent mental illness

KEY FACTS

- The WSPHN region has seen a substantial increase in the rate of persons aged 16 years and over with high or very high psychological distress from 9.7% in 2013 to 16.3% in 2017.²
- In 2014-15, the rates per 100,000 persons aged 18 years and over within the Western Sydney region with high or very high psychological distress was substantially higher in specific areas, including Mount Druitt (16.0), Merrylands-Guildford (13.4), and Blacktown (13.0) compared to NSW and WSPHN and overall (11.0 and 11.7 respectively).³
- There has been a substantial increase in psychological distress from 2015 to 2017 among the NSW population that fall into the most disadvantaged quintile (12.5% up to 18.7%).¹ While socioeconomic disadvantage varies across the WSPHN region, the LGA of Cumberland has the most disadvantage with close to a standard deviation lower than that of the standardised Australian score (930 compared to 1000).⁴

SUMMARY

It is estimated that 45% of Australians aged 16-85 years will experience a high prevalence mental health disorder including, depression, anxiety, or a substance use disorder. Research also suggests that within a 12-month period, around 20% of the population will experience a mental health disorder. Mental illness can have a range of adverse health and socioeconomic outcomes.

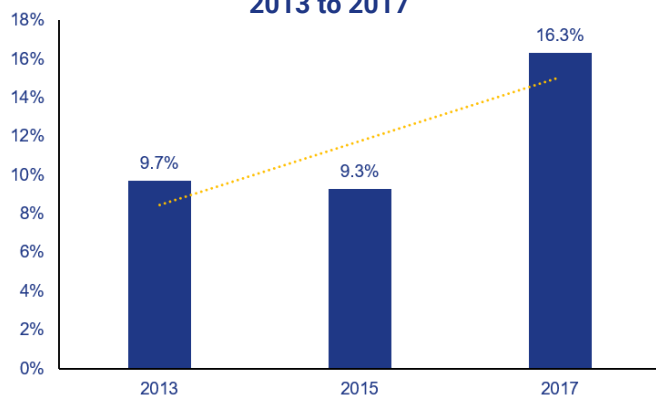
PRIORITY AREAS

Key areas for focus in western Sydney include:

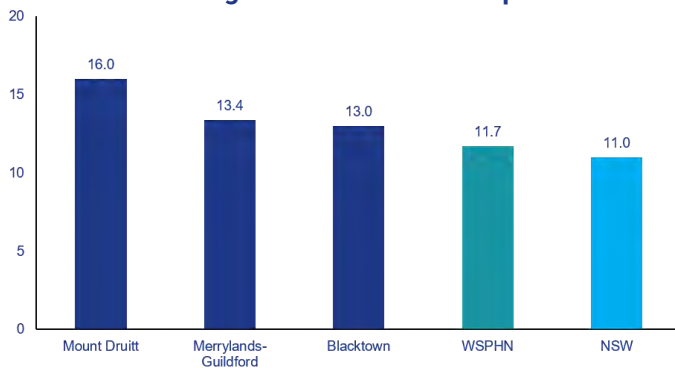
- People with severe and complex mental illness.
- Ability for consumers to provide independent (and productive) feedback to assist funding bodies to assist providers to deliver better care for the consumers.
- Expand the type and diversity of services in western Sydney. Include Language and cultural diversity as well as experience and skills set.

Severe and persistent mental illness

High or very high psychological distress, persons aged 16 years and over, Western Sydney PHN, 2013 to 2017



High or very high psychological distress, people aged 18 years and over, by SA3, WSPHN, NSW 2014-15 Age Standardised Rates per 100



KEY FACTS CONTINUED

- In Australia, it is estimated that 3.3% of adults experience a severe mental illness each year, one-third of which experience a persistent mental illness that requires ongoing services to address residual disability. It is estimated that 0.4% of adults that experience severe and persistent mental illness have complex needs requiring multi-agency support.⁵ Assuming an even distribution of persons with severe mental illness across Australia, approximately 3,980 people in the western Sydney region have severe mental illness requiring multi-agency support.⁴ This is approximately 1,500 more people than estimated in the Partners in Recovery (PIR) Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16.⁶
- In 2014-15, the number of people in the region accessing Mental Health Nurse Incentive Program (MHNIP) services was substantially higher in Blacktown, Baulkham Hills, and Parramatta. The MHNIP has been limited by workforce availability in the region, and as a result the commissioned Mental Health Nurse are now delivering services under the PMHC (Primary Mental Health Care) services as a contracted provider.⁷
- Consumer consultations in the region are consistent with findings from the academic literature indicating gaps in follow-up care for people with severe and persistent mental illness, including: The post-discharge period being a high-risk point for suicide, limited access to psychiatrists, and lack of continuity of care.^{8,9}

PHN PROGRAM PERFORMANCE INDICATORS

- MH3** Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness
- MH7** Clinical outcomes for the regional population receiving services – psychological therapies delivered by mental health professionals to underserved groups

References

- Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
- HealthStats NSW: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed October 2018.
- Public Health Information Development Unit. Social Health Atlas of Australia: Data by Primary Health Network. 2016.
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- Whiteford H., et al., Estimating the number of adults with severe and persistent mental illness who have complex, multi-agency needs. Australian & New Zealand Journal of Psychiatry, 51(8), 799-809.
- Australian Government Department of Health. Partners in Recovery (PIR): Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs initiative. 2015.
- MHNIP Patients and Services by SA3, 2014/15. Department of Health (2015c), MHNIP Tables.
- Brooke, M. 2016. Consumers and after-hours health care in Western Sydney: Summary of Research Insights. Report prepared for WSPHN. March 2016.
- Chung DT et al. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. Journal of the American Medical Association Psychiatry, 74(1), 694-702.

Mental health comorbidities

KEY FACTS

- Data from a Consumer Needs Analysis in the WSPHN region shows a high level of comorbidity, with respondents reporting a chronic mental health condition also reporting an average of 2.2 health conditions (in addition to their mental illness). The most common conditions included arthritis, asthma or a lung condition, chronic back pain, and alcohol or drug addiction. People with chronic mental health conditions have a reduced capacity to navigate health system and knowledge of available support options.²
- Mental and substance use disorders often co-exist, the relationship between them is one of mutual influence, with both conditions serving to maintain or exacerbate the other. Such comorbidity leads to poor treatment outcomes and severe illness course.³
- GP data from WSPHN indicates that around 15% of all drinkers attending WSPHN primary care practices have an associated mental health condition and 60% of all drug users have a mental health condition.⁴

SUMMARY

Comorbidity is the existence of two or more chronic conditions or diseases experienced by an individual at the same time. In 2016, national data indicated that mental health conditions were reported as a comorbidity among 38% of people with COPD, 30% of people with back pain issues, and 29% of people with asthma.¹

People with a mental illness are at increased risk of experiencing problems relating to alcohol. There is growing evidence that alcohol increases the risk of highly prevalent mental health conditions, such as depression and anxiety in some people.¹

PRIORITY AREAS

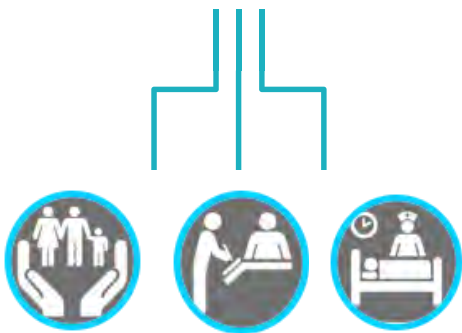
People with chronic, complex conditions and mental illness, with a specific focus on:

- Access to and affordability of services.
- Health literacy (navigation of health system and support options).

Mental health comorbidities



An estimated 3,980 people living in the WSPHN region have a mental illness requiring multi-agency support



KEY FACTS CONTINUED

- In 2014-15, over 60% of Australians with a mental health condition experienced comorbidity with two or more other chronic conditions. Comorbidity of mental health conditions with chronic diseases are most common among people aged 0-44 years.¹

PHN PROGRAM PERFORMANCE INDICATORS

- P9 Rate of GP team care arrangements / case conferences
- MH2 Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals

References

1. Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. AUS 199. Canberra: AIHW.
2. The Science of Knowing, (2018). WentWest Consumer Needs Assessment Project: Final Report. March 2018.
3. WSPHN facilitated conference to address comorbidity in the region – Identified actions to address service needs.
4. Patient Assistance Tool: WSPHN patient database. 2017.

Suicide prevention

KEY FACTS

- From 2010 to 2014, 44% of suicide deaths in NSW were people from the lowest two socio-economic quintiles (36% among the top two quintiles).³
- The average annual age standardised rate per 100,000 suicide deaths and self-inflicted injuries (0 to 74 years) within the WSPHN region from 2011-15, were highest in Blacktown (8.8) compared to other LGAs (6.2 – 6.7). Blacktown also has high relative socio-economic disadvantage.⁴
- Information from the Suicide Modelling Tool, indicate that focus should be placed on follow up of clients who have elevated risk of suicide. This includes longer term follow up (up to 6 months) and assertive follow up until contact has been made.

SUMMARY

Suicide is a major public health issue in Australia, and suicide prevention has become a national imperative. In Australia, suicide and self-inflicted injuries were the fourth leading cause of fatal burden of disease in 2011.¹

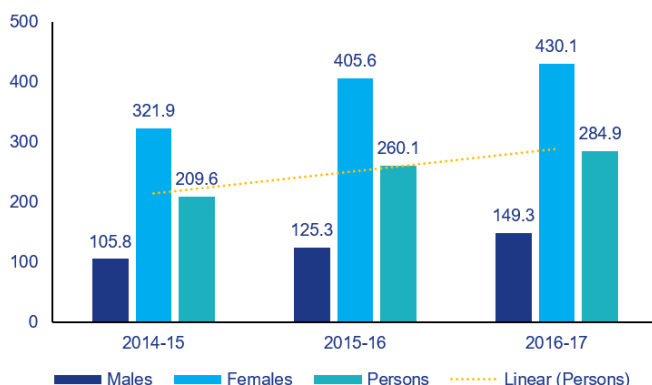
In 2017, suicide was the leading cause of death among all people aged 15-44 years of age, and the second leading cause among people aged 45-54 years. The total number of deaths due to suicide in 2017 was 3,128.²

PRIORITY AREAS

- A regional approach to suicide prevention activities with a focus on improved follow-up for people who have attempted suicide or are at high risk of suicide.
- Priority populations include: Aboriginal and Torres Strait Islander peoples, low socio-economic areas, and young people.

Suicide prevention

Intentional self-harm hospitalisations, persons aged 15-24 years, Western Sydney PHN, 2014-15 to 2016-17



In the WSPHN region, intentional self-harm hospitalisations per 100,000 people are highest in SA3s with lower socioeconomic status

- Blacktown
- Mount Druitt
- Merrylands-Guildford



KEY FACTS CONTINUED

- In 2016-17, the rates of hospitalisations for self-harm in the western Sydney PHN region were lower than the national average, however rates in the region are increasing, particularly for young people.
- In 2015/2016, the rate of intentional self-harm hospitalisations in NSW was 606.2 per 100,000 for females aged 15-19 years, and 350 per 100,000 for females aged 20-24 years. While data by PHN and 5-year age cohorts is not available, it is possible that there are similarly higher rates of intentional self-harm in the WSPHN region among females in the 15-19 age cohort.⁵
- In 2015-16, hospitalisation rates for intentional self-harm were highest in SA3s with the lowest socioeconomic status (e.g. Blacktown, Mount Druitt, Merrylands-Guildford).
- Based on age standardised rates per 100,000, the number of bed days for intentional self-harm in some parts of the WSPHN region (Carlingford, Mount Druitt) is substantially higher than regional and national rates, and have increased from 2013-14.⁵

PHN PROGRAM PERFORMANCE INDICATORS



Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness



Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they were at risk of suicide followed up within 7 days of referral

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. Australian Bureau of Statistics, Causes of Death, Australia, 2017. September 2018.
3. Public Health Information Development Unit. Monitoring inequality in Australia: New South Wales. Data by Quintile of Socioeconomic Disadvantage. September 2017 Release. Accessed October 2017.
4. Public Health Information Development Unit. Social Health Atlas of Australia: Data by Primary Health Networks (incl. Local Government Areas). Oct 2018.
5. Australian Institute of Health and Welfare (2017). Hospitalisations for mental health conditions and intentional self-harm. Canberra

Hospitalisations for mental health conditions

KEY FACTS

- Overall, hospitalisations for all mental health conditions in the western Sydney region were lower than the national rate in 2015-16, but were higher in the SA3s of Blacktown and Auburn.³
- The rate of bed days is higher than national average for more than half the region's SA3s, notably the SA3s of Auburn and Carlingford. Rates for both measures are relatively consistent from 2013/14.⁴
- The western Sydney region has a higher than national rate of hospitalisations and bed days for people with schizophrenia and delusional disorders. More than half of the region's SA3s have a bed day rate higher than the national average, and rates have increased from 2013/14.³ In Auburn, hospitalisations are more than double the national rate, and the rate of bed days is more than five times the national rate. Auburn previously recorded the highest rate of hospitalisations in 2013/14, and the rate of bed days has increased the most out of all the region's SA3s from 2013/14 to 2014/15.⁴

SUMMARY

Chronic mental health conditions have a significant impact on both individuals and on the Australian health system. Research suggests that in 2015, 50% of Australians reported having at least 1 of 8 chronic conditions, including mental health conditions.¹

In 2015-16, mental health conditions made up 7.9% of hospitalisations for chronic conditions. ² Some hospital admissions could be prevented through improved preventive care and management of conditions in primary care and community-based care settings.¹

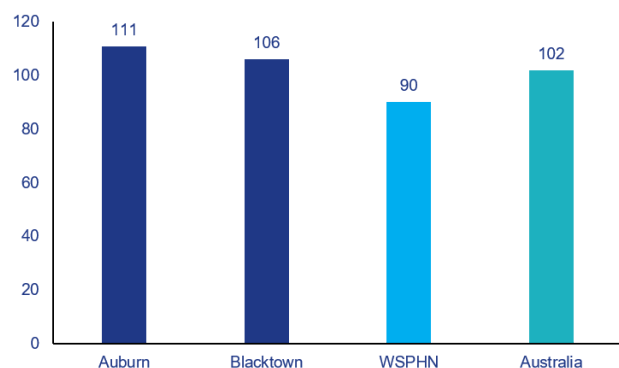
PRIORITY AREAS

Key areas for focus in western Sydney include:

- Improved management of patients across the health system.
- Reduction in potentially preventable hospitalisations.
- Increase in primary care capability and capacity to manage patients with chronic and complex health care needs in the community.
- Community based early intervention programs and services.
- Family and carer focused services to assist in home care.

Hospitalisations for mental health conditions

Hospitalisations for all mental health conditions,
2015-16, rate per 100,000 people (age standardised)



All mental health conditions, 2015-16, age
standardised rates per 10,000 people (SA3s listed in
order of highest rate of bed days)

	Hospitalisations	Bed days
Australia	102	1,401
WSPHN	90	1,524
Auburn	111	3,143
Parramatta	89	1,597
Merrylands - Guildford	93	1,554
Rouse Hill - McGraths Hill	90	1,393
Blacktown	106	1,387
Mount Druitt	98	1,269
Baulkham Hills	75	1,215

KEY FACTS CONTINUED

➤ Based on age standardised rates per 100,000, hospitalisations in 2014-15 for mental health conditions including, bipolar and mood disorders, anxiety and stress, and depressive episodes were consistently highest in SA3s including Auburn, Dural-Wisemans Ferry, and Rouse Hill-McGraths Hill when compared to WSPHN and Australia overall.⁴

➤ In 2014-15, the rate for Schizophrenia and Delusional Disorders in the WSPHN region was slightly higher, at 172 per 100,000, than the national rate at 164 per 100,000, and was the 9th highest in Australia.⁵

PHN PROGRAM PERFORMANCE INDICATORS

P9

Rate of GP team care arrangements/case conferences

MH4

Formalised partnerships with other regional service providers to support integrated regional planning and service delivery

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW
2. ABS (Australian Bureau of Statistics) 2015. National Health Survey: first results 2014-15. ABS cat. no. 4364.0.55.001. Canberra.
3. Australian Institute of Health and Welfare analysis of the National Hospital Morbidity Database 2014-15 and Australian Bureau of Statistics, Estimated Resident Population 30 June 2014.
4. AIHW (2015), Analysis of the National Hospital Morbidity Database.
5. Connetica. WentWest, the Western Sydney Primary Health Network (2017). Overview of mental health and service data.

Variations in care

KEY FACTS



There is a high variation in prescription rates for antidepressant medication within the WSPHN region. In western Sydney, the SA3 with the highest age standardised rate of antidepressant prescriptions for people aged 17 years and under (Rouse Hill – McGraths Hill), is more than three times that of the lowest SA3 (Auburn). Also, of note is that there appears to be an inverse correlation between the rate of prescriptions and socio-economic disadvantage, with lowest prescription rates in the lowest SES areas in the region (Mount Druitt, Merrylands-Guildford and Auburn SA3s).¹



There is a high variation in prescription rates for ADHD medication within the region. The Mount Druitt prescription rate places it in the decile with the highest prescription rate in Australia, and Blacktown falls in the second highest decile.¹



Pharmaceutical Benefits Scheme prescriptions for antipsychotic medicines appear to be relatively higher in the Mount Druitt SA3, particularly among people 65 years and older, which in 2013/14 amounted to 2,937 prescriptions. It is also worth noting that the SA3 areas with relatively higher prescription rates are in lower SES areas.¹

References

1. Australian Institute of Health and Welfare, 2017. The second Australian Atlas of Healthcare Variation (2017). Sydney.
2. Australian Institute of Health and Welfare, 2015. Australian Atlas of Healthcare Variation (2015). Sydney.

SUMMARY

Patient care provided by health care providers can vary. Some variation can be expected and reflects appropriate responses to differing patient needs and requirements. However, when differences in care do not reflect such factors and is not based on best practice guidelines, it represents unwarranted variation in care.¹

In Australia, the greatest variation relating to mental health was seen in prescriptions for psychotropic medications for children and adolescents aged 17 years and under.²

PRIORITY AREAS

Key areas for focus in western Sydney include:

- Prescription rates and addressing data gaps.
- Develop lifestyle prescriptions to nutritionists, exercise physiologists, and social support groups.

Mental health service needs

KEY FACTS

- A health literacy responsiveness survey was conducted with 94 local stakeholders from the mental health and AOD sector within the WSPHN region. Results suggest that non-government organisations had the highest levels of health literacy responsiveness, and government organisations are perceived to have the lowest levels of health literacy responsiveness.²
- Survey results in the region suggests that only 33% of patients with long-term mental health concerns are aware of available after hours services, and awareness was poorest among consumers of CALD backgrounds.³
- As at 2017, there were 344 general practices in the WSPHN. Overall, 33% of GP practices did not have after hours arrangements in place, and only 22% were open Saturdays and Sundays. Of the 86 general practices that are not open on weekends, only 35% had after hours arrangements in place.⁴

SUMMARY

People with mental illness access a range of mental health care services which are provided by various health providers, and are delivered in a variety of settings including community-based care organisations, general practice, and hospitals.¹

A range of mental health services needs exist within the WSPHN region, including health literacy responsiveness, access issues (such as wait times and after hours access), and integration and coordination of services.

PRIORITY AREAS

Support commissioning of mental health and suicide prevention services for identified service gaps to ensure the implementation of a stepped care model, including:

- Psychological therapies delivered by mental health professionals to under serviced groups (PMHC)
- Low intensity psychological interventions for people with, or at risk of, mild mental illness
- Early intervention services for children and young people with, or at risk of mental illness
- Services for people with severe and complex mental illness who are being managed in a primary care setting.
- Enhanced Aboriginal and Torres Strait Islander mental health services

Mental health service needs

Consumer demands are changing requiring services to be available online, telephone and extended hours to meet the needs of consumers and assist with access to high quality and experienced care.



20%

of PMHC providers in the WSPHN region have wait times of more than 2 weeks.



85%

of mental health providers in the WSPHN region who responded to a survey reported **responding to referrals within 48hrs.**

KEY FACTS CONTINUED



A survey of mental health service providers within the WSPHN region found that the majority of providers were satisfied with the ability of the PMHC program to address patient needs, provide appropriate referral pathways, and 85% of providers respond to referrals within 48hrs. Survey results also found that around 20% of providers have wait times of 1-2 weeks or more, and close to 20% have wait times of more than 2 weeks, suggesting that there are opportunities for WSPHN to assist providers in service delivery, including better matching of provider expertise with client needs, and increased communication between general practitioners and providers to enhance patient outcomes and experiences.³



A recent survey of regional mental health service providers indicated that the majority of respondents expressed that they wanted to know more about other services or be involved with (e.g. private practice models, local networking, support groups, peer work).³

PHN PROGRAM PERFORMANCE INDICATORS



Rate of regional population receiving PHN commissioned low intensity psychological interventions



Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals



Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness



Clinical outcomes for the regional population receiving services – psychological therapies delivered by mental health professionals to under-served groups



Formalised partnerships with other regional service providers to support integrated regional planning and service delivery



Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they were at risk of suicide followed up within 7 days of referral



Clinical outcomes for the regional population receiving services – low intensity psychological interventions

References

1. Australian Institute of Health and Welfare 2018. Mental health services—in brief 2018. Cat. no. HSE 211. Canberra: AIHW.
2. The Science of Knowing, (2018). WentWest Consumer Needs Assessment Project: Final Report. March 2018.
3. WentWest. 2017. Survey of Mental Health Service Providers, February to October 2017.
4. Western Sydney PHN General Practice Database. 2017.

ALCOHOL AND OTHER DRUGS (AOD)

- ⊕ Prevalence and hospitalisations
- ⊕ Vulnerable and at-risk populations
- ⊕ Clinical issues
- ⊕ Service and workforce needs








Prevalence and hospitalisations

KEY FACTS

- Higher prevalence of substance misuse is observed among the homeless, people who identify as LGBTIQ+, and among people recently released from prison.¹
- NSW has the lowest rate of treatment, with 356 clients per 100,000 population. This is half the treatment rate than in the ACT, NT and Queensland.²
- Pharmaceutical drugs such as opioids can be addictive, and misuse of prescribed and illicit opioids can have harmful social, psychological, and physical impacts on individuals.¹
- In 2016-17, just under 5% of Australians had misused a pharmaceutical drug in the last 12 months (e.g. opioids). Approximately 6% of treatment episodes in 2016-17 were pharmaceutical-related treatment.³

SUMMARY

Population modelling of disorder prevalence rates using Australian Burden of Disease data and the Network of Alcohol and Other Drugs Agencies toolkit for substance use prevalence indicates that, within the WSPHN region:

-  **79,500 people have an alcohol use disorder**
-  **20,300 people have a cannabis use disorder**
-  **6,800 people have a non-medical opiate use disorder**
-  **6,300 people have a methamphetamine use disorder**
-  **3,600 people have a benzodiazepine use disorder**

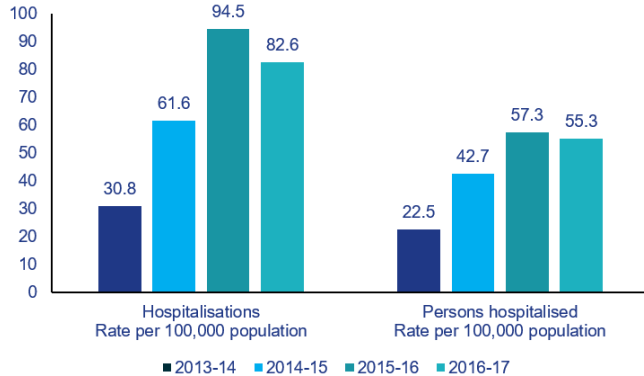
PRIORITY AREAS

Ensuring commissioned activities attempt to support hard-to-reach populations, including:

- People experiencing homelessness
- LGBTIQ+ community
- People recently released from prison.

Prevalence and hospitalisations

Methamphetamine-related hospitalisations and persons hospitalised, persons aged 16 years and over, Western Sydney PHN 2013-14 to 2016-17



KEY FACTS CONTINUED

- For all Drug & Alcohol Diagnosis Related Groups (DRG) combined, WSPHN have the fifth highest relative utilisation, 1.41 times the average of all PHNs. This rises to as high as 2.5 times the average for same day drug treatment DRGs and 1.73 times as high for 'other drug misuse disorder and dependence' DRGs.¹
- Data indicates methamphetamine hospitalisations per 100,000 have more than doubled between 2013-14 (22.5) and 2016-17 (55.3) within the WSPHN region. These hospitalisations are increasing much faster than 'total hospitalisations'.⁴
- Based on National Drug Strategy Household Survey data, in the WSPHN population there are 131,800 people who need screening and brief intervention for alcohol use in a given year, 83,600 who need screening and brief interventions for cannabis use, and 8,100 who need screening and brief intervention for amphetamines.⁵
- New data available from the 2016 National Drug Strategy Household Survey, indicate there was no change to the 12-month alcohol intervention population rates in this survey, however life time rates declined from 18.1% to 17.2%. This would not affect the assumptions that underpin the 12-month alcohol intervention rates above.⁵

PHN PROGRAM PERFORMANCE INDICATORS

AOD1

Rate of drug and alcohol commissioned providers actively delivering services

AOD2

Partnerships established with local key stakeholders for AOD treatment services

References

1. Network of Alcohol and Other Drug Agencies Planning tool for Drug and Alcohol services. 2017.
2. Australian Institute of Health and Welfare 2018. Alcohol and other drug treatment services in Australia. Canberra: AIHW.
3. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
4. HealthStats Website: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed October 2018.
5. National Drug Strategy Household Survey and Drug and Alcohol Service Planning modelling adjusted for Western Sydney PHN population.

Vulnerable and at-risk populations

SUMMARY

Some at-risk groups are more likely to engage in substance use that increases their risk of poor health outcomes. For example, smoking is more common among Aboriginal and Torres Strait Islander people, people living in the lowest socioeconomic areas, and people who identify as homosexual/bisexual.¹

There are significant disparities in health behaviours among Indigenous Australians when compared to non-Indigenous Australians. For example, in 2014-15 Aboriginal and Torres Strait Islander people were almost three times more likely to smoke than non-Indigenous Australians. While there have been positive changes in risky alcohol consumption within Aboriginal and Torres Strait Islander populations, the overall prevalence rates are still higher than that of non-Indigenous Australians.¹

People who identify as LGBTIQ+ are more likely to drink alcohol at levels posing risk to health and use illicit substances at higher rates than heterosexual people. Likewise, smoking and licit drug use is significantly higher among prison entrants when compared to the general adult population.¹

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.

SUMMARY CONTINUED

Vulnerable and at-risk populations in the western Sydney region, include:

- People identifying as LGBTIQ+
- Young people
- CALD community
- People recently released from prison
- Aboriginal and Torres Strait Islander peoples
- Older residents

PRIORITY AREAS

- Reducing presentations of drug use disorders among people identifying as LGBTIQ+
- Reducing high rates of AOD disorders among people experiencing homelessness and those recently released from prison
- Youth-focused treatment services and improved help-seeking behaviours of young people
- Identifying drug use patterns in CALD, refugee and asylum seeker communities
- Improved access to treatment for CALD communities, and capacity of AOD treatment services to work with CALD communities
- Integrated care for Aboriginal and Torres Strait Islander people whereby physical, AOD use and mental health issues are managed together
- Health promotion activities for older people, and support for the primary care sector to recognise and address substance misuse issues among older people

LGBTIQA+



When compared to heterosexual people, people who identify as LGBTIQA+ are **more likely to consume alcohol at levels that place them at risk of immediate and life-time alcohol-related harm.**¹

People who identify as LGBTIQA+ are more likely to use illicit drugs compared to heterosexual people, including:



5.8x as likely to use ecstasy



5.8x as likely to use meth/amphetamines



3.2x as likely to use cannabis



3.7x as likely to use cocaine



2.8x as likely to misuse pharmaceuticals.⁴

KEY FACTS

- For the 2016 Census, the ABS recognised that individuals may identify as a sex or gender other than the sex they were assigned at birth, or may not identify as exclusively male or female, and they were provided with methods for all form types so that people could record their sex in the way each thought most appropriate.²
- Despite the new question, there is a paucity of data on the geographical distribution of the LGBTIQA+ community within NSW. Only 1,260 people identified themselves as sex/gender diverse across the country in the 2016 Census.²
- People who identify as lesbian, gay, bisexual, transgender and/or intersex (LGBTI) can be at an increased risk of alcohol, tobacco and other drug problems. In 2013, use of licit and illicit drugs was more common in people who identified as homosexual or bisexual in Australia than for those identifying as heterosexual.³

PHN PROGRAM PERFORMANCE INDICATORS



Rate of AOD commissioned providers actively delivering services



Partnerships established with local key stakeholders for AOD treatment services


References


1. Department of Health. National Alcohol Strategy 2018-2026 – Consultation Draft.
2. ABS. 2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016, Sex and gender diversity in the 2016 Census. Released 28/06/2017.
3. Department of Health. National Drug Strategy 2017-2026. Canberra: 2017.
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4. Australian Institute of Health and Welfare. Alcohol, tobacco & other drugs in Australia - Web Report. Cat. no: PHE 221. 2018.
<https://www.aihw.gov.au/reports/phe/221/alcohol-tobacco-other-drugs-australia/contents/population-groups-of-interest/patterns-of-consumption-by-drug-type>


People experiencing homelessness

Western Sydney PHN






 Approx. **6,000 people** experiencing homelessness

 An estimated **2,300 people** experiencing homelessness have **alcohol dependence**

 An estimated **1,500 people** experiencing homelessness have **drug dependence** ¹

KEY FACTS

-  2016 census data indicates the estimated number of people experiencing homelessness within the WSPHN region was more than 6,000. ¹
-  The definition of homeless includes factors, such as persons living in improvised dwellings and supported accommodation. ¹
-  A meta-analysis of studies from western countries assessed the pooled prevalence estimate of alcohol dependence at 37.9% of the homeless population. Similarly, the pooled prevalence estimate of drug dependence was 24.4% of the homeless population. Both of these rates are many magnitudes higher than for the general population. When extrapolating to the homeless people within the WSPHN region in 2016, this equates to approximately 2,300 people experiencing homelessness with alcohol dependence and 1,500 with drug dependence. ²

PHN PROGRAM PERFORMANCE INDICATORS

 **AOD1** Rate of AOD commissioned providers actively delivering services

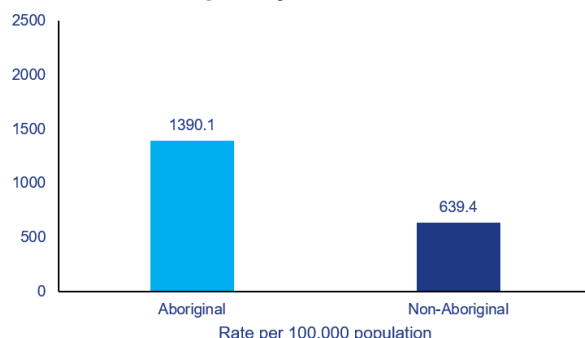
 **AOD2** Partnerships established with local key stakeholders for AOD treatment services

References

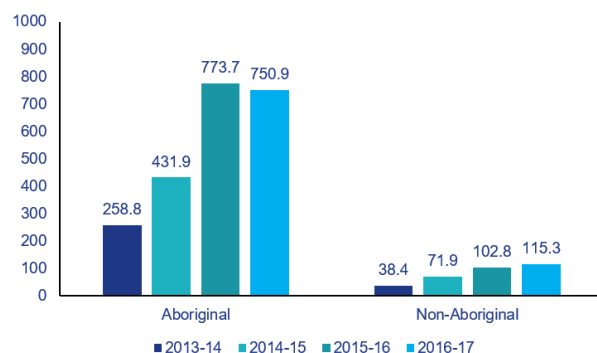
1. Australian Bureau of Statistics. 2016 Census of population and housing: Estimating homelessness, 2016. Canberra. 2018.
2. Fazel, S. et al., (2008). The prevalence of mental disorders among the homeless in Western countries: Systematic review and meta-regression analysis. PLOS Medicine.

Aboriginal and Torres Strait Islander peoples

Alcohol attributable hospitalisations by Aboriginality, NSW 2014-15



Methamphetamine-related hospitalisations by Aboriginality, persons aged 16 years and over, NSW 2013-14 to 2016-17



KEY FACTS

- State level data indicate that in 2017, alcohol consumption at levels posing long-term health risks were higher among Aboriginal and Torres Strait Islander people (41.3%) compared to non-Indigenous people (30.7%).¹
- Alcohol attributable hospitalisations among Aboriginal people in NSW decreased in 2014-15 from that of previous years. However, rates per 100,000 people were more than double among Aboriginal people (1390.1) compared to non-Indigenous people (639.4).¹
- General practice data indicates that of 6,272 people who identified as Aboriginal attending general practice in WSPHN, 13% identified as drinkers and 1.2% identified as drug users. Of these, 24.5% of drinkers indicated they had a mental health problem and 61.6% of drug users indicated a mental health issue.²
- Methamphetamine-related hospitalisations among Aboriginal people in NSW has significantly increased over the last four years. Rates per 100,000 people have almost tripled between 2013-14 (258.8) to 2016-17 (750.9).¹
- NSW data indicates that in 2016-17, 11% Aboriginal and Torres Strait Islander people were seeking treatment for someone else's drug use.³

PHN PROGRAM PERFORMANCE INDICATOR



Evidence that all AOD commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people

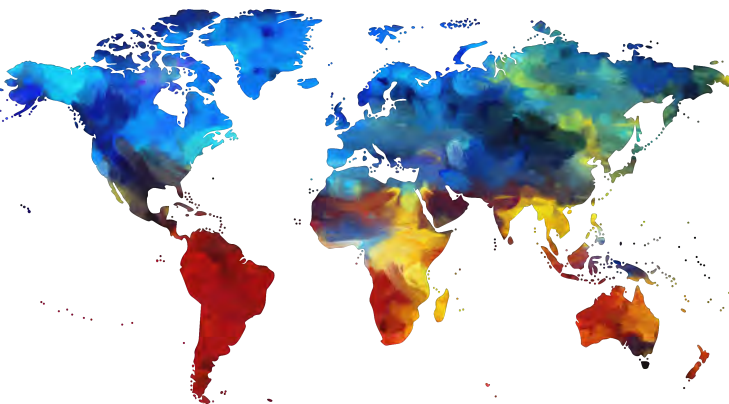
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- Patent Assistance Tool (PAT) – WSPHN PAT database.
- Australian Institute of Health and Welfare 2018. Alcohol and other drug treatment services in Australia: 2016–17. Canberra: AIHW.

CALD communities

A study of CALD groups in the greater Sydney region identified **lower levels of short-term risky drinking and illicit drug use** across all the CALD groups studied, compared with the general NSW population.

CALD groups included: Italian, Chinese, Vietnamese, Spanish-speaking, Arabic-speaking and Pasifika.



KEY FACTS

- Overall, drug use patterns in CALD and refugee communities are hard to discern due to the lack of data collected.
- Data is also limited on the prevalence of substance use disorders in communities where English is not the primary language. The Drug and Alcohol Multicultural Education Centre (DAMEC) estimates that about 6% of all AOD specialist service presentations relate to this group, however they are significantly underrepresented on a population basis in treatment services.¹
- A 2012 survey of 118 service users on the drugs used by particular sub-groups identified alcohol as the predominant drug of concern in most communities, with the exception of the South East Asian communities who identified opiates and amphetamines.¹
- The Australian Psychological Society indicated that substance misuse is a common consequence of the psychological impacts of the refugee and asylum seeker experience, however there is almost no data that provides insights into the prevalence within local communities.²
- State data indicates that in 2017, for people aged 16 years and over, rates of alcohol consumption posing immediate and long-term risk to health among people born in non-English speaking countries was almost three times lower compared to people born in Australia (11.4% compared to 31.1%, and 13% compared to 37.6%).³

PHN PROGRAM PERFORMANCE INDICATOR

P1 PHN activities address prioritised needs

References

1. Drug and Alcohol Multicultural Education Centre (DAMEC). 2017.
2. Murray K, Davidson G & Schweitzer R. Psychological Wellbeing of Refugees Resettling in Australia: A Literature Review. August 2008. <https://www.psychology.org.au/getmedia/73cf6347-82f2-4b2d-bb27-6ccc123f8bb8/Refugee-Literature-Review.pdf>
3. HealthStats Website: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed October 2018.
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People in prison

Approximately

12%

of all NSW prisoners' last known address was within the WSPHN region, and therefore are more likely to return when released. In a given year this equates to approx. 2000 persons per year with around

55%

of those coming from Parramatta LGA.⁵

KEY FACTS

- Research findings investigating the health of inmates in NSW indicate:
 - In the 12 months prior to entering custody 63% of men and 40% of women reported drinking alcohol in the hazardous and harmful range
 - Majority of participants reported lifetime use of illicit drugs (78% women and 86% men), 44% reported daily use prior to incarceration and 43% reported to using drugs in prison.¹
- The Justice Health & Forensic Mental Health Network runs the Connections program that links patients up with community AOD programs post prison release. In 2016-17, among participants, the most common drug of concern was amphetamines. Participants also report a range of health complications, including various mental health concerns.³
- Crime statistics indicate that western Sydney has higher rates of resident drug offences than South West Sydney or Northern Sydney. Crime statistics in the WSPHN region based on five-year trends (2013-18) for possession and/or use of drugs, also show increases among certain drugs within certain LGAs:
 - Blacktown - amphetamine (up 15%)
 - Cumberland - cannabis (13%), amphetamine (5%), other drugs (7%)
 - Parramatta - other drugs (4%).⁴

PHN PROGRAM PERFORMANCE INDICATOR

P1

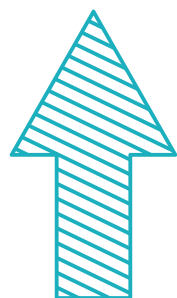
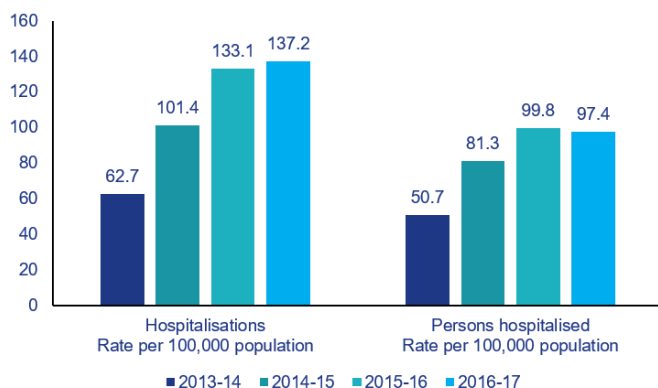
PHN activities address prioritised needs

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2. Community Restorative Centre. Retrieved from: <https://www.crcnsw.org.au/get-help/getting-out-of-prison>
3. Connections Program database. 2017.
4. Bureau of Crime Statistics and Research. Incidents of crime recorded by the NSW police force by Local Government Area: number, rates, and trends 2013-2018.

Young people

Methamphetamine-related hospitalisations and persons hospitalised, persons aged 16-24 years, NSW 2013-14 to 2016-17²



Methamphetamine-related hospitalisations increased in NSW among people aged 16-24 years, from 50.7 per 100,000 in 2013-14 to 97.4 in 2016-17.²

KEY FACTS

➤ The 2014 Australian Secondary Schools AOD survey of 23,000 students was released by the Australian Government in November 2016. Survey results found that among young people aged 12-17 years:

- Approximately half reported drinking alcohol in the preceding year, and 68% reported lifetime (defined as 'in previous month/year and prior to that') consumption of alcohol, 7% reported using cannabis in the month before the survey, and 16% reported lifetime use. 6% had used inhalants in the month before the survey, and 2% of students reported lifetime amphetamines use, and there was a statistically significant decrease in lifetime amphetamine use between 2008 and 2014.¹

➤ Consultation with generalist youth service providers in the region identified numerous barriers impeding their capacity to support young people with AOD issues, including:

- Lack of existing AOD-related organisational policies and processes to inform practice
- Training and support gaps
- Low levels of awareness of existing AOD training and support opportunities
- Low levels of awareness and understanding of referral pathways and AOD specialist service provider types
- Low levels of collaboration and communication between individual generalist youth service providers and with AOD specialist providers
- Attitudes and perceived hierarchies between clinical and community workforce, and how they should respond to AOD issues
- Confusion around mandatory reporting requirements and maintaining confidentiality and trust with a young person after they disclose their AOD use.

PHN PROGRAM PERFORMANCE INDICATOR



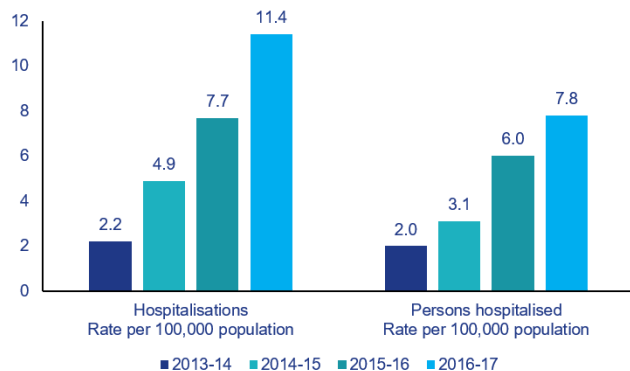
P1 PHN activities address prioritised needs

References

1. Department of Health. Australian secondary school students use of tobacco, alcohol, and over-the-counter and illicit substances in 2014. 2016.
2. HealthStats Website: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed October 2018.

Older populations

Methamphetamine-related hospitalisations and persons hospitalised, persons aged 55 years and over, NSW 2013-14 to 2016-17



KEY FACTS

- There is increasing recognition of substance misuse issues amongst older people. In 2016, 11.3% of the population within the WSPHN were aged 65 years and over.¹
- Older people with AOD issues are likely to experience comorbidities, including mental and physical health issues. Ageing and the associated increased incidence of physical health issues may result in reduced mobility, increased and multiple morbidities, and may impact on detoxification. Whilst aged health services and older people's mental health services are familiar with comorbidities and physical health issues common in older people, these issues are less familiar to AOD services and will require workforce and service development responses.²
- On average, older people have the lowest rates of alcohol misuse, illicit drug use and tobacco consumption, but the highest rates of prescription drug misuse.²
- Alcohol is the most common drug used by older people, and older people in Australia are less likely to binge drink, but are the most likely age group to be daily drinkers.²
- Based on rates per 100,000 people, methamphetamine-related hospitalisations among people aged 55 years and over have been increasing, 2014-15 (3.1), 2015-16 (6.0), and 2016-17 (7.8).³

PHN PROGRAM PERFORMANCE INDICATORS

P1

PHN activities address prioritised needs

References

1. Public Health Information Unit. Social Health Atlas of Australia: Data by Primary Health Networks (incl. Local Government Areas). October 2018.
2. NSW Ministry of Health. Older people's drug and alcohol project: Full Report. 2015. Sydney.
3. HealthStats Website: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed October 2018.

Clinical and service issues

KEY FACTS

- The WSPHN region has 35 AOD treatment agencies, including government and non-government agencies.²
- There were 2,745 closed treatment episodes provided in the WSPHN region in 2016-17. 40.2% of these episodes were for counselling, 26.4% were for assessment only, 18.4% for withdrawal management, 5.7% for rehabilitation, 5.2% for support and case management only, 3.2% for information and education only, and 0.9% were other treatment types.²
- An estimated 1,827 clients sought treatment in the WSPHN region in 2016-17. 97% were seeking treatment for their own AOD use, and 3% were seeking treatment for other's AOD use.²
- 12.4% of clients seeking treatment were Indigenous, 86% were non-Indigenous, and 1.6% did not state their Indigenous status.²
- The four most common principle drugs of concern in the WSPHN region in 2016-17 were: Amphetamines 32%, Alcohol 27.2%, Cannabis 21%, and Heroin 10.5%.²

References

1. Australian Institute of Health and Welfare 2018. Alcohol and other drug treatment services in Australia: 2016–17. Drug treatment series no. 31. Cat. no. HSE 207. Canberra: AIHW.
2. Alcohol and other drug treatment services national minimum data set (AODTS NMDS). <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2016-17-phn/contents/primary-health-network-phn-analysis/aod-treatment-agencies>

SUMMARY

Alcohol and other drugs (AOD) treatment services support people with their substance use through a range of treatments, which include detoxification and rehabilitation, counselling, and pharmacotherapy. Treatment objectives can include reducing drug use, providing social support, and offering support to friends and family members of people using substances.¹

Access to appropriate AOD services, an adequate AOD workforce, access to suitable and culturally appropriate services for at-risk populations, and effective and efficient service structures are essential for providing relevant support to people with substance use issues.¹

PRIORITY AREAS - ALL

Areas of focus for improving clinical and service issues, include:

- Access to rehabilitation and withdrawal services
- Increased linkages between MH and AOD services, particularly for people with complex co-morbid AOD, mental health and chronic physical issues
- Increased support for carers
- improved withdrawal management provision and service linkages
- Addressing workforce issues
- Specialised services for at-risk populations
- AOD service models and funding structures

Access to treatment

Aggregation of treatment needs for the NSW population, based on the Drug and Alcohol Service Planning Model of Australia, indicates that a total of 2149 rehabilitation places are needed, including:



1022 for alcohol use disorders



637 for amphetamine use disorders



267 for cannabis use disorders



223 for non-medical opiate misuse disorders.

KEY FACTS

- The Network of Alcohol and other Drugs Agencies, estimates that there are approximately 1,000 rehabilitation places in NSW, indicating a deficit of around 1,400 places.¹
- The AIHW Alcohol and Other Drugs Treatment services in Australia report 2016-17 indicates:
 - NSW has the lowest treatment rate of any state or territory, and less than half of the rate in the ACT and NT and close to half that of QLD.
 - NSW has the lowest proportion of publicly funded agencies in the non-government sector at less than 25%.²
- Regional consultations and previous work conducted by WSPHN, indicate various challenges relating to access to residential withdrawal management, including:
 - Significant wait times and distances required to travel to services
 - Access to home detox is limited
 - A lack of culturally appropriate services for Indigenous clients.
- Consumer consultation identified a number of barriers to seeking treatment, including: misinformation and fear spread within the AOD community regarding accessing support and withdrawal outcomes, cultural shame and stigma within some CALD communities, and poor access to a range of treatment options, including non-medicated detox and rehab.

PHN PROGRAM PERFORMANCE INDICATORS



Rate of drug and alcohol commissioned providers actively delivering services



Partnerships established with local key stakeholders for AOD treatment services

References

1. Network of Alcohol and Other Drugs Agencies (NADA). Online resources. <https://www.nada.org.au/>
2. Australian Institute of Health and Welfare 2018. Alcohol and other drug treatment services in Australia: 2016–17. Canberra: AIHW.

Comorbidity - mental health and AOD use



Comorbidity of substance use disorders
with mental health issues ²

15% of people attending western
Sydney primary care practices
who **drink at risky levels** have an
**associated mental health
condition.**

60% of people attending western
Sydney primary care practices
who **use illicit drugs** have an
**associated mental health
condition.**

KEY FACTS

- Substance use disorders often co-occur with one or more mental health issues and this typically complicates treatment and service delivery for either conditions. Substance use may also exacerbate symptoms of mental illness and make treatments less effective.
- Prevalence of comorbidity in Australia indicates:
 - 26% of substance users had been diagnosed or treated for mental health issues in the previous 12 months
 - 22% of substance users reporting experiencing either high or very high psychological distress.¹
- General practice data from Western Sydney PHN indicates that around 15% of all drinkers attending western Sydney primary care practices have an associated mental health condition and 60% of all drug users have a mental health condition.²

PHN PROGRAM PERFORMANCE INDICATORS

- P1 PHN activities address prioritised needs
- MH2 Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals
- MH3 Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. Patient Assistance Tool (PAT) – WSPHN PAT database.

Support for carers

KEY FACTS

- Around 7% of all contacts with specialist treatment services are with carers seeking assistance for someone else. Carers are more likely to suffer mental health and physical health consequences from prolonged periods without assistance for their cause of concern.¹
- In 2016-17, 3.3% of clients were seeking treatment for someone else's drug use, with the majority being women (66%). In addition, Aboriginal and Torres Strait Islander people are over represented in this area, with 8.4% of people seeking treatment for someone else's drug use identifying as Indigenous.²



PHN PROGRAM PERFORMANCE INDICATOR

P1

PHN activities address prioritised needs

References

1. Network of Alcohol and Other Drugs Agencies (NADA). Online resources. <https://www.nada.org.au/>
2. Australian Institute of Health and Welfare 2018. Alcohol and other drug treatment services in Australia: 2016–17. Canberra: AIHW.

Specialised services for at-risk populations



The Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS-NMDS) collects information on clients who seek treatment for alcohol and other drug services, yet it **does not collect information on the client's experience of homelessness.**



The AODTS-NMD reported that in 2016–17, the majority of closed treatment episodes were for clients born in Australia. While 72% of the general population was born in Australia, in 2016–17, **87% of treatment episodes were provided to Australian-born clients.**



In terms of treatment, **referral episodes from police or court diversion programs accounted for 17% of episodes** for clients receiving treatment for their own drug use in 2016–17.

KEY FACTS

- There is limited availability of residential treatment services that cater for women and their children. Currently only 5 services exist across NSW.
 - There are no services in the WSPHN region that cater for women and their children specifically.
 - Resources are not available to organisations to cover costs relating to childcare, developing and maintaining child friendly and safe environments and services.¹
- Limited services available that cater specifically to the needs of at-risk populations, specifically:
 - Homeless people: Most services provide accommodation respite rather than modified interventions based on client needs.¹
 - CALD populations: DAMEC reports a paucity of effective models for engaging CALD people, and there is only one CALD AOD-related specialist service in NSW.²
 - Prisoners released from custody: Residential treatment facilities do not always meet the needs of people leaving custody (e.g. restrictive entry criteria).¹

PHN PROGRAM PERFORMANCE INDICATORS



P1 PHN activities address prioritised needs



Partnerships established with local key stakeholders for AOD treatment services

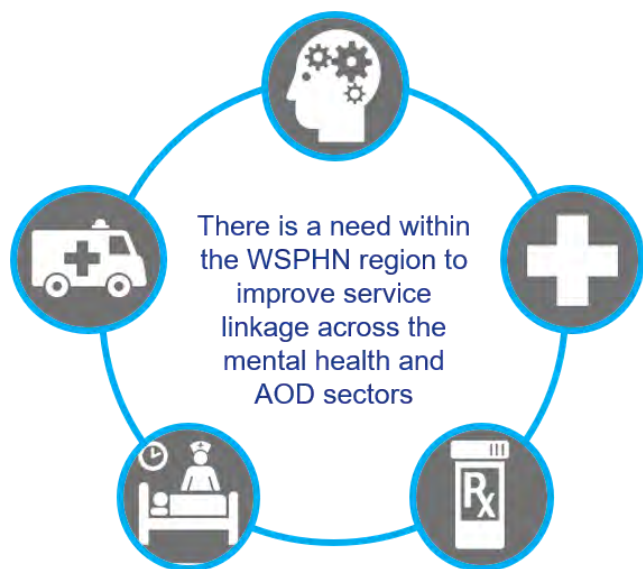


AOD1 Rate of AOD commissioned providers actively delivering services

References

1. Stakeholder consultations with WentWest personnel.
2. Drug and Alcohol Multicultural Education Centre. 2017.

Integration and coordination



Opportunities include: integration of community care approaches, reducing resource silos, integrated assessments, and jointly targeted commissioning.²

KEY FACTS

- Community consultations with consumers and health professionals has indicated significant gaps in the coordination of patient records. WSPHN has identified improved information exchange as a priority in future service planning, including communication between primary care and hospital services.
- Research investigating the AOD service needs of young people in the WSPHN region indicates:
 - Low levels of awareness and understanding of referral pathways and AOD specialist service provider types by generalist youth service providers.
 - Low levels of collaboration and communication between individual generalist youth service providers and with AOD specialist providers.¹
- Consultations with multiple AOD providers within the region also indicate several limitations, including:
 - Differences in operational definitions around thresholds for entry criteria and reporting requirements within the sector.
 - Sub-optimal patient discharge practices, particularly with regard to the psychosocial circumstances of patients.

PHN PROGRAM PERFORMANCE INDICATORS

P2

Health system improvement and innovation

AOD2

Partnerships established with local key stakeholders for AOD treatment services

References

1. The Science of Knowing. Investigating alcohol and other drug service needs of young people in western Sydney Final Report 2018.
2. Connections conference. Western Sydney PHN facilitated conference for service providers, consumers and experts 2017.

Workforce issues

Occupational groups involved in reducing AOD-related harm⁴



Specialist AOD, clinical and prevention workers



Corrections



Police



Generalist health and welfare workers



Mental health



Pharmacy workers



Education



Emergency medical services

KEY FACTS

- Workforce related challenges within the WSPHN region relate to:
 - A need for improved certification of AOD workers
 - A need for increased peer support workers
 - A lack of opioid substitution therapy (OST) prescribers.¹
- There is a reluctance of some health professionals in the WSPHN region to work with patients with AOD issues. Consultation evidence suggests that a significant proportion of emergency departments have negative attitudes regarding AOD users.¹
- In NSW, only 35% of community pharmacies provide OST medications.²
- Low levels of awareness of existing AOD training and support opportunities by generalist youth service providers.³

PHN PROGRAM PERFORMANCE INDICATORS



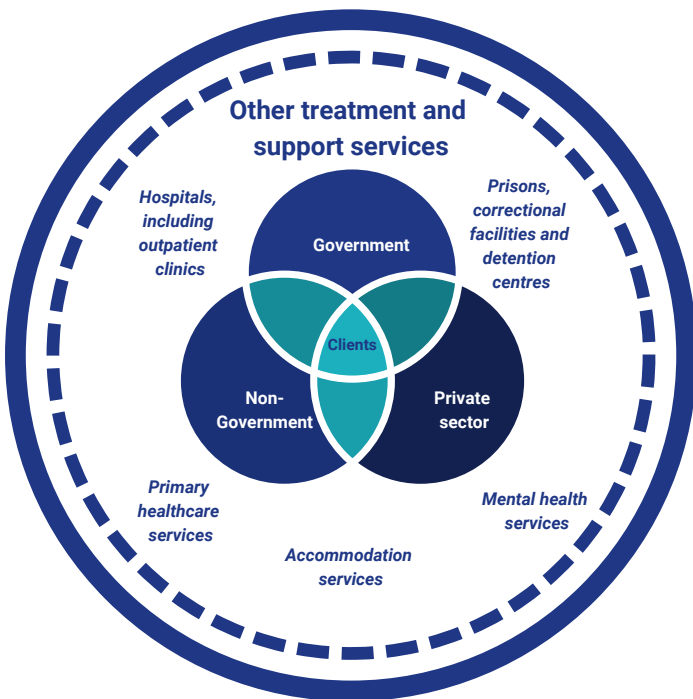
P4 Support provided to general practices and other health care providers

References

1. Stakeholder consultation activities with WentWest personnel.
2. Chaar, B. et al. Provision of opioid substitution therapy services in Australian pharmacies. *Australasian Medical Journal*, 4(4), 210-216:2016.
3. The Science of Knowing (2018). Investigating alcohol and other drug service needs of young people in western Sydney.
4. Intergovernmental Committee on Drugs. National Alcohol and other Drug Workforce Development Strategy 2015-2018.

System level issues - service models and funding structures

AOD treatment and support services in Australia³



KEY FACTS

- New models of care are needed that reflect current literature relating to stepped-care models.¹
- Suggestions have been made that rehabilitation services can be broadened to include:
 - One stop treatment centres
 - Supported living/transitional housing programs
 - Aftercare and continuing care programs
 - Drop in centres and day centres
 - Stabilisation services post release from prison.²
- Several challenges relating to funding models have been identified, including:
 - Increased complexity and business infrastructure not being recognised in funding models
 - Multiple funding sources with burdensome and varied reporting requirements and limited flexibility
 - Sustainability and planning issues due to 12-month funding contracts.²

PHN PROGRAM PERFORMANCE INDICATORS

- P1 PHN activities address prioritised needs
- P2 Health system improvement and innovation

References

1. Network of Alcohol and Other Drug Agencies Planning tool for Drug and Alcohol services. 2017.
2. Consultation data collected from stakeholder engagement activities with WentWest personnel.
3. Australian Institute of Health and Welfare 2018. Alcohol and other drug treatment services in Australia: 2016–17. Canberra: AIHW.

SYSTEM LEVEL ISSUES

- ⊕ Health literacy and health literacy responsiveness
- ⊕ After hours services
- ⊕ Integration and coordination
- ⊕ Digital health
- ⊕ Health workforce



Health literacy and health literacy responsiveness

KEY FACTS

- Research suggests that only 41% of Australian adults have health literacy levels required to deal with the complex demands of everyday life. Health literacy in the Australian context is also lowest among people on low incomes, and who speak English as their second language.⁴
- Research conducted in the WSPHN region indicated low levels of health literacy were highest amongst vulnerable populations, including migrant populations, people with multiple chronic conditions, and people with poor English proficiency.²
- Service providers in western Sydney have recognised low levels of health literacy as a major challenge in working towards better health outcomes for Aboriginal and Torres Strait Islander people.⁵
- Service providers in western Sydney have identified limited knowledge of available services and how to access them, difficulties navigating the health system, and poor computer literacy as issues contributing to low levels of health literacy.²

SUMMARY

Health literacy is an important factor in an individual's ability to actively engage and maintain their own health. Low individual health literacy is associated with poor health outcomes, including increased hospitalisation, and emergency department presentations.^{1,2}

Health literacy responsiveness (HL-R) describes the way in which services make health information, resources, supports and environments available and accessible to people with different health literacy strengths and limitations. The higher the health literacy responsiveness of an organisation, the lower the health literacy required by consumers to engage with their health care.³

PRIORITY AREAS

- Increasing the health literacy of the western Sydney community with a specific focus on: CALD communities, notably migrants who have been living in Australia for more than 5 years, and Aboriginal and Torres Strait Islander peoples.
- Improving the health literacy responsiveness of organisations, including primary care providers, community, and government organisations.

Health literacy and health literacy responsiveness

HL-R Domains in need of improvement



KEY FACTS CONTINUED

- A survey of 94 stakeholders from western Sydney mental health and drug and alcohol services from government and non-government organisations found that health literacy responsiveness was perceived as lowest among government organisations and highest among non-government organisations.²
- According to survey results, all organisations struggled most with four health literacy responsiveness domains: Professional support and resources, Service accessibility, Service mix, and Organisational qualities.²
- Consultations with GPs who regularly service refugee and asylum seeker populations have identified that many are unaware of the services and supports available in the region for these patients.⁶

PHN PROGRAM PERFORMANCE INDICATORS

- P1 PHN activities address prioritised needs
- P2 Health system improvement and innovation

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. The Science of Knowing (2018). WentWest consumer needs assessment project: Final report. March 2018.
3. Bush R, Boyle F, EJ et al. 2010. Advancing health literacy through primary health care systems. Canberra: Australian National University.
4. Australian Bureau of Statistics. (2009). Health literacy, social trends. Canberra, 2009.
5. Community consultation; Close the gap team; Allied health provider focus groups; Engagement with a range of Non-Government organisations and Semi-structured interviews with Aboriginal and Torres Strait Islander health service providers and community organisations.
6. Western Sydney Refugee Health Coalition. GP Consultation. 2018

After hours services

KEY FACTS

- A substantial proportion of families who frequently present with children to emergency departments for non-complex and/or non-urgent conditions are first time and/or anxious parents.²
- Overall awareness of after hours support services is low, with only 52% of consumers aware of one or more health services available in the after hours period.³
- There is a low number of general practices with hours extending into the after hours period, and there are currently no 24-hour pharmacies in the WSPHN region.
- Stakeholder feedback suggests that approximately 20% of patients transferred to ED from RACFs were treated and discharged from ED without the need for admissions. Such cases could be more appropriately treated through after hours care.⁴

References

1. Morley, C., et al., (2018). Emergency department crowding: A systematic review of causes, consequences and solutions. PLOS ONE, 13(8), e2023316.
2. Linking kid's Care Project, Progress report, 2017.
3. Brooke, M, 2016. Consumers and after-hours health care in Western Sydney: Summary of Research Insights. Report prepared for WentWest. March 2016
4. Consultations with Westmead Emergency Department staff, 2016.

SUMMARY

After hours primary health care services are an important part of the health care system, and provide care to people whose health condition cannot wait for treatment until regular treatment hours. After hours services may also help reduce the impact of non-urgent presentations to emergency departments.⁴

PHN PROGRAM PERFORMANCE INDICATORS

- P6 Rate of general practices receiving payment for after hours services
- P7 Rate of GP style emergency department presentations

PRIORITY AREAS

- Increasing the rate of general practices receiving a Practice Incentives Program (PIP) level 1-5 payment for after hours services.
- Increasing consumer awareness of After Hours services available in the region.

Integration and coordination

KEY FACTS

➤ Consultations with patients, carers, and health professionals within the WSPHN region have highlighted that collaboration between health services and individual providers, particularly between hospitals and primary care services is sub-optimal. Identified areas in need of improvement include communication, information management and sharing, and enhancement of the patient journey.²

➤ In 2016, the proportion of patients aged 45 years and over in the WSPHN region who rated the quality of care they received from their usual GP or other health care provider was lower (79.5%) compared to the top five ranking PHNs (86.4% to 87.3%) and Australia overall (84.1%).³

➤ In 2016, the proportion of patients aged 45 years and over in the WSPHN region who felt that they were always or usually involved in decisions about their care by their usual GP or other care provider was lower (85.2%) compared to the top five ranking PHNs (91.3% to 92.2%) and Australia overall (89.1%).³

➤ Research conducted within the WSPHN region indicates a lack of continuity of care following discharge from ED, with sub-optimal information exchange between ED and GPs being a key issue.⁴

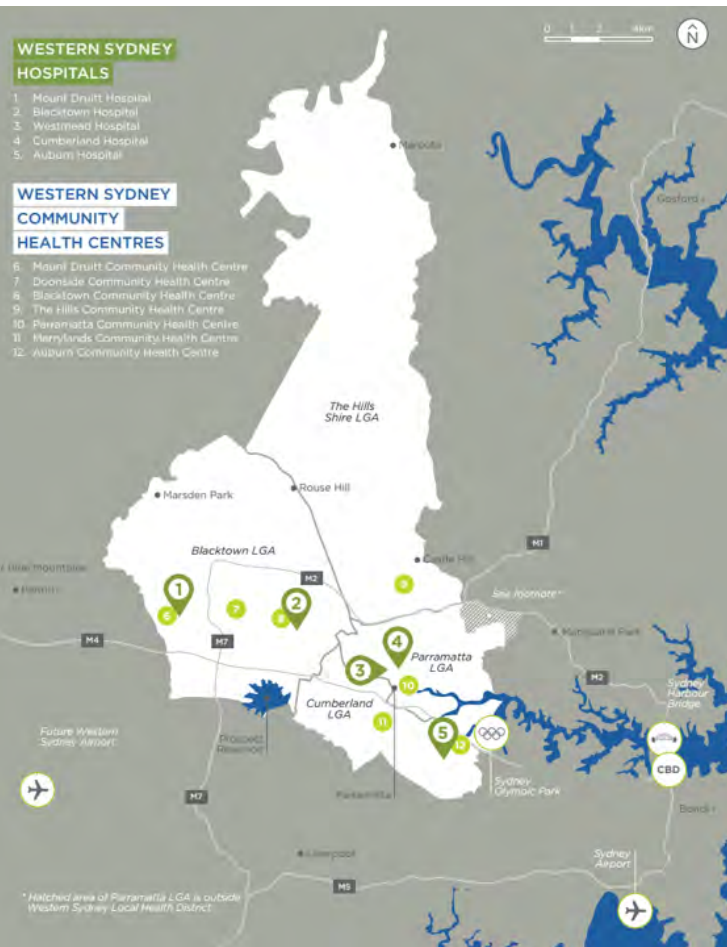
SUMMARY

Coordination of health care is the process of providing consistent and connected health services to patients, including positive relationships with health care providers, appropriate referrals to relevant health services and providers, and the timely transfer of patient information between health services and providers. With the growing number of patients with multiple chronic conditions, and complex care needs, efficient and effective integration and coordination of care is increasingly important.¹

PRIORITY AREAS

- Data integration with NSW Health and WSLHD.
- Improve the healthcare management of patients with long-term chronic conditions by building and supporting capacity in primary care.
- In partnership with the WSLHD, implement coordinated interventions, clinical services and enablers to: improve the patient's experience of the healthcare system, improve health outcomes and quality of life of the population, provide a less complex and more appropriate patient journey, reduce waiting times for patients as they navigate the system, reduce avoidable hospital admissions and ED presentations, reduce re-admission rates, reduce duplication of tests through better sharing of information, improve communication between GPs, community services and specialists; and identify cost efficiencies and better use of health resources.
- Work in collaboration through Western Sydney Service Delivery Reform, with the aim of improving outcomes for vulnerable children, young people and their families through purposeful, coordinated and integrated service delivery and strengthened multi-agency approaches to prevention and early intervention.

Integration and coordination



Map source: The New Frontier of Healthcare: Western Sydney Integrated Care Demonstrator 2014-2017. Report by Western Sydney Local Health District and Western Sydney Primary Health Network.

KEY FACTS CONTINUED

- In October 2017, the Australian Government's Productivity Commission released a report identifying key issues with the Australian healthcare system including a lack of integrated care, insufficient patient-centred care, the need to focus funding towards innovation or outcomes, a greater focus on quality of health and using information, data sharing and data linkage more effectively.⁵
- In 2013 western Sydney was selected by the NSW Ministry of Health for an integrated care demonstrator, the only metropolitan region in the State - The Western Sydney Integrated Care Program (WSICP).⁵
- Western Sydney clinicians have articulated a need for improved collaboration, accountability, prevention and patient-centred care that manages more patients in the community than in acute settings.⁵
- Western Sydney clinicians have articulated a need for improved collaboration, accountability, prevention and patient-centred care that manages more patients in the community than in acute settings.⁵

PHN PROGRAM PERFORMANCE INDICATORS

P2

Health system improvement and innovation

P12

Rate of potentially preventable hospitalisations

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. WentWest General Practitioner Survey 2015; Consultation and engagement activities with service providers, NGOs, LHD professionals, and refugee and multicultural services, 2016-2017.
3. Australian Institute of Health and Welfare 2018. Healthy Communities: coordination of health care – experiences with GP care among patients aged 45 and over, 2016. Cat. no. CHC 2. Canberra: AIHW.
4. Brooke, M. (2016). Consumers and after-hours health care in Western Sydney: Summary of Research Insights. Report prepared for WentWest. March 2016.
5. WSLHD & WSPHN. The New Frontier of Healthcare: Western Sydney Integrated Care Demonstrator 2014-2017. Report.

Digital health

KEY FACTS

- Uptake of My Health Record by health consumers is sub-optimal, a large proportion of the WSPHN population do not have one. In general, understanding and uptake of eHealth is low, as is the uploading of patient health summaries.² This may change significantly with the introduction of the 'opt-out' approach.
- Electronic shared care planning is a key tool in ensuring up to date exchange of patient clinical measures and goals for care. The sharing of this information amongst health providers is crucial for an integrated system. Uptake of Linked EHR, as a key electronic shared care planning tool, remains challenging.
- Use of health technologies such as HealthPathways can help health care providers identify appropriate patient referral options and pathways, which can help reduce variations in care and improve patient outcomes. Uptake of HealthPathways in the WSPHN region is increasing, as well as the completion of localised pathways.

SUMMARY

The use and uptake of effective technology to improve an individual's health and/or the transfer of patient information between services and providers is an important part of providing quality and effective health care. Digital health can include technology that informs patients about health care (e.g. websites, apps), as well as technology that supports service providers with decision-making, information sharing, and providing appropriate referrals to other health care providers (e.g. clinical decision-making tools, My Health Record).¹

PRIORITY AREAS

- HealthPathways collaborative project to better understand its efficacy of and increase uptake within the WSPHN region.
- Data driven improvement through the development of practice data dashboards integrated with quality improvement activities.
- Data sharing and integration to improve flow of information between health system partners and to enhance service planning and patient care.
- Deliver digital health awareness sessions to improve capacity and capability of primary, community and allied health workforce.
- Engage with health providers and people to encourage digital health use, including My Health Record.
- Develop and commission strategies to improve adoption of digital health systems, including testing new models of care.

Digital health



KEY FACTS CONTINUED

- Data driven improvement is an important enabler to high quality general practice and quality care. WSPHN data shows that practices that routinely review their clinical data and build quality improvement activities around it, demonstrate enhanced patient outcomes.
 - Research into the digital behaviours of older Australians (aged 50+) identified:
 - Many older Australians have real concerns about the safety of the internet and want to understand how digital participation can improve their lives.
 - There is a strong relationship between age and digital literacy levels: three-quarters of the digitally disengaged group were aged 70 years +.
 - 11% of the population aged 50 years and over did not have any form of internet access. They were likely to be older (aged 70 years and above).
- The most common way older Australians connected to the internet
- was through a home internet connection, with four-in-five doing so.³

PHN PROGRAM PERFORMANCE INDICATORS

P4	Support provided to general practices and other health care providers	P11	Rate of discharge summaries uploaded to My Health Record
P5	Rate of regular uploads to My Health Record	DH1	Rate of health care providers informed about My Health Record
P10	Cross views of My Health Record	DH2	Rate of health care providers using specific digital health systems

References

1. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.
2. Department of Health. My Health Record statistics by Primary Health Network (PHN). Retrieved from www.health.gov.au
3. Office of the eSafety Commissioner. Understanding the digital behaviours of older Australians: Summary of national survey and qualitative research. Australian Government. May 2018.

Health workforce

KEY FACTS

- WSPHN primary care workforce will be continually challenged in coming years by the projected population growth and growth in numbers of people aged 65 years and older.
- A number of workforce capacity issues have been identified in the WSPHN region, including maldistribution of GPs, an ageing GP workforce, a disproportionate number of solo GPs and changing hours of work for younger GPs.¹
- Analysis of the ratio of GPs to patient, shows marked variation (e.g. the former Holroyd LGA is one of significant disadvantage and has a high patient/GP ratio).¹
- There is a low proportion of practice nurses in the WSPHN region when compared to national estimates (52.3% compared to 63%).¹
- There is an increased demand and poor access to allied health professionals (AHP). Consultations with GPs in the WSPHN region suggests that speech pathologists, exercise physiologists, and social workers are among the AHPs in short supply.²

SUMMARY

The impact of the increase in population numbers has significant population health implications, as people are living longer and presenting with more complex chronic conditions. Increases in chronic conditions creates a greater need for a health workforce with relevant skills and knowledge to manage patients with a broad range of health conditions.

Increasingly this will be achieved through multi-disciplinary and team based care, with general practice leading a comprehensive and coordinated service focused on evidence based, safe quality care.

PRIORITY AREAS

- Support general practices and other health care providers in western Sydney to ensure they are able to respond appropriately and confidently to the health needs of our region and improve their service delivery.

Health workforce

The Australian healthcare system provides a wide range of services, from population health and prevention through to general practice and community health; emergency health services and hospital care; and rehabilitation and palliative care. The health workforce includes a range of professions to deliver these services, including general practitioners, nurses, pharmacists, community-based workers, specialists, and allied health professionals. An adequately skilled workforce that is equitably distributed is critical to delivering these services.



KEY FACTS CONTINUED

- In the WSPHN region, there are 348 General Practices, 1,243 GPs, 461 Practice Nurses.¹
- Approximately half (52.3%) of the general practices in the WSPHN region have a Practice Nurse.¹

PHN PROGRAM PERFORMANCE INDICATORS

- | | | | |
|-----|--|-----|--|
| P4 | Support provided to general practices and other health care providers | IH6 | PHN provides support for Aboriginal and Torres Strait Islander identified health workforce |
| P13 | Numbers of health professionals available | W1 | Rate of drug and alcohol treatment service providers with suitable accreditation |
| IH3 | Evidence that all drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people | W2 | PHN support for drug and alcohol commissioned health professionals |
| IH5 | ITC improves the cultural competency of mainstream primary health care services | W3 | PHN Commissioning Framework |

References

1. WSPHN Chilli database: Analysis of extracted data. November 2017 and November 2018.
2. WentWest GP survey 2017 – Allied Health Professionals in General Practice.