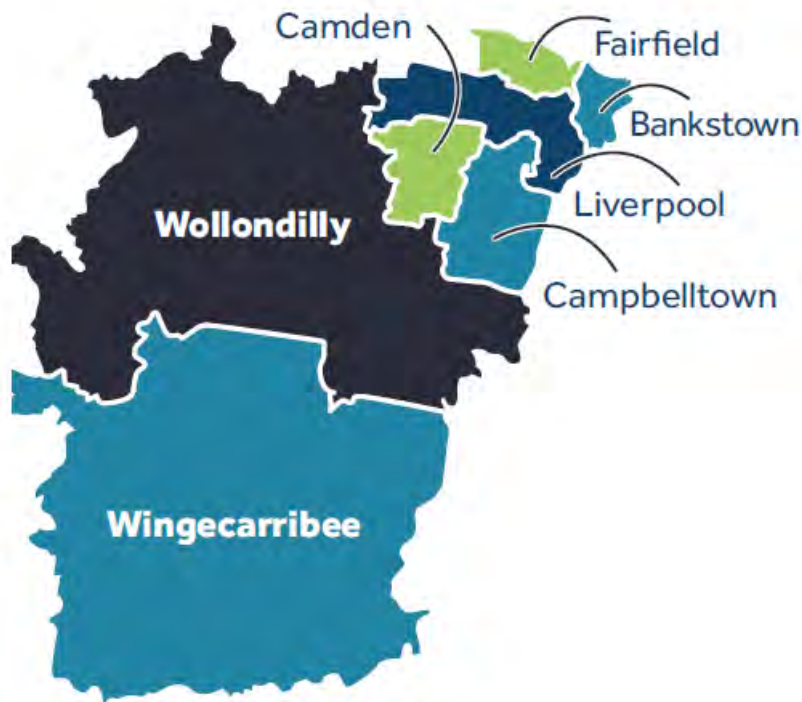


# SWSPHN 2022-2025 Needs Assessment

2024 Update



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# Section 1: Narrative

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# SWSPHN NEEDS ASSESSMENT 2022 – 2025

## *1.1: Needs Assessment process and issues*

This report reflects the key areas SWSPHN has assessed as priority needs in 2022-25. The needs assessment is an ongoing process, which includes literature review, data collection and analysis, stakeholder and community surveys, consultations and focus groups, to identify any emerging needs.

### ***Data collection and analysis***

We analysed demographic and epidemiological data from national, state and local level data sources including (but not limited to):

- Australian Bureau of Statistics (ABS)
- Australian Institute of Health and Welfare (AIHW)
- Medicare and Pharmaceutical Benefits Scheme statistics
- NSW HealthStats
- PHN commissioned services
- Primary Mental Health Care Minimum Data Set (PMHC-MDS)
- Drug and Alcohol MDS
- Clinical and workforce data from General Practices, including, ChilliDB, POLAR and LUMOS
- Data collected from surveys and consultations with stakeholders.

Where possible, data at smallest geographic level (e.g., LGA, SA3, Postcode) has been analysed. We also analysed data from the LUMOS project (a collaboration with the NSW Ministry of Health) which links data from general practices with NSW Health data to follow patient journeys and identify underlying trends and gaps.

### ***Consultations with stakeholders***

SWSPHN is committed to engaging with local communities and health professionals throughout the needs assessment process. Some of our ongoing stakeholder engagement activities include:

- Joint South Western Sydney Local Health District (SWSLHD) / South Western Sydney Primary Health Network (SWSPHN) Population Health and Planning Committee which meets quarterly to advise and review health planning activities
- SWSPHN Community Advisory Committee
- Bi-annual hosting of Local Health Forums across South Western Sydney

These are in addition to area or health need specific consultations and co-design activities. We use face-to-face consultations, phone interviews and an online platform (HealthChat) for the collection of qualitative information from consumers and service providers. Some of the consultations completed in 2023 include:

- How healthcare is provided for older people in the Wingecarribee Shire
- Mental health needs and service gaps
- Suicide prevention services
- Workforce needs and gaps

The needs assessment has synthesised the main themes identified consistently throughout the analysis process and triangulated these with available evidence to identify key opportunities, priorities and options.

Latest consultations have identified gaps in the following key areas:

- **After Hours Services** – Through surveys, focus groups and co-design workshops, we have identified gaps in the areas of comprehensiveness and quality of care, location and out-of-pocket costs as well as waiting times. There are gaps in effective and equitable access to after-hours care, the standard of care being lower than what is provided during business hours, with minimal gap fee and with a blended delivery model (including home visits and telehealth). Low health literacy and different health beliefs are the major barriers for people from culturally and linguistically diverse backgrounds (CALD) to access after-hours care.

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- **Gambling Harm Screening** – Residents in Fairfield experience the worst gambling harm in NSW, with a 2019 survey showing there is a lack of gambling harm screening as well as culturally appropriate services to identify and treat health and social ramifications of problem gambling.
- **Chronic disease** – With the estimated increase in population, there will be an increase in chronic disease burden, which will lead to increase in associated complications and hospitalisations. There is a need for better coordination, planning, regular follow up and review of at-risk patients with multidisciplinary involvement.
- **People from culturally and linguistically diverse background (CALD)** – Surveys and focus groups showed the CALD population have lower levels of health literacy and lower awareness of or access to afterhours services and mental health services due to language and/or cultural barriers.
- **People with mental illness living in residential aged care homes (RACFs)** – Consultations with carers and clinicians at RACFs provided their perspective of the service gaps at RACFs: early identification, timely diagnosis and multidisciplinary team care are needed at RACFs. Predicted increase in people over 65 years of age will increase the demand for dementia, palliative, and end-of-life care.
- **Young people with severe mental health illnesses** – Surveys and consultations with young people and clinicians identified the specific service needs for this group and the need for a specialised, youth friendly and person-centred service. The Psychosocial Needs Assessment, 2021 highlighted there are gaps in community based psychological support for people with mental illness outside of NDIS.
- **Men's suicide prevention** – We consulted with consumers, people with lived experience and clinicians and codesigned proactive, community-led men's suicide prevention support services. Mentoring and support groups have been identified as key strategies to reduce suicide rates in men.
- **Peer Worker Support** – We used surveys, interviews, an online forum and workshops to codesign a peer support model for people experiencing mental health conditions.
- **Older Person's Health** – Through surveys, large-format consultations and focus groups, we have identified gaps in the areas of care navigation, access and equity across the region. Further issues surrounding insufficient services to meet the demands (current and forecast).
- **Medicare-subsidised GP, allied health and specialist health care across local areas: 2021-2022** – Analysis of MBS data showed increased usage of Medicare-subsidised services in SWS between 2020-2021 to 2021-2022. In 2021-2022, service usage has been consistently higher in SWS compared to the national average for the following categories: GP (27% higher), Specialist (13% higher) and Diagnostic Imaging (17% higher). SWS has much higher usage of GP After Hours compared to the national average.
- **Potentially preventable hospitalisations 2017-18** – Around 60% of all chronic condition PPH were among people aged 65 years and over in SWS and nationally. Among all chronic conditions, COPD had both the highest number of PPH and per 100,000 people in SWS and nationally. About 1 in 5 chronic condition PPH were due to COPD.
- **Use of Emergency Departments (ED) for lower urgency care: 2015-16 to 2018-19** – There has been a gradual decrease of after-hours ED presentations for lower urgency care in SWS between 2015-16 and 2018-19. Attendance decreases with age. People aged less than 15 years have the highest attendance while people aged 80 years and older have the lowest attendance.

### Workforce

SWS has the lowest number of general practitioners per capita of any region in Greater Sydney and much lower than the NSW average. This shortage of skilled workforce has been accelerated by the pandemic. The region does not have enough GPs, Psychiatrists, Practice Nurses, early childhood nurses, palliative care professionals to meet the demands of a growing population. SWSPHN has commenced the development of a primary care workforce strategy in partnership with Western Sydney and Nepean Blue Mountains PHNs. The objectives of the strategy are to identify and address current and emerging workforce shortages and ensure the workforce is responsive to the local needs with suitable clinical and cultural competency.

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## ***Digital Health***

The new PIP Quality Improvement (QI) Incentive for General Practices started on 1 August 2019. In our region, 255 practices submit PIPQI data. There has been a great demand to support practices with the data submission and use POLAR to analyse and use the data for quality improvement. Currently, 147 local practices are participating in Lumos which enables data linkage between NSW Health and practices. Lumos data insights will help us analyse service gaps and needs at a granular level, while also helping participating practices to better understand their patient cohort and their journey through the health system.

Electronic prescription was recognised by Commonwealth legislation as an alternative to paper prescriptions. We assist primary care providers to adopt and use electronic prescribing and electronic pathology ordering.

Currently 86 practices have Integrated Real-time Active Data (iRAD) installed, which enables participating providers to view historical patient data of patients who have consented between participating providers in our region. We anticipate iRAD will have view access between HealtheNet (NSW Health hospital data) and vice versa in the coming year. It prevents duplication, facilitates communication, and overall, improves coordination of care between providers.

## ***Synthesis and triangulation***

The needs assessment has synthesised the main themes, identified consistently throughout the analysis process, and triangulated these with available evidence to identify key opportunities, priorities and options. Issues and needs from literature review, data analysis and consultations were summarised into themes. A prioritisation process was applied to identify the emerging priorities for SWSPHN. The process included the following evidence-based criteria:

- Scale of the issue – number of people affected, prevalence/incidence of the issue, trends over time
- Benchmarking of the issue – benchmarking against national/state, neighbouring regions, comparisons of smaller geographic areas within SWS, comparison between population groups
- Impact of the issue – consequences of the issue, consequences of inaction
- Inequity of the issue
- Practicality of addressing the issue

The prioritisation was undertaken with SWSPHN Population Health Steering Committee and Subject Matter Experts at SWSPHN to ensure it was balanced and views of different stakeholders were considered.

## ***1.2: Additional Data Needs and Gaps***

Due to the impact of COVID-19 pandemic in 2020-2021, we had to cancel many of our planned face-to-face consultations and pivot to online platforms to engage stakeholders. It has been challenging to rely on online tools as the main source of data collection. SWSPHN held face-to-face consultations and co-designs in early 2022. Due to the impact of the COVID-19 Omicron wave, SWSPHN had to revert to online engagements for the remainder of the year. The bi-annual Local Health Forums were facilitated face-to-face in 2023 which improved quality and volume of stakeholder feedback.

There is generally a lack of disease prevalence and health services data at smaller geographic levels (LGA, SA3, Postcode), such as mental illness prevalence, communicable diseases, MBS and hospitalisations. It is difficult to assess the current needs without current data. In addition, as health data is collected by different government agencies and care providers, the care patients receive, and the outcomes they experience, is fragmented. To better understand a patient's journey in the health system, linking data from the whole of system would be necessary.

We also identified data gaps in the following population groups:

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

- Aboriginal and Torres Strait Islander population
- People from culturally and linguistically diverse background (CALD)
- People experiencing homelessness and those at risk of homelessness
- People experiencing domestic and family violence
- LGBTQIA+ communities

The Standards for Statistics on Cultural and Language Diversity developed by ABS recommend four variables in the minimum core set of Cultural and Language Indicators:

- Country of Birth of Person
- Main Language Other Than English Spoken at Home
- Proficiency in Spoken English
- Aboriginal and Torres Strait Islander Status [10]

Currently most data collections by Commonwealth, State and Territory agencies and other relevant national agencies do not include most of the above variables. This data gap leads to insufficient evidence for better understanding of the health needs of the Aboriginal and Torres Strait Islander and CALD populations.

### ***Disaster affected communities***

The 2019-20 bushfires impacted the Wingecarribee and Wollondilly Shires, with many businesses and homes destroyed. The most recent 2022 floods affected the Camden, Wollondilly and Wingecarribee LGAs.

SWSPHN had provided funding for counselling and other mental health services, coordinated services to help the community navigate access, and has supported recovery to promote resilience and social connections. Community consultations identified a need for community-led engagement and capacity building in disaster preparedness.

In 2023, SWSPHN commenced planning and coordinating a disaster management response for general practices in SWS.

### ***Health Impact of COVID-19***

The COVID-19 pandemic with constantly evolving variants has posed major challenges to the delivery of health services.

A 2020 survey of Australian general practices found general practices have undertaken major innovation and realignment to respond to staff safety and patient care challenges during the COVID-19 pandemic. Increased administration, reduced billable time, managing staffing and pivoting to telehealth service provision had negatively affected practice viability and patient care. This continued to be reflected in a 2021 survey, with particular challenges related to vaccine rollout. Almost three in five GPs (59%) reported that managing patient expectations about vaccinations is one of the most challenging issues. The second-most reported challenge is finding a financially viable way to provide COVID-19 vaccinations (37%), with another 33% reporting financial pressure. The pandemic forced many aged care providers to lock down their facilities and residents endured months of isolation which has had, and continues to have, a terrible effect on their physical, mental and emotional wellbeing.

A review of existing literature shows COVID-19 is associated with adverse mental health impacts and long-term complications (e.g., long COVID). In March 2020, temporary MBS telehealth consultations were introduced. From August 2020 additional 10 Medicare subsidised psychological therapy services became available under Better Access. The most recent lockdown in NSW and SWS has presented new challenges such as increased demand for crisis support services. SWSPHN recognises that a range of services (such as Head to Health) will continue to be needed to support the local recovery from COVID-19. To understand the changes in service usage we will need access to recent MBS data.

### 1.3: Additional comments or feedback

Clarity on the format of needs assessment submissions would be very helpful. Currently, there is limited guidance as to the format the DoHAC would like needs assessments to be submitted. For example, we currently draft our submissions to include both wording and charts, however we have seen other needs assessment submissions from other PHNs which utilise infographics to demonstrate needs.

Throughout the needs assessment process, we often find the health needs and service needs are interrelated, and in many cases, it's better to assess them as one. The current format of having separate sections for health and service needs makes it difficult for the audience of the needs assessment to connect the issues and evidence. This decreases the utility of the document for our stakeholders and requires us to create an audience-friendly communication of this information for stakeholders as they enquire. A more intuitive format would be helpful to increase efficiency and utility of the information presented in this needs assessment.

We will continue to build partnerships with the relevant organisations such as the Local Health District, the local governments, non-government organisations, community organisations, universities and neighbouring Primary Health Networks to better understand and address the health needs of our region.

We will also further develop our community consultation strategies to find ways to better engage with hard-to-reach groups.



# Section 2: Outcomes of the Health and Service Needs Analysis

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*Note: The SWSPHN Needs Assessment has combined Sections 2 and 3 of the Department of Health and Aged Care Needs Assessment template into a single section for ease of reading*

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## Section 2.1: Demographics, Growth and Access to Health Services

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## 2.1.1 General Population

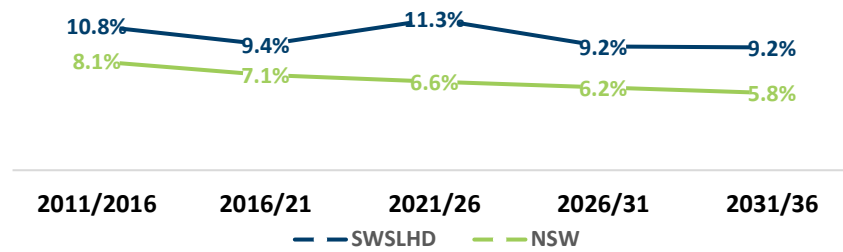
### Current population and expected growth

SWS is one of the fastest growing regions in the state, driven mostly by greenfield developments and urban intensification. The population grew to 1,057,080 people in 2021, an increase of 9.6% from 2016 (ABS, 2022).

<b>Key Issue for our region</b>	<b>South Western Sydney continues to experience significant population growth, particularly in greenfield areas, putting continued pressure on healthcare access across the region</b>
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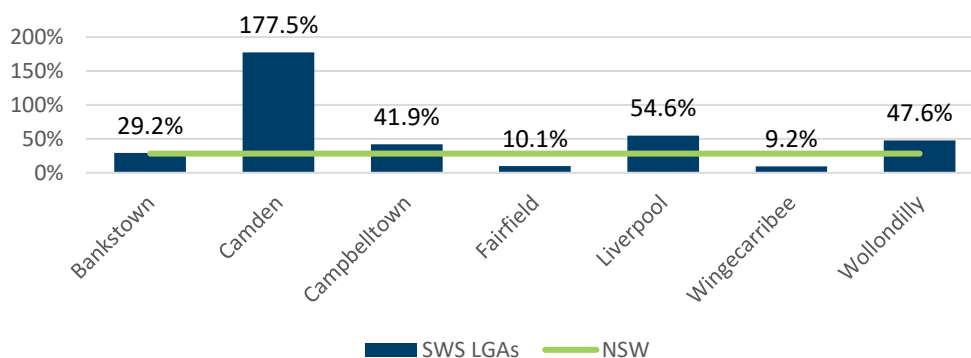
Between 2021 and 2026, the SWS population is projected to grow by 11.3% and will increase to 1,402,810 by 2036 with a need for an additional 184,500 homes between 2016 and 2036 (ABS, 2022). SWS was expected to have an increase of approximately 42,000 new housing units in the five years to 2021-22, with 12,350 of those in the Camden LGA (DPE, 2018).

Figure 1: Projected population growth in South Western Sydney and NSW, 2016-2031(DPE, 2016)



All LGAs across South Western Sydney will experience population growth over the next 15 years ranging from 7.3% in Fairfield LGA to more than double growth in Camden LGA. The Macarthur region which includes Camden, Campbelltown and Wollondilly LGAs will experience the most rapid population growth of 58% by 2031 due mainly to the growth in greenfield areas.

Figure 2: Projected population growth in South Western Sydney by LGA, 2016-2031(DPE, 2016)



It is estimated that by 2031, the working age population (15 to 64 years) will make up most of the population (61.6%), followed by children aged 0-14 years (21.3%) and people over 65 years of age (17.1%).

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## Socio-economic status

The SEIFA Index of Relative Socio-economic Disadvantage (IRSD) has a base of 1,000 for Australia, where scores above 1,000 indicate relative lack of disadvantage and those below 1,000 indicate relatively greater disadvantage.

<b>Key Issue for our region</b>	<b>South Western Sydney has significant pockets of socio-economic disadvantage</b>
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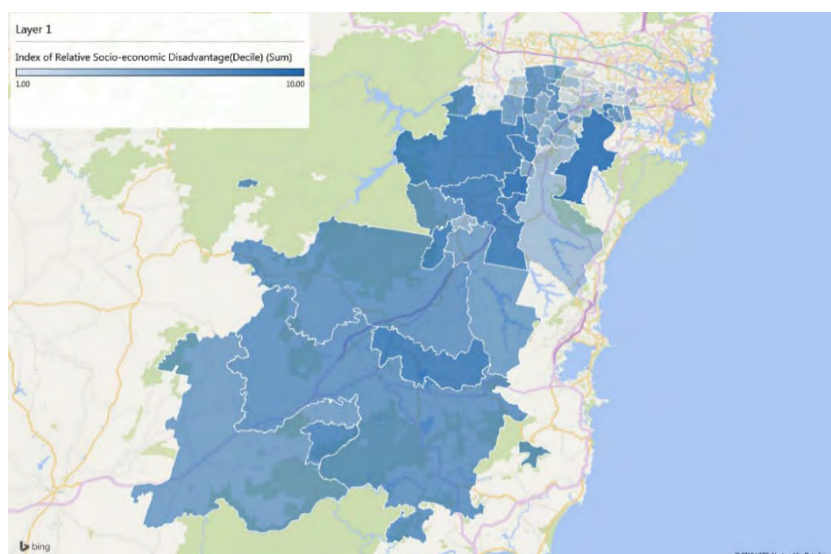
SEIFA 2016 by SA1 shows more than 70% of the population in SWS resides in areas with (IRSD) decile below 5; 24% of the population reside in the most disadvantaged areas decile.

**Table 1: Local Government Area (LGA) Index of Relative Socio-economic Disadvantage (IRSD), 2016(ABS, 2018a)**

2016 Local Government Area (LGA) Name	IRSD		Index of Economic Resources		Index of Education and Occupation	
	Score	Decile	Score	Decile	Score	Decile
Camden (A)	1056	10	1104	10	1003	8
Campbelltown (C) (NSW)	950	4	977	5	932	4
Canterbury-Bankstown (A)	935	3	956	3	967	6
Fairfield (C)	856	1	943	2	882	1
Liverpool (C)	952	4	1008	8	953	5
Wingecarribee (A)	1034	9	1046	10	1025	9
Wollondilly (A)	1043	9	1096	10	977	7

Within SWS LGAs, Fairfield LGA is the most disadvantaged LGA with IRSD of 1, followed by Bankstown, Campbelltown and Liverpool. Across postcodes, there are pockets of disadvantage, mostly in the metropolitan areas as shown in Figure 3 below. Six SWS suburbs were ranked among the most disadvantaged in NSW: Claymore (1) Airds (2), Miller (7), Cartwright (14), Sadleir (15) and Villawood (17).

**Figure 3: Postcode (POA) Index of Relative Socio-economic Disadvantage, 2016**



Assisting Communities through Direct Connection reports were completed in 2022 for Cabramatta and Wollondilly LGAs (ACDC, 2022a) (ACDC, 2022b). Both regions identified financial stress, housing issues and the COVID-19 pandemic as the largest areas of both community and personal concern.

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

There is strong evidence from Australia and other developed countries that low socioeconomic status has a direct correlation with poor health, higher incidence of risky health behaviours and reduction in access to health care services (Mathers, 2000, Blakely T, 2004).

### People living with a disability

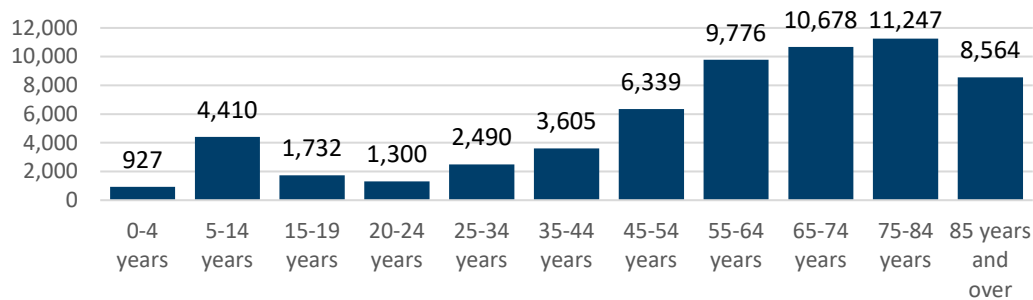
People living with a disability often have higher levels of illness than the general population such as multiple chronic and complex care issues. People with an intellectual disability are more likely than the rest of the population to be under-diagnosed or under-treated. They also face significant financial and physical barriers to accessing health services as well as discrimination (AIHW, 2010).

#### Key Issue for our region

**South Western Sydney has a higher percentage of people living with a disability, resulting in increased demand for health services**

In 2016, 5.7% (61,069) of the population in SWS had a profound or severe disability, higher than the NSW average of 5.4% and an increase of 11,000 compared with 2011 (AIHW, 2017a). About half of the people living with disability in SWS were aged over 65 years. Within SWS, Fairfield (7.6%) and Bankstown (6.5%) LGAs had the highest proportion of people with disability (ABS, 2016c).

Figure 4: Number of South West Sydney residents with profound disability by age group, 2016 (AIHW, 2017a)



### Access to housing

The rate of homelessness in SWS was 20 per 10,000 compared to 42 per 10,000 for NSW in 2010. This excludes Wingecarribee, which is reported under the Illawarra region, with the rate of 34 per 10,000 and had the second highest number of homeless people for this region. In 2010 homelessness is more prevalent in Bankstown (388) and Fairfield (325). Approximately 25% of NSW residents living in severely crowded dwellings reside in SWS according to the 2010 report.

The primary reason people sought Specialist Homelessness Services Program (SHS) accommodation was domestic violence (30% in SWS compared with 15% for NSW), time out from family and relationship breakdown and eviction (7% compared with 4% for NSW). Local clients of housing support are generally younger than the state average and more likely to be female, either alone or with children (DHS, 2010).

#### Key Issue for our region

**South Western Sydney has a high proportion of over-crowded residences and unstable housing**

Expected waiting times for social housing are greater than 10 years for any kind of property in Liverpool and Fairfield. Campbelltown (11.9%), Bankstown (9.7%), Liverpool (8.1%) and Fairfield (8.0%) have a higher proportion of people renting social housing compared with NSW (4.9%) (Housing-NSW, 2013).

People who are homeless experience numerous other barriers to service access due to issues such as disengagement with the health sector, lack of a GP, Medicare card or health insurance, and no fixed address or contact details. Among

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

issues raised through SWSPHN consultations in the Fairfield LGA was lack of specialised homelessness services for frail aged people.

### Access to primary care services

SWS has the lowest number of general practitioners per capita (112 per 100,000) of any part of the greater Sydney metropolitan area, much lower than the NSW average (120 per 100,000). Shortage of health workforce may result in people delaying or not seeking treatment, increased avoidable hospital presentations, and poorer health and wellbeing outcomes.

<b>Key Issue for our region</b>	<b>South Western Sydney has the lowest number of GPs per capita of any part of the greater Sydney Metropolitan Area with higher rates of older GPs and solo GP practices</b>
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Due to the rapid population growth in SWS, the service needs to see GPs have been increasing. Many general practices in SWS are having difficulties to recruit GPs to work in the area. NSW legislative council 2020 report highlighted anecdotal evidence from medical professionals that it was difficult to get health care workers to live and work in SWS, as opposed to areas of Sydney. Many medical professionals working in SWS live in other parts of Sydney and face long commutes to work. Other reasons identified were poorer and stressful working conditions compared to other health districts, including heavy workloads, lack of resources and limited career paths.

South Western Sydney has an ageing GP workforce, with 23% of GP FTEs over the age of 65 compared to the national average of 16%. South Western Sydney also has a higher rate of solo, non-accredited practices as well as bulk-billing practices. Due to GPs electing to retire and the rising costs of doing business, South Western Sydney has seen 22 practices close since September 2022 with another 5 indicated they are at high risk of closure due to not being financially viable.

These difficulties have resulted in a dependence on overseas medical professionals but hiring Overseas Trained Doctors (OTD) is difficult because the section 19AB of the Health Insurance Act 1973 have placed restrictions on where OTDs can work.

Table 2: Number of General Practices and General practitioners by LGA, SWS, 2021 (SWSPHN, 2021a)

LGA	Number of practices	Percentage of total	Practices per 100,000 population	Number of GPs	Population	GPs per 100,000 population
Bankstown	98	21.0%	48.1	229	203,660	112
Camden	27	5.8%	33.4	140	80,920	173
Campbelltown	62	13.3%	37.7	213	164,420	130
Fairfield	116	24.8%	56.2	227	206,270	110
Liverpool	83	17.8%	38.8	221	214,090	103
Wingecarribee	20	4.3%	41.9	80	47,740	168
Wollondilly	16	3.4%	32.4	49	49,350	99

There is significant regional variation in the GP workforce, from 99 per 100,000 population in Wollondilly to 173 per 100,000 population in Camden. The areas of greatest need for additional GPs within South Western Sydney include:

- Oakdale due the limited number of GPs (2.5 per 10,000 population)
- Fairfield and Bankstown (ageing workforce without new GP replacement)
- Camden (current workforce unable to meet expected population growth)

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

- Liverpool (nine practice closures since September 2022 due to GP shortages)

Many GPs request workforce support from the PHN, with requests ranging from assistance to advertise and help navigating NSW health and Department of Health workforce support programs such as Area of Need, District of Workforce Shortage programs.

Issues raised through community and GP consultation included:

- Community concern regarding attracting health care professionals to SWS, particularly the southern sectors of Wingecarribee and Macarthur
- Need for funding for early intervention and general preventative/educational projects
- Providing workforce support, such as resources and professional development on chronic disease care to GPs and nurses
- Poor access to psychiatrists
- Services targeted to the Aboriginal community highlighted that cultural competency should be included in the education and training of entire health workforce
- Multicultural Health Workers are underutilised by clinicians.

<b>Key Issue for our region</b>	<b>Many previously bulk-billing GP practices are now moving to mixed billing or gap payment reducing access to primary care for many SWS residents due to affordability of care</b>
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Community consultation regarding primary care access indicated concerns with long waiting times (82% of respondents) and lack of bulk-billing practices (62%). South Western Sydney has always had a high bulk-billing rate (83%), but this has been dropping over the past 12 months with many practices moving to mixed billing or gap payment.

Feedback from the community has indicated that many residents are now delaying visiting their GP unless absolutely necessary due to the financial cost, resulting in a decrease in preventative health care. It also coincides with an increase in Category 4 and 5 presentations to Emergency Departments, particularly in Camden and Campbelltown LGAs.

### ***Primary care professional development***

Following the COVID-19 pandemic, GPs have indicated a shift in preference regarding CPD training with only 88% of CPD survey respondents indicating they preferred either virtual or a mixture of virtual and face to face training events (SWSPHN, 2022). The top five clinical areas for CPD events were:

- Mental health
- Aged care
- Diabetes
- Women's health
- Preventative health

### ***Recruitment and retention of nurses at General Practices***

To better understand the needs of the nurses working in General Practices (GPNs), SWSPHN collaborated with University of Wollongong in two studies of the GPNs in SWS. One study showed low job satisfaction among GPNs, caused by lack of clinical supervision/mentoring (35.6% of respondents), unsatisfactory pay (40% of respondents) and inadequate staffing (23.3% of respondents). The second study of new graduate nurses at general practices in SWS showed that (McInnes, Halcomb et al., 2019):

- New graduate nurses had limited understanding of general practice nursing
- General Practices often lacked policies and resources to support new graduate nurses
- Workplace culture and acceptance into the team were seen as crucial in optimising the new graduates experience in general practices
- Support from mentors and practices was key to a positive experience for new graduate nurses.

# SWSPHN NEEDS ASSESSMENT 2022 – 2025

## Access to community health services

SWS has more than 60 sites including early childhood and other centres from which community health services are delivered. Eleven of these are major community health centres. Community health facilities have inadequate space to respond to the high demand for services (lack of treatment and meeting rooms, office areas and parking spaces); and to respond to specific needs e.g., needle and syringe program facilities.

Other specialist clinical services which provide care in community settings will experience increased demands as their target populations and their health needs grow, including oral health, drug health, mental health, aged care and rehabilitation, respiratory and cardiovascular. There is also increased demand on services in areas with more vulnerable populations and complexity of their health problems (e.g. people from low socioeconomic backgrounds, Aboriginal people and people from non-English speaking background including refugees(SWSLHD, 2013a).

Issues raised through the consultations include:

- Lack of community-based services from chronic and palliative care in Wingecarribee
- Lack of home visiting nurses for patients with a long-term chronic condition, including severe mental illness
- Service closure has a high impact on the community
- Mental health respite services are minimal.

## Access to private health services

In 2016-17 in SWS:

- 44.6% of adults reported having private health insurance in the preceding 12 months, much lower than national average (57.4%)
- 7.1% of adults delayed or did not see a medical specialist, GP, get an imaging test and/or get a pathology test when needed due to cost in the last 12 months, higher than the national rate (7.6%)
- 8.9% of adults delayed or avoided filling a prescription due to cost (national rate of 7.3%)
- 18.5% of adults did not see or delayed seeing a dentist, hygienist or dental specialist due to cost, similar with the national rate (18.4%) (AIHW, 2018a).

The National Health Performance Authority (NHPA) reports on surgery waiting times shows:

- Bowel cancer surgery patients: treated within 30 days Bankstown >= 90%, Campbelltown 76%, Liverpool 78%
- Breast cancer surgery patients: treated within 30 days - Campbelltown 83%, Bankstown, Liverpool all >= 90%, Fairfield, Bowral 100%
- Lung cancer patients: treated within 30 days - Liverpool 47%
- Elective surgery waiting time - % of patients seen within clinical urgency - 100% for Bankstown, Campbelltown, Fairfield and Bowral(NHPA, 2013).

**Key Issue  
for our  
region**

**South Western Sydney has half the private hospital beds and day-procedure centres than other areas of Sydney**

South western Sydney has fewer private hospitals and other services than in other parts of Sydney. Only 4% of private hospital beds and 6.5% of day procedure centres in NSW are in SWS and there are more than twice as many private beds in the northern, eastern and southern parts of Sydney compared with SWS. This gap in private supply together with lower levels of private health insurance resulted in poorer use of private hospitals with 27% of care of SWS residents provided by private hospitals compared with 36% of NSW residents overall(SWSLHD, 2013b).

Issues identified in the consultation include:

- Need for affordable training for NGO staff, including areas such as patient education/support programs on chronic diseases and care
- Significant support among providers for multidisciplinary team models



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- Equitable distribution of Early Childhood Nursing resources and activity
- Concerns regarding the undersupply of child allied health therapists

### Access to after-hours services

#### Utilisation of after-hours services

Between 2020-21 and 2021-22-, there has been a steady decline in Medicare subsidised GP after-hours services usage in both SWS and nationally. In SWS, GP After-hours attendance decreased from 64.2 per 100 people in 2020-21 to 54.9 per 100 people in 2021-22, much higher than national average of 29.6 per 100 people (2021-22). Females have higher attendances compared with males. People aged 80 years and over have the highest attendances among all age groups (125.8.0 per 100 people). Across SA3 areas, Campbelltown has the highest attendances, followed by Bankstown and Fairfield.

<b>Key Issue for our region</b>	<b>Significantly higher utilisation of after-hours services in South Western Sydney</b>
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Lower urgency care are ED presentations at a formal public hospital ED, where the patient:

- did not arrive by an emergency services vehicle
- was assessed as needing semi-urgent or non-urgent care, and
- was discharged without referral to another hospital [3].

Some lower urgency presentations to hospital ED may be avoidable through provision of other appropriate health services in the community [3].

Between 2015-16 and 2017-18, the use of ED for this type of care has fallen both nationally and in SWS. In SWS, there has been a gradual decrease of after-hours ED presentations for lower urgency care, from 54,453 in 2015-16 to 52,413 in 2017-18, slightly lower than national average. Among all age groups, people aged less than 15 years have the highest attendance, while people aged 80 years and older have the lowest attendance. Across SA3 areas, Southern Highlands has the highest attendance, followed by Camden and Wollondilly. Fairfield has the highest number of presentations, followed by Campbelltown and Bankstown.

Community surveys show overall awareness of after-hours services is high (82%) in SWS. However, people are more likely to go to hospital ED (35.4%) than use after hours service (23.6%) or go to another GP that is open (17.3%). Issues raised through community consultations include:

- Confidence in differentiating between urgent and non-urgent conditions is low
- Lack of ancillary services compared to hospital or services during sociable hours (e.g., no access to pathology, radiology, specialists and pharmacy)
- Obscure or inaccessible locations (e.g., due to actual distance from home or limited access via public transport routes)
- Out of pocket costs for after-hours primary healthcare services
- Limited workforce associated with unappealing hours
- Waiting time is perceived as too long and comparable to hospital waiting times.

Service needs identified through consultations include:

- Effective and equitable access to medical care in after-hours period to all residents of SWS
- Minimise out-of-pocket expenses for after-hours medical care (no co-payments)
- Blended delivery of service – after-hours facility, home visit, telephone and telehealth consultation
- Interactions in after-hours period communicated effectively and in a timely manner to a patient's regular GP
- Coverage for RACFs across SWS
- Encourage and support more GP practices to operate their own after-hours service provisions.

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

### **Emergency Department presentations for lower urgency care**

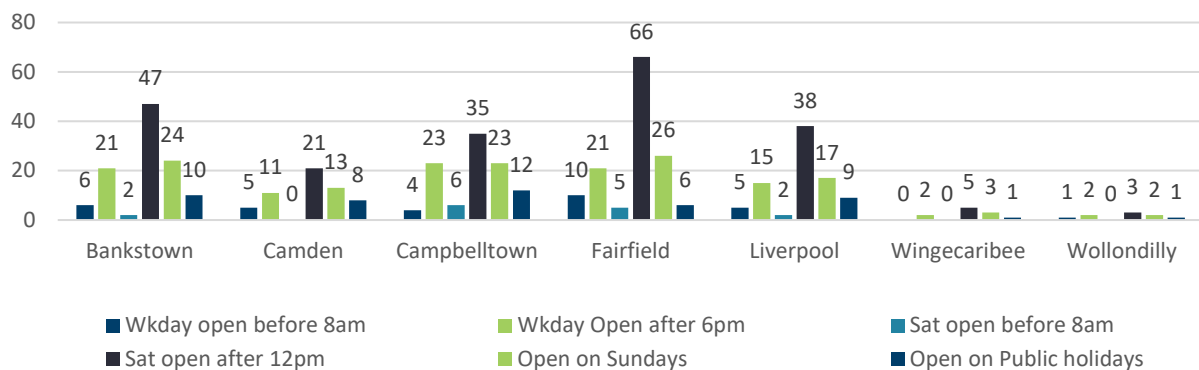
Between 2015-16 and 2017-18, the number of ED presentations for lower urgency care remains similar. During a 24-hour period, the number of ED presentations starts to increase from around 5am, and reaches the peak at around 11am, then gradually declines from 7pm to 5am. In 2019-2020, there were 82,996 ED presentations from SWS residents. 41.9% of all ED presentations are lower urgency care (Triage category 4 & 5).

The most common diagnosis for lower urgency care ED presentations is unknown and unspecified causes of morbidity, unspecified abdominal pain and unspecified injury. 84.8% (29,503 presentations) of the presentations which were self-referred or referred by family and friends, 9.7% (3,375) were referred by a General Medical Practitioner or Dentist (not hospital based), 1.1% (374) were referred by other hospital in the LHD, and 0.5% (166) were referred by RACFs. Most of the lower urgency ED presentations arrived between 10am and 7pm.

### **General practices opening after hours in South Western Sydney**

128 general practices in SWS operate after hours (before 8am or after 6pm) during weekdays. There is significant variability in opening hours across the region, with majority of the after-hours practices located in the Campbelltown, Fairfield, Bankstown and Liverpool LGA. Most of the practices close by 8pm. There's no general practice operating after 8pm in Wingecaribee and Wollondilly LGA(SWSPHN, 2020).

Figure 5: General Practice opening after hours by LGA, SWS, 2019(SWSPHN, 2020)



### **Data sharing between primary and secondary care services**

Data sharing between mainstream health services and GPs in the area through electronic referrals and hospital discharge reports is poor. GPs have limited to no access to hospital pathology therefore unnecessarily duplicate effort. NSW Health transition to HealtheNet may address some of these issues.

Issues raised through the consultation:

- The My Health record system is seen as an important tool by the community
- Perceived cultural clash between the government promoting My Health record and community concerns about privacy and confidentiality

Opt-out My Health Record reform provides a positive opportunity to address data sharing between providers.

### **Barriers to accessing healthcare for rural areas**

SWS consumers, NGOs, and LHD staff continue to raise, and report concerns in relation to limited transport options which would enable access to a range of services across the region to meet their needs. Community transport options are available but are insufficient to cope with demand. Safe, timely and affordable transport in the after-hours period is a community concern.

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Recent consultations have highlighted access to acute GP care in the after-hours period as a significant barrier. Limited access to GPs is a contributing factor for older people self-presenting to ED for low-acuity issues. Poor access to home visits, same day appointments, and the lack of GPs in Wingecaribee have been raised as concerns.

The built environment, such as poor infrastructure, impacts access to healthcare in rural areas. Older people are at highest risk of mechanical falls within community due to poor mobility and balance issues.

There is disproportionate access to healthcare services in Wingecaribee compared to other regions in SWS. Consultations have indicated the availability of services, both public and private, do not meet the demand of older person's health needs and goals. Need for increased access to falls prevention clinics, specialist geriatricians, and pain clinics were emphasised.

## 2.1.2 First Nation’s Community

SWS includes the traditional boundaries of the Dharawal, Gundungurra and Darug nations. Migration and historic settlement patterns have resulted in the diverse Aboriginal community of SWS, made up of people from across the state and country. Although sharing many similarities, Aboriginal people also have significant individual and cultural differences.

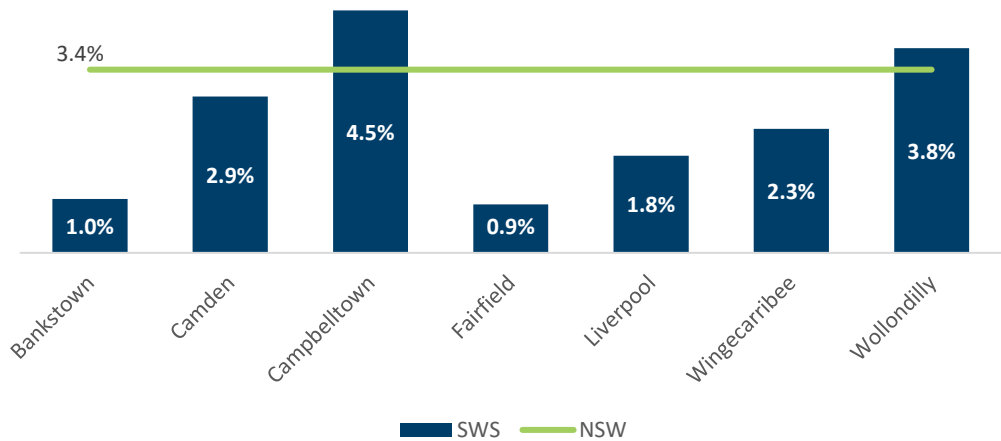
### Current population and expected growth

In 2016, about 20,181 people in SWS identified as Aboriginal and Torres Strait Islander, representing 7.7% of the Aboriginal and Torres Strait Islander population in NSW and 2.1% of the total South Western Sydney population (compared with 3.4% for NSW). This is an increase of 7000 Aboriginal and Torres Strait Islander people from the Census 2011.

<b>Key Issue for our region</b>	<b>South Western Sydney has a large urban First Nation’s community</b>
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There are considerable variations between LGAs in the proportion of the population identifying as Aboriginal and Torres Strait Islander. In SWS more than a half of the Aboriginal and Torres Strait Islander population live in the Macarthur region, mainly in Campbelltown 36%, and further 18% in Liverpool LGA (ABS, 2016c, SWSLHD/SWSPHN, 2018).

Figure 6: Proportion of Aboriginal population in South Western Sydney by LGA, 2016[2]



There are considerable variations between LGAs in the proportion of the population identifying as Aboriginal. In SWS more than a half of the Aboriginal population live in the Macarthur region, mainly in Campbelltown 36.3%, and further 18.7% in Liverpool LGA (Table 54).

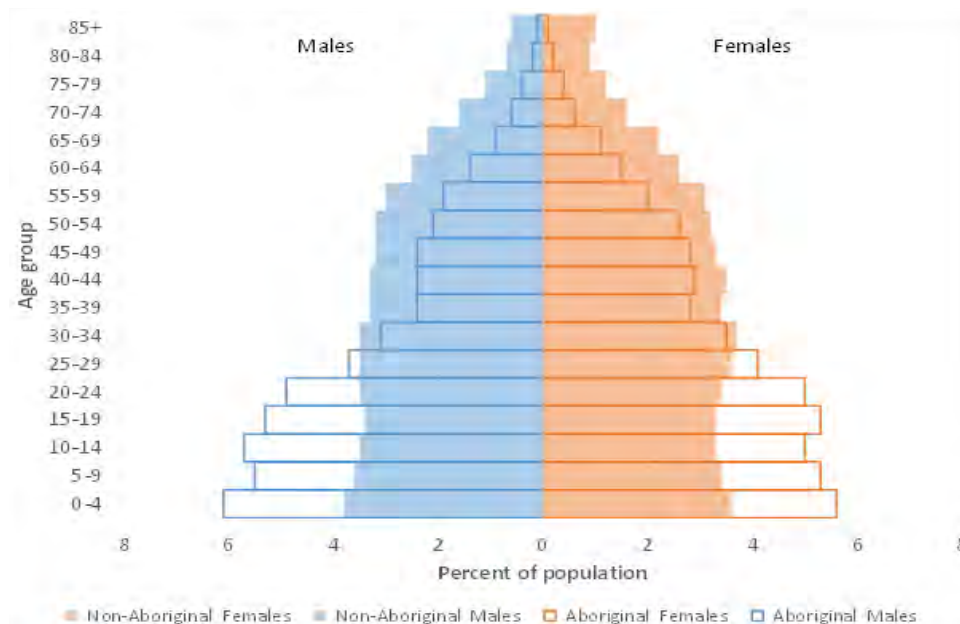
The age profile of the Aboriginal community in South Western Sydney reflects the same pattern as for Australia and NSW. The SWS Aboriginal community is much younger than the non-Aboriginal and Torres Strait Islander population, with the median age for Aboriginal population in 2016 being 23 years of age compared with 38 years of age for non-Aboriginal and Torres Strait Islander population.

Almost half of the Aboriginal population in SWS is aged less than 20 years, compared to around 30% for the non-Aboriginal population. The proportion of children aged 0-14 years (35.7%) and youth aged 15-24 years (20%). Very few

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

Aboriginal people are aged 65 years and over, with only 488 people or (3.7%) of the Aboriginal population in this age group compared to the non-Aboriginal population (11.7%)(ABS, 2016a).

Figure 7: Aboriginal and non-Aboriginal population in South Western Sydney by age group and gender, 2016[2]



### Socio-economic status

SWS includes pockets of significant socioeconomic disadvantage, in communities such as Claymore, Airds, Miller and Cartwright. These suburbs have traditionally had high levels of social housing stock and have been home to a high proportion of Aboriginal people. Aboriginal people are also disproportionately represented in the criminal justice system, with rates of incarceration at least 14 times higher than the general population.

<b>Key Issue for our region</b>	<b>First Nation's communities experience higher levels of socio-economic disadvantage</b>
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Compared with 2011 Census, the 2016 Census shows some areas worsened for Aboriginal people including: homeownership, preschool education and disability(ABS, 2016a).

Table 3: Demographic characteristics of Aboriginal population in SWS, change between 2011 and 2016(SWSLHD/SWSPHN, 2018)

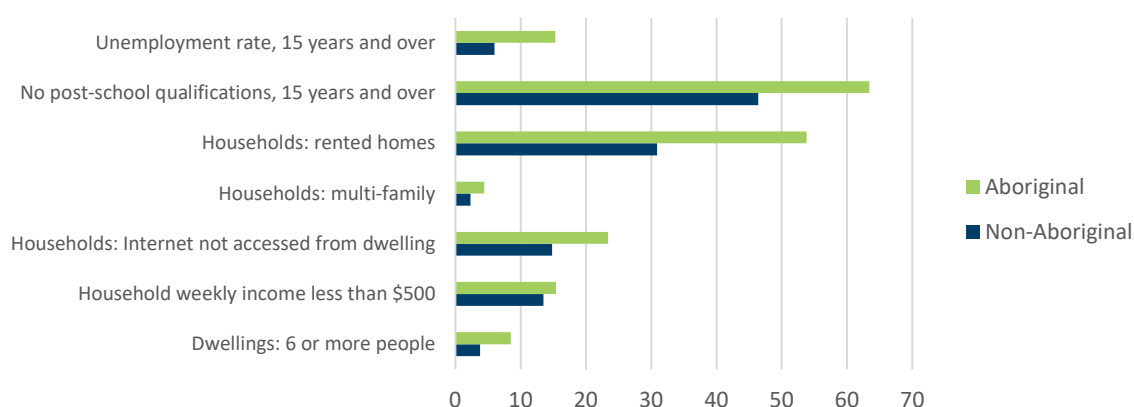
Indicators	Canterbury - Bankstown	Camden	Campbelltown	Fairfield	Liverpool	Wingecarribee	Wollondilly
Home - ownership	Rate worsening	Rate worsening	No change	Improvement	No change	Improvement	No change
Personal income	Improvement	Improvement	Improvement	Improvement	Improvement	Improvement	Improvement
Household income	Improvement	Improvement	Improvement	Improvement	Improvement	Improvement	Improvement
Preschool education	No change	Rate worsening	No change	Improvement	No change	Rate worsening	Rate worsening
Children at school	Improvement	Improvement	Improvement	Improvement	Improvement	Rate worsening	No change
Average years of schooling	No change	Improvement	No change	No change	Improvement	No change	No change
Disability	Rate worsening	No change	Rate worsening	No change	No change	No change	No change

■ Improvement
 ■ No change
 ■ Rate worsening

Figure 7 below shows the difference between Aboriginal people and non-Aboriginal people in NSW relation to some key determinants.

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

Figure 8: Socioeconomic factors by Aboriginality, NSW 2016[4]



### Utilisation of Aboriginal Health Assessments

Numbers of Aboriginal health assessments (MBS item 715) performed by GPs in SWS has been increasing between 2012 and 2017. Within SWS region (SA3), Campbelltown has the highest percentage of patients (2,020 people or 55% in 2016-17)(DoH, 2018).

Table 4: MBS data,715, GRP and Financial Year, 2016-17 SWSPHN(DoH, 2018)

Year of Processing	Number of providers	Number of patients	Services
2012-13	182	2089	2124
2013-14	245	2493	2539
2014-15	260	2776	2823
2015-16	267	3446	3539
2016-17	274	3675	3734

Table 5: MBS data by SA3, 715, 2016-17, SWSPHN(DoH, 2018)

SA3 Name	Number of providers	Number of patients	Services
Southern Highlands	24	151	153
Bankstown	32	91	91
Camden	21	262	268
Campbelltown (NSW)	91	2020	2057
Wollondilly	17	154	154
Merrylands - Guildford	19	62	62
Bringelly - Green Valley	24	450	462
Fairfield	19	153	155
Liverpool	26	332	332
SWSPHN	274	3675	3734

### Health Equity and Access issues

Aboriginal people may experience a range of barriers to accessing health care including but not limited to:

- Cultural barriers, including a lack of culturally safe and competent health services

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

- A lack of trust in the health service as a result of transgenerational trauma
- Social determinants of health, including income, employment status, education and housing
- Inability to meet the financial obligations for treatment, including transportation to and from appointments.

These barriers may also limit Aboriginal people from participating in preventative health programs, and may cause an Aboriginal person to delay seeking medical attention for their condition until well after the onset of the ailment(SWSLHD/SWSPHN, 2018).

### ***Specific Aboriginal health services***

Specific Aboriginal health services have been successfully established to support health and wellbeing in the Aboriginal community by means of providing culturally safe and holistic health care for Aboriginal people in SWS. Tharawal Aboriginal Medical Service and Gandangara Health Services are examples of non-government primary health care providers established to meet the specific health needs of Aboriginal communities. The intersection and collaboration between Aboriginal Community Controlled Health Organisations and SWSLHD is essential in addressing health inequity for Aboriginal communities. Issues raised through consultations:

- 5As initiative should include intergenerational drug abuse among Aboriginal communities
- Need for workforce interventions to attract and support Aboriginal people to be trained in specialised areas such as psychology and counselling, nursing and midwifery, and other supports
- Services need more Aboriginal liaison positions, and employing staff of Aboriginal background
- Cultural barriers when accessing cancer screening, cancer services and prohibitive cost of cancer treatment
- Lack of awareness among some GPs of cultural safety, Closing the Gap initiative and other Aboriginal specific programs
- Lack of awareness of cultural issues associated with mental illness and available support services
- Group model approach interventions are preferred in the Aboriginal community where people support each other to participate
- Involvement of Aboriginal health workers are key to support programs to engage Aboriginal community.

The Aboriginal Chronic Care Program (ACCP) works with Aboriginal people to effectively manage their chronic conditions including cardiovascular, renal, respiratory conditions, diabetes, mental health, and cancer.

A team consisting of Aboriginal Health Workers, Care Coordinators and a number of allied health professionals (Dietitian, Exercise Physiologist, Social Worker) work together with the patient as well as their families to support them in improving their health and wellbeing.

### ***Culturally appropriate mental health services***

In a survey conducted to explore GPs barriers to referring patients with mild-to-moderate mental health problems, 27% of GPs reported their patients experience barriers such as cultural appropriateness, cost of support and general understanding of mental illnesses. 55% of the responding GPs reported they didn't have any clients who identify as Aboriginal and/or Torres Strait Islander. Based on the recent co-design prioritisation, trust, lack of culturally appropriate workers, awareness of the culturally appropriate services and the coordination between these services act as barriers for Aboriginal and Torres Strait Islander people when seeking help and support.

Specialised SWSLHD mental health services are provided for Aboriginal and Torres Strait Islander people through the Aboriginal Mental Health staff who work across community and inpatient services. There are Aboriginal specific mental health services in Bankstown, Liverpool and Macarthur and SWS Aboriginal and Torres Strait Islander Early Child Development Unit. Specialised mental health assessment and treatment services are also provided at Tharawal Aboriginal Corporation and Miller Community Health Centre to improve accessibility. There is a particular need to ensure the physical and emotional health of Aboriginal people with a mental health issue is addressed. Tharawal Aboriginal Corporation provides mental health support to clients through mental health workers and mental health professionals. The service also links clients into GP services and other programs based on clients' needs. Gandangara

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Land Council operates a health brokerage service utilising Aboriginal outreach workers and a primary medical clinic(SWSLHD, 2015b).

There is variable access to culturally appropriate mainstream private services. Consultation revealed there are limited opportunities to address complex social issues with Aboriginal clients who are experiencing mental illness. These issues are related to maintaining housing, securing employment and basic resources to function. Lack of integration between services, and variability of culturally sensitive practice compounds this issue. Brokerage services were suggested to overcome this gap.

### ***Culturally appropriate alcohol and other drugs services***

Two Aboriginal health workers (AHW) provide culturally appropriate casework and run groups for Aboriginal people with drug and alcohol related conditions. These workers are located at SWSLHD Liverpool and Campbelltown hospitals. There is a Drug Health Outreach Service at Tharawal (includes AHW, RN, Staff Specialist, D&A Counsellor), D&A Counsellor Outreach at Budyari Aboriginal CHC and Aboriginal Drug Health Drop-in Clinic Wingecarribee. There is also an Aboriginal Maternal & Infant Health Service (AMIHS) at Macarthur to provide support to pregnant Aboriginal women with drug and alcohol issues. In 2014/15, the proportion of Aboriginal clients in treatment with SWSLHD Drug Health Services was 14.5%, which was higher than the proportion of clients in a previous year (11.2%)(South Western Sydney Local Health District Drug Health Service, 2016). The rate of hospitalisation was six-times higher among Aboriginal people than non-Aboriginal people in 2014-15(MoH, 2016).

Community members reported limited access to culturally appropriate drug and alcohol treatment services. Aboriginal clients reported feeling supported when Aboriginal and Torres Strait Islander workers were available. In-patient services that were accessed outside the region were reported to present challenges to recovery as people are great distances from their family and social support network. Both inpatient and outpatient models should be readily available to promote consumer choice in terms of access to treatment.

SWSPHN co-commissioned NADA to develop core cultural competency training and standards for our commissioned AOD service providers to improve the cultural appropriateness of their services.

Service providers reported limited access to harm minimisation approaches for drug users within Aboriginal communities. SWSLHD Aboriginal Sexual Health Promotion and HIV/AIDS and Related Programs (HARP) are planning to support the work of NSW Aboriginal Health and Medical Research Council in working with Aboriginal Community Controlled Health Services to provide needle and syringe programs and STI testing(SWSLHD, 2015a).

Consultation revealed the complexity, and often interrelated issues of mental health and drug and alcohol use within Aboriginal and Torres Strait Islander communities. Service providers emphasised the importance of co-designing approaches to address these issues within Aboriginal communities within a broader cultural context. The SWSLHD Aboriginal Mental Health Team reports directly to the SWSLHD Mental Health service. Team members provide culturally appropriate support to Aboriginal people with mental health issues in the community and inpatient setting and deliver a range of support group services to aid recovery.

### ***Culturally appropriate after-hours services***

Consultation revealed community concern relating to the availability of Aboriginal staff within the ED to support the community. This is particularly a concern within mental health. Aboriginal Liaison Officers (ALOs) are not available after hours in SWSLHD. There is a need to meet the NSW Ministry of Health target that Aboriginal people represent 2.6% of the workforce and achieve a greater spread of representation across the workforce.



## 2.1.3 Culturally and Linguistically Diverse Populations

### Current population and expected growth

In 2016, 43.3% of residents in SWS were born overseas compared with 34.5% for NSW. Four (Fairfield, Liverpool, Bankstown and Campbelltown) of the seven SWS LGAs had a higher proportion of their residents born overseas compared with NSW, with Fairfield having the highest percentage (59%). Wingecarribee (23%), Camden (22.6%) and Wollondilly (18%) were all below the state average (ABS, 2022).

#### Key Issue for our region

**South Western Sydney has one of the largest populations of CALD communities within Australia, resulting in most complex health access and equity challenges**

### Refugee and asylum seeker communities

People from refugee backgrounds often have complex health problems related to their prior access to health care and /or their individual experiences of persecution or trauma. Health needs commonly identified in refugees and asylum seekers after arrival in Australia include (Milosevic, Cheng and Smith, 2012):

- Psychological issues and other physical consequences of torture or trauma
- Nutritional deficiencies
- Infectious diseases and under-immunisation
- Poor dental health, optical health and management of chronic diseases
- Delayed growth and development in children

#### Key Issue for our region

**More than a third of the national refugee intake is settled in South Western Sydney**

Most humanitarian entrants who arrive in NSW tend to settle in South Western Sydney and Western Sydney. About 1955 refugee entrants settled in NSW under the Humanitarian Resettlement Program in 2020, representing 37% of refugees settled nationally.

Of the refugees who settled in NSW, 57% settled in South Western Sydney, predominantly in Fairfield and Liverpool LGAs (47%). As of 31 December 2020, the postcodes with the greatest number of people seeking asylum in SWS were postcodes 2166, 2170 and 2165.

Table 6: Place of settlement for humanitarian entrants and refugees in SWS by LGA, 2020(ADHA, 2021b)

LGA	Number of humanitarian entrants	% of SWS humanitarian entrants
Canterbury-Bankstown	151	13.6%
Camden	7	0.6%
Campbelltown	40	3.6%
Fairfield	655	59.1%
Liverpool	255	23%
Total SWS	1108	57% of NSW intake
NSW intake	1955	37% of National intake

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Most of the refugees settling in NSW are from Iran, Sri Lanka, Bangladesh, Afghanistan, Iraq, Syria or stateless (ADHA, 2021a). Due to the large number of refugees re-settling into the region and their health needs, it is expected to have a significant impact on provision of health and social welfare services in the area.

### Health access and equity impacts

Previous studies have reported individuals with limited English language proficiency have more difficulty in gaining access to health care compared to English proficient individuals (Shi, 2009).

<b>Key Issue for our region</b>	<b>Significant health access and equity issues for CALD communities</b>
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SWS (9.9%) includes more than double the state average (4.5%) of population who identify they speak English 'not well or not at all'. English language proficiency varies across SWS with a higher proportion of Fairfield (20%), Bankstown (≈10%) and Liverpool (≈10%) LGA residents reporting they "speak English not well or not at all" (ABS, 2016c).

Table 7: Cultural diversity, NSW and SWS, 2016 (ABS, 2013)

Measure	SWS	NSW
Population born overseas	43.3%	34.5%
Speaks a language other than English at home	45.3%	25.2%
Speaks English 'not well or not at all'	9.9%	4.5%

### Health literacy

Data from Australian Bureau of Statistics (ABS) shows people from culturally and linguistically diverse backgrounds (CALD) have considerably lower levels of health literacy compared with the general population (ABS, 2009). According to the ABS *Health Literacy Survey (HLS)*, 2018 (ABS, 2018b):

- Individuals whose first spoken language was English were more likely to have 'adequate or better' health literacy (44%) than those whose first language was not English (25%).
- Australian born individuals were more likely to have 'adequate or better' health literacy skills (43%) compared to overseas born individuals (30%).

There are many reasons for low health literacy in CALD populations, such as low English language proficiency, unfamiliarity with the health system in Australia, and cultural differences (Murray and Skull, 2005, Henderson and Kendall, 2011). This means CALD population groups are less likely to access the services they need, or understand issues related to their health, and are more likely to experience social isolation and be at risk of mismanaging their medication (CIRCA, 2017).

SWSPHN has developed an online health literacy resource called Health Resource Directory (HRD), which provides factsheets on a range of health conditions and psychosocial presentations. The website and printable factsheets are available in English, Arabic, simplified Chinese, and Vietnamese. Audio versions, including in-language versions, are also available. HRD includes information on local services, distinguishing itself from national and state-based translated health literacy resources to ensure residents in SWS who do not speak English have the same access to content as English-speaking people. Usage of HRD has continued to increase, in particular the Arabic language resources.

### Health access

The 2019 after-hours GP survey showed that compared with people whose main language is English, people from a CALD background are less likely to have a regular GP, are less aware of after-hours GP services and more likely to go to ED when they need after-hours medical care (SWSPHN, 2019a).

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

In SWS, issues raised at the focus group by refugees in Fairfield include: lack of language specific and culturally safe services; long waiting time to see a GP who speaks Arabic; lack of support to fill medical/Centrelink forms; and differences in cultural perceptions in the health systems (e.g., “hospital is the place to go when you are sick, doctors outside of hospitals are no good”)(SWSPHN, 2019a).

### *Access and equity of services*

#### ***Culturally appropriate health services***

Community consultations revealed lack of information available to bilingual GPs about available services, lack of translated information in GP’s first language to be given to their clients. Low uptake of interpreter services among GPs and lack of bilingual service providers. There is a need to increase GP awareness of free of charge interpreting service available through the Doctors Priority Line. There is limited awareness of culturally appropriate services by some GPs.

Issues around refugees accessing health care in SWS raised through community consultations including:

- Incorporate flexibility in programs to include minority languages or develop special targeted interventions
- Need for information to be delivered in community languages by partnering with multicultural and refugee health services and use interpreters or trained bilingual community educators
- Lack of access to preventative health education and programs for refugees, GPs could fill this gap

#### ***Ongoing care for refugees***

Initial health assessment for newly arrived refugees is provided through the Refugee Health Nurse Program run by NSW Refugee Health Service. Refugee nurse clinics are provided in Liverpool, Cabramatta, Bankstown and Fairfield(DoH, 2011). After an initial assessment, newly arrived refugees’ families are referred to local GPs for further assessment and ongoing care. GPs could use a refugee specific assessment template for provision of comprehensive health assessment.

Some of these issues have been raised through the consultations:

- Lack of access to preventative health education and programs for refugees
- Need for consideration of mental health issues with newly arrived refugees
- Lack of continuity in the health care of refugees after an initial health assessment
- GPs needs to provide universal refugee specific health assessments and an ongoing car
- Training to GPs around refugee health care
- Limited utilisation of interpreter services in general practice (Doctors Priority Line).

## 2.1.4 Older Persons

### Current population and expected growth

Older persons are those aged 65 years and over for non-Aboriginal and 50 years and over for Aboriginal population. It is estimated that in 2016, in South Western Sydney, about 126,720 people were older adults. The largest distribution of older adults across SWS is in Bankstown and Fairfield LGAs, followed by Liverpool, while proportionally about 24.7% of Wingecarribee population are over 65 years of age. Locally, 1 in 3 older people were born in a non-English speaking country.

#### Key Issue for our region

**The number of older people living in South Western Sydney is expected to increase by 74% over the 15 years.**

It is expected the number of people aged 65 years and older will reach up to 220,620 by 2031, an increase of 74%. The growth in the next 15 years is expected to be particularly significant among those over 85 years of age (an increase of 92%) with additional 14,660 people. The most significant increase in the older population in the next 15 years will be in the Macarthur region: Camden (181.5%), Campbelltown (83.1%) and Wollondilly (81.9%) LGAs; followed by Liverpool LGA (94.9%).

Table 8: Older population distribution in South West Sydney and by LGA, 2016(DPE, 2016)

LGA	Number	% of LGA population	% of SWS older population
Bankstown	29,250	14.4%	23.1%
Camden	8,700	10.8%	6.9%
Campbelltown	19,400	11.8%	15.3%
Fairfield	28,460	13.8%	22.4%
Liverpool	22,720	10.6%	17.9%
Wingecarribee	11,800	24.7%	9.3%
Wollondilly	6,390	12.9%	5.0%
Total	126,720	100%	100%

#### Key Issue for our region

**Older people living in the rural areas of South Western Sydney have additional challenges in accessing healthcare services**

Wingecarribee LGA residents tend to be older with 17% aged 70 years and over compared with SWS population (8.7%). Wingecarribee LGA has the highest proportion of lone person households in SWS (26.1%) which is higher than the rest of NSW (23.8%). As people age, their use of health services increases and the “rurality” of these residents will become increasingly important, particularly as by 2031, the number of older people in Wingecarribee will increase by 58%(SWSLHD/SWSPHN, 2018).

Physical access to healthcare and other services is a concern for some rural communities primarily in outlying towns and properties within Wollondilly and Wingecarribee. Camden, Campbelltown, Fairfield and Liverpool also have some less accessible areas, although this is expected to change with urban development.

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### Usual Residence

In 2021, an estimated 165,867 people aged >65 years residing in private dwellings within community as per the ABS 2021 census. The highest number of older people residing in community is in Canterbury-Bankstown (52,207 people) followed by Fairfield (32,909) and Liverpool (25,460).

### Residential Aged Care Homes (RACFs)

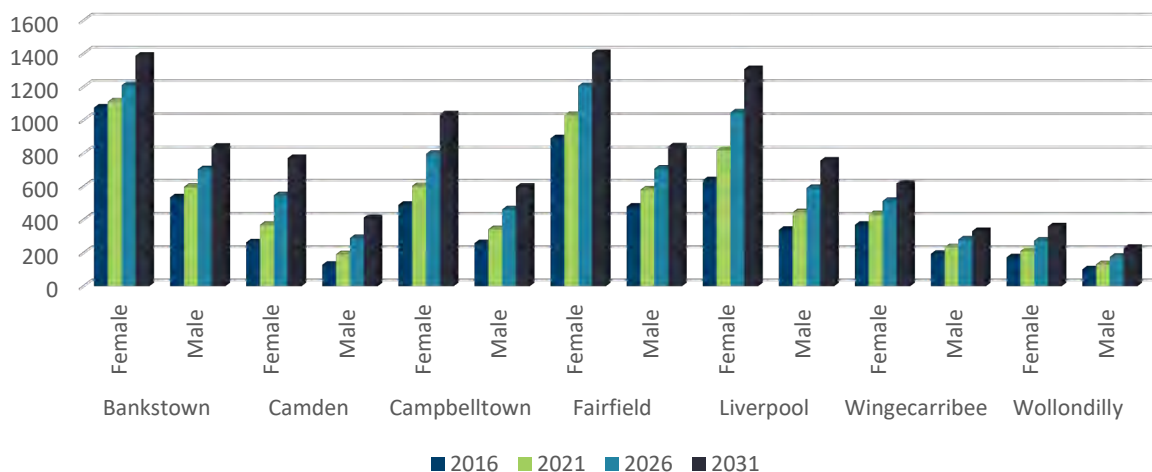
Residential aged care is provided in aged care homes on a permanent or respite basis. Residents receive accommodation, support (cleaning, laundry, and meals) and personal care services. Those with greater needs may also receive nursing care, continence aids, basic medical and pharmaceutical supplies, and therapy services.

#### Key Issue for our region

**The projected demand for residential aged care services in SWS is expected to exceed capacity, resulting in older people being unable to access the level of care required**

The rate of persons requiring permanent residential aged care in SWS in 2016 was 0.7% of the region, ranging from 0.3% for males in Campbelltown, Liverpool and Camden to 1.6% for females in Wingecarribee. The demand for permanent residential aged care is expected to increase significantly in the region with the number of persons requiring this type of care expected to almost double in the next 15 years (from 5,937 to 10,894 by 2031).

Figure 9: Number of persons requiring or in residential aged care for SWS by LGAs and Gender, 2016 to 2031(SWSLHD/SWSPHN, 2018)



Between 2017 and 2022, the availability of RACF places in SWS decreased from 81.8 to 74.9 per 1,000 people (AIHW, 2023). The rate of residential care recipients (70 years and over) across the PHN as of 30 June 2022 was 57.7 per 1000 people and rate of home care recipients in the same period was 41.4. The rate was 171.7 for home support recipients in the 2020-21 financial year (AIHW, 2023).

As of 30 June 2022, there were 69 RACFs (7838 places), 70 home care services and 75 home support outlets. The occupancy rate for residential care in SWS was 84.4% with 57.1% among those having a diagnosis of dementia.

By ABS remoteness, the majority (86.4%) are in a major city, the rest (13.6%) are in an inner-city region [132].

Table 9: Places in aged care by type, 30 June 2020 (AIHW, 2021a)

Region	Residential Care	Transition Care
SWS (PHN)	7,838 (98.0%)	124 (1.6%)
NSW	71,915 (95.5%)	1,497 (2.0%)
Australia	94.9%	1.9%

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As of 30 June 2022, not-for-profit providers were dominant in residential aged care (52.7%) in SWS, 45.7% were charitable, and 16% were government operated.

Table 10: Places in aged care by organisation type, SWS (PHN region), June 2022 (AIHW, 2023)

Organisation Type	Number	Percentage
Not for profit	4215	52.7%
Private	3659	45.7%
Government	124	1.6%

### **Transition Care and Short-term Restorative Care**

Transition Care assists older people in regaining physical and psychosocial functioning following an episode of inpatient hospital stay to help maximise independence and avoid premature entry to residential aged care. Short-term restorative care is similar to transition care but is provided to people who have had a setback or decline in function without having been in hospital. Respite or short-term care facilities also provide a break for informal carers. In 2016, 236 persons in SWS were estimated to require respite support. This number is expected to increase to 439 persons in 2031. The region has one short term restorative care providing three beds operated by a charity. In SWS, there are two facilities with 112 beds for transition care both of which are operated by the NSW government.

SWS has a higher proportion of aged care recipients over 55 years of age who need assistance with core activity (17.6%) and significantly higher proportion of recipients born overseas (58.2%) and who preferred a language other than English (44.7%) compared with NSW (20.7%) and Australia (16.5%).

Table 11: Characteristics of aged care recipients, SWS (PHN region), NSW, and Australia, 2022 (AIHW, 2023)

Region	Aboriginal and Torres Strait Islander (50+)	Core activity need for assistance (55+)	Lives alone (65+)	Born overseas (65+)	Preferred other language than English (65+)
SWS	1.1%	17.6%	17.5%	58.2%	44.7%
NSW	1.68%	13.3%	22.1%	35.9%	20.7%
Australia	1.7%	13.0%	22.7%	34.6%	16.5%

### **Retirement Villages**

Retirement villages refers to a purpose-built housing complex of multiple dwellings on a single site, designed for people in later life (typically aged 55 and over), who are provided with communal facilities and services but who are independent in the sense that they do not need the level of support provided by RACFs. (Commission, 2018) There are 22 retirement villages in South Western Sydney ranging in size from 10 units to campus-style 162 units.

In the context of an ageing population, there has also been an increase in the number of facilities offering 'ageing-in-place' services, combining retirement village independent living units, serviced apartment or hostel places and nursing homes in the one facility. More than one-third of all retirement villages had ageing-in-place services, the majority of these being operated by private sector organisations.

### **Manufactured Home Parks (MHP)**

Manufactured homes are self-contained dwellings which are manufactured off-site in major sections and transported to a site for installation. Manufactured home parks (MHPs) are a medium density communal type of development which includes some form of community facilities and services in addition to the normal residential services of water, electricity, sewerage and drainage<sup>i</sup>. Marketing for these parks have targeted seniors and in practice are age-restricted, usually to the over-50s. There are two MHPs in South Western Sydney (ABS, 2019)

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### Caravan Parks

Caravan parks may provide both temporary accommodation and longer-term or permanent sites where residents rent or own their own caravans or demountable structures. Parks with a residential component are the chosen option for many people over retirement age. Retirees form one of three distinct sub-groups of long-term residents in caravan parks. Often, they have made a deliberate choice to live in a caravan park and are happy with the lifestyle, including the sense of community and access to communal facilities. In addition, they tend to be more affordable than conventional housing. There are 15 caravan parks in SWS.

### Aged Care Supports

#### Home Care Packages Program (HCPP)

HCPP is a program that supports older Australians with complex needs to remain living at home through a coordinated package of care and services to meet the individual needs of consumers (Commission, 2018). There are four levels of care ranging from low level care needs (home care package level 1) to high care needs (home care package level 4). Services provided under these packages are tailored to the individual and might include personal care, support services and/or clinical care (Commission, 2018). As of 31 December 2021, there were 8933 people in a HCPP across SWS and Southern Highlands APCR, of which 1568 people were new entries in the December 2021 quarter (DoH, 2021).

#### Key Issue for our region

**Insufficient community-based aged care supports available**

In SWS, there are 55 HCP providers with an equal mix of charitable, private incorporated bodies and community/religious-based. There is one facility operated by the state government.

There is 1810 people waiting on a HCPP at their approved level on 31 December 2021, who had yet to be offered a lower lever HCPP.

### Home medication reviews

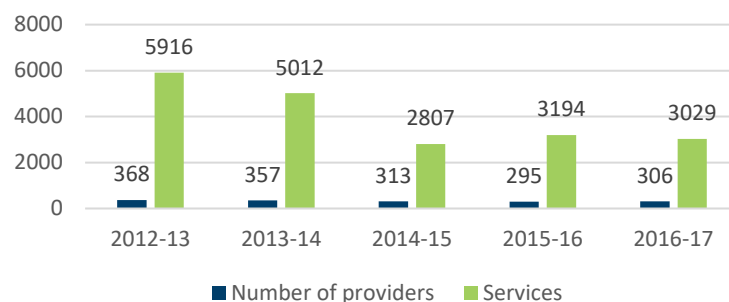
The following figure depicts the decline in recent years of utilisation of home medication reviews (MBS item 900). MBS data shows there has been a steady decline in SWS in services and providers between 2012-2013 and 2016-17 (DoH, 2018). Use of Residential and Home Medication Management Reviews remains low.

#### Key Issue for our region

**Continual decline in the use of Residential and Home Medication Management reviews in South Western Sydney**

People aged 80 and over were the most common recipients accounting for roughly 75% of services provided from 2018 to 2021. Between 4.4 to 5.6% of the 80+ population had the service in the same period.

Figure 10: Home Medication Reviews (MBS item 900), SWSPHN, 2012-13 to 2016-17 (AIHW, 2021b)



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## 2.2.1 Preventative Health in South Western Sydney

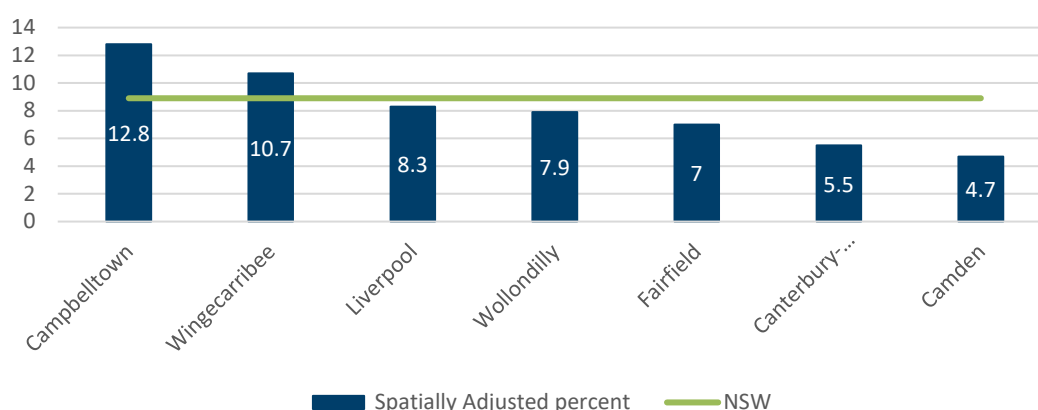
### Antenatal Care

Antenatal care has been found to have a positive effect on the health outcomes for both mother and baby.

### Smoking during pregnancy

Smoking during pregnancy is associated with a wide range of complications impacting both mother and baby. In 2020, the proportion of mothers who reported any smoking during pregnancy was 8.6% for SWS compared to 7.9% for NSW. Between 2014 and 2016, significantly higher rates of smoking in pregnancy was reported in Campbelltown and Wingecarribee (CEE, 2016a).

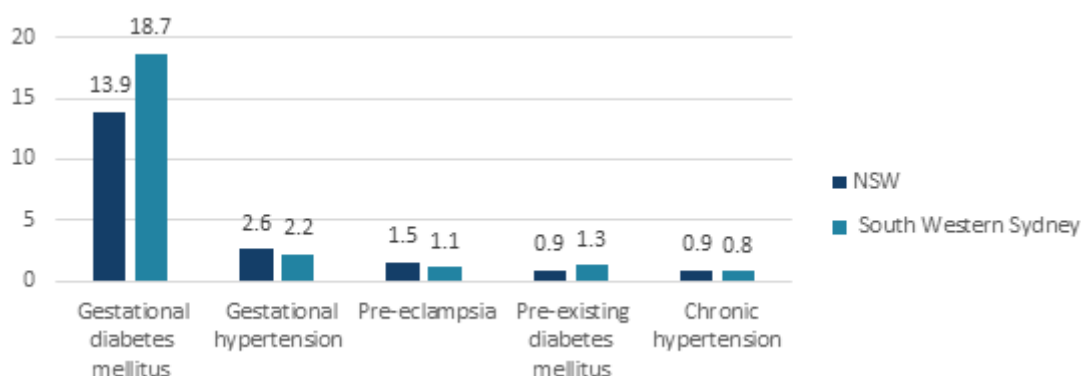
Figure 11: Maternal smoking in pregnancy (all women by %) by Local Government Area, SWS, 2017-2019(CEE, 2020a)



### Maternal medical conditions

In 2019, a higher proportion of SWS mothers (13.9%) had diabetes in pregnancy (either pre-existing or it was diagnosed in pregnancy) compared to the rest of NSW (18.7%)(CEE, 2016a). For uncontrolled gestational diabetes, the adverse pregnancy outcomes could include pregnancy loss, premature delivery and stillbirth. Complications to the baby might include excessive birth weight, preterm birth, respiratory distress syndrome, hypoglycaemia, jaundice, increased future risk for developing obesity and type 2 diabetes (Simmons, 2015).

Figure 12: Maternal medical conditions by % SWS and NSW, 2019(CEE, 2020a)



### Tobacco smoking

Tobacco smoking is the single most preventable cause of death and disease globally. Despite Australia now having one of the lowest daily smoking proportions among Organisation for Economic Co-operation and Development (OECD) countries, the harm from tobacco smoking continues to affect current smokers and ex-smokers, as well as non-smokers via exposure to second-hand smoke.

Tobacco is the leading cause of cancer in Australia (nearly half of the of attributable disease burden) in Australia and

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was responsible for 9.3% and 8.6% of the total burden of disease and injury in 2015 and 2018 respectively (AIHW, 2021c). Tobacco use contributed to 39% of the total burden from respiratory diseases and 22% of the total burden from cancers. It was estimated 80% of lung cancer burden and 75% of chronic obstructive pulmonary disease burden were attributable to tobacco smoking(AIHW, 2018c). Burden linked to past smoking increased by 15% between 2003 and 2015 and was larger in females. However, the rate of burden from overall tobacco use fell between 2003 and 2015 and further reductions are expected by 2025AIHW (2019).

In NSW, men are more likely to smoke daily compared to women (21.4% and 19.3% respectively). Smoking rates are higher among those with mental health issues or alcohol and drug dependency, lesbian and bisexual women and among HIV positive men(MoH, 2017). People aged 55-64 have the highest prevalence of daily smoking compared to general population. People in the lower socioeconomic area (IRSD) are more likely (2.6 times higher) to smoke. Amongst CALD communities, three priority communities with high smoking rates include: Chinese men (20.3%) including Mandarin and Cantonese-speakers, Vietnamese men (32%) and Arabic-speaking men (39.3%). Previous research has indicated the need for consistent and tailored messages to reduce smoking in these communities(CINSW, 2013).

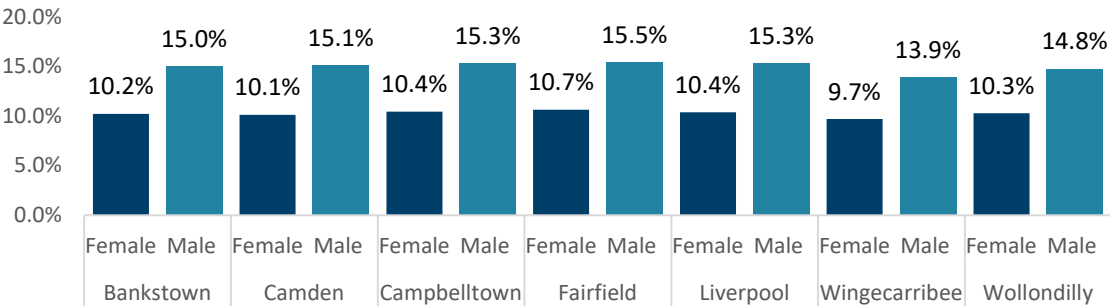
Key Issue for our region

The prevalence of tobacco smoking in South Western Sydney is 20% above the state average

In 2023, the estimated smoking rate in adults was 14.5% in SWS, higher than the NSW average of 12%. Men in SWS (21.4%) have been consistently more likely to smoke daily than women (19.3%) (CINSW, 2023).

It is estimated 102,055 people were smoking daily in SWS in 2016. The prevalence of daily smokers in SWS ranged from 9.7% for females in Wingecarribee to 15.5% for males in Fairfield.

Figure 13: Estimated prevalence rate for daily smoking for SWS residents by LGA and gender, 2016(AIHW, 2021d)



## Smoking attributable hospitalisations

Smoking-attributable hospitalisation rates were lower in SWS compared to NSW (651.1 and 709.9 per 100,000 population respectively). Females have lower smoking-attributable hospitalisation rates compared to males. In SWS, Wollondilly, Campbelltown and Wingecarribee LGAs had significantly higher hospitalisation rate than NSW rate(CEE, 2020d).

Table 12: Smoking attributable hospitalisations, number and age standardised rate per 100,000 population, 2018-19(CEE, 2020d)\*

	Male	Female	Total	Rate per 100,000
SWSPHN	3,946	2,995	6,941	651.1
NSW	36,984	30,429	67,413	709.9

\* Including rehabilitation admissions

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Table 13: Smoking attributable hospitalisations by LGA, SWS, 2017-18 to 2018-19(CEE, 2020d)\*

Local Government Areas	Spatially Adjusted Number of Separations per Year	Spatially Adjusted Rate per 100,000 population
Fairfield	1029.2	494.1
Canterbury-Bankstown	2281.5	610.9
Liverpool	1412.7	630.4
Camden	612.1	665
Wollondilly	358	710.9
Campbelltown	1279.6	761.9
Wingecarribee	458.9	934.9
NSW		705.5

### Smoking attributable deaths

Between 2001 and 2018, the smoking attributable deaths have steadily declined in SWS, from 99.8 to 60.9 per 100,000 population. In 2018, The smoking attributable death rate was lower in SWS than in NSW (56.3 and 64.1 per 100,000 population respectively). The smoking attributable death rate for males is almost twice as high as the rate for females. In SWS, Wingecarribee, Wollondilly and Campbelltown LGAs have higher smoking attributable death rates than NSW rate(CEE, 2020d)

Table 14: Smoking attributable deaths by socioeconomic status, NSW, 2018(CEE, 2020d)

Socioeconomic status	Number	Rate per 100,000 population
1st Quintile least disadvantaged	862	43.2
2nd Quintile	1,076	56.9
3rd Quintile	1,268	64
4th Quintile	1,752	77
5th Quintile most disadvantaged	1,718	84.7
Total	6,702	65.7

Table 15: Smoking attributable deaths by LGA(CEE, 2020d)

Local Government Areas	Spatially Adjusted Number of deaths per Year	Spatially Adjusted Rate per 100,000 population
Canterbury-Bankstown LGA	226.7	61.2
Liverpool LGA	138.7	62.7
Camden LGA	56	62.9
Fairfield LGA	135.1	65
Wingecarribee LGA	33.5	68.3
Wollondilly LGA	35.4	70.4
Campbelltown LGA	133.1	80
NSW		67

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### Electronic cigarette use

The AIHW *National Drug Strategy Household Survey (NDSHS) 2019* report showed that the use of e-cigarettes is increasing (AIHW, 2020a). The short and long-term health effects of e-cigarettes are currently being researched. As e-cigarettes are relatively new, there is not enough data or evidence available to determine the long-term health effects. Available research shows (DoH, 2021a):

- A strong association between the use of e-cigarettes by non-smoking youth and chances of future smoking
- That many e-cigarette users appear to be continuing to use conventional tobacco products at the same time (dual users). Dual users may be exposing themselves to even higher levels of toxicants compared to people who solely use conventional tobacco products

#### Key Issue for our region

**Increasing rates of e-cigarette use, particularly among young people**

In NSW, there have been increases in people who are current users and people who have ever used electronic cigarette between 2017 and 2019. Young people are more likely to use electronic cigarette than older people. People aged 16-24 had the highest rates of electronic cigarette use, with 18.1% of people in this age group reported to have ever used electronic cigarette (among which 2.7% being current users).

Issues raised through the consultations include:

- Culturally sensitive approaches to smoking required e.g., more information needed about harmful effects of 'hookah' or 'shisha' smoking and social/family issues beyond smoking e.g., it is considered rude to ask guests to smoke outside
- Passive smoking among CALD communities needs to be addressed, particularly passive smoking associated with communal smoking devices such as shisha at family events with children in attendance
- Long term program with exit strategy is needed to be sustainable after funding is finished
- Promotion of existing language-specific QUIT lines and of subsidised availability of NRT patches required. People unaware of what's available
- In refugees - nicotine addiction may occur in detention, where cost is subsidised, or is seen as a stress related coping mechanism
- People with mental illness often smoke and needs to be addressed as part of the treatment
- Early intervention is needed targeting students at school as young people don't see long term consequences associated with smoking
- The need for positive examples of peer-based interventions to address smoking in Camden and Wollondilly
- RACGP recommended pharmacotherapy (nicotine replacement therapy, varenicline or bupropion) accompanied by behavioural support to all people who smoke who have evidence of nicotine dependence (RACGP, 2020).

### Cancer Screening

Some cancers can be detected before symptoms appear. Early detection by cancer screening can find cancer while it is still in its early stages where treatment can be more successful and likely to be survived.

#### Key Issue for our region

**South Western Sydney has lower cancer screening rates for breast, bowel and cervical cancer than the NSW average**

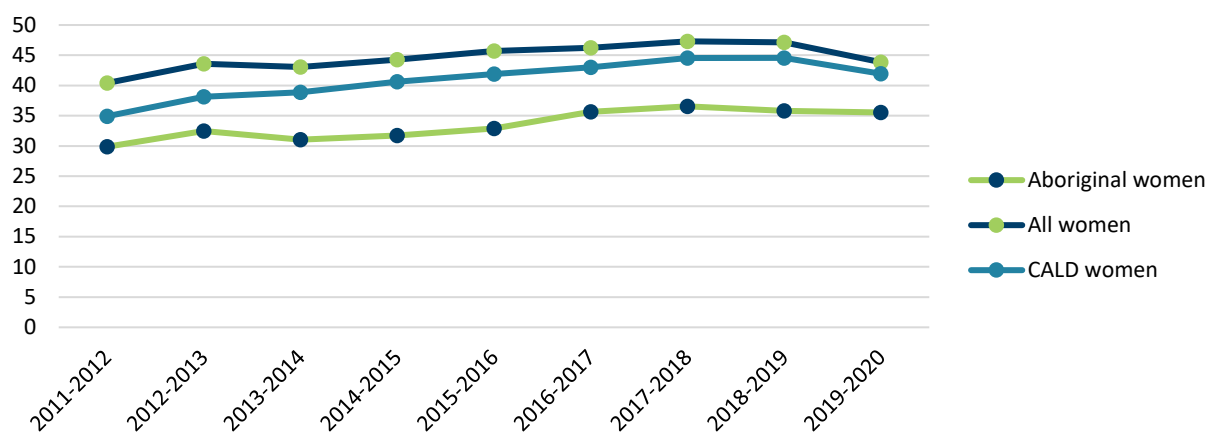
### Breast Cancer

In 2019-20, the breast cancer screening participation rate for women aged 50-74 years was lower in SWS (41.7%) compared with NSW (46.1%) (CINSW, 2023). This includes 28.8% of eligible women in SWS that have never been screened.

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The participation rate for SWS women from a CALD background was 42%, while the participation rate for Aboriginal women was 35.5%. Screening rates for were highest in Wingecarribee (52%) and lowest in Liverpool (40.7%). In SWS, breast cancer has the second highest incidence and the third highest mortality by tumour site (CINSW, 2016). It is estimated that eligible women missed out on 15,000 screening appointments during the lockdown period in SWS (from June-November 2021).

Figure 14: Breast screening participation rate by population group, SWS, 2011-2020 (CINSW, 2021)



Issues raised through consumer consultations regarding breast cancer screening included:

- There is a need for promotion of preventative screening among refugee communities
- Specific culturally appropriate and respectful approaches are required to address under screening in Aboriginal communities
- More availability of screening locations at more appropriate times of the day
- Majority of women believed their GP could do more to encourage them to participate in cancer screening

Consulted GPs mentioned patients were looking for an 'adequate and women friendly' site for having mammogram referring to the site in Penrith located with the Myers/David Jones shops. Some GPs revealed reluctance to refer to BreastScreen locations, as their patients can't get in at a reasonable time/or the screening locations are all booked out. Some suggestions were made regarding the cost analysis and whether BreastScreen NSW should consider subsidising private imaging organisations instead of paying for the buses and the radiographers themselves. In addition, consultations revealed that within some communities there were misconceptions about mammograms and fear of radiation levels.

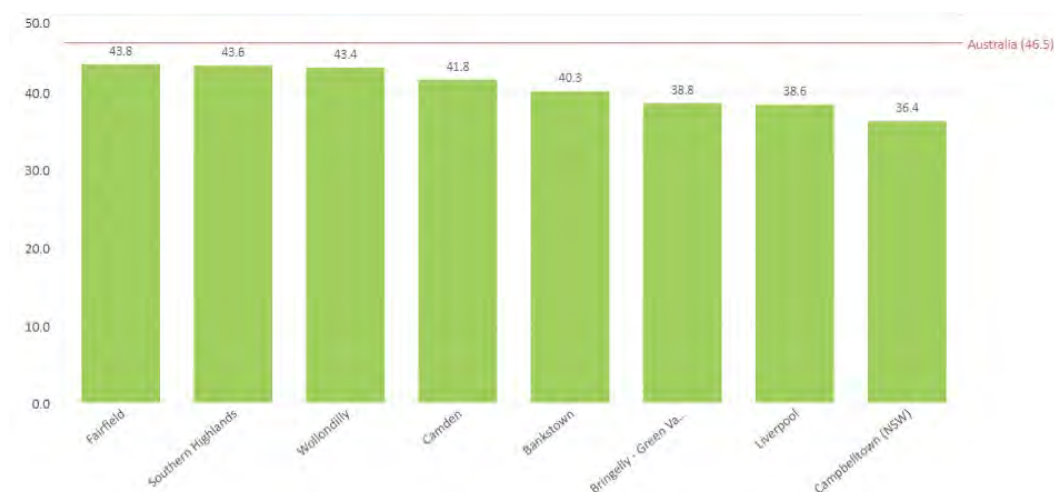
### Cervical Cancer Screening

In 2018-19, the cervical screening participation rate for women aged 25-74 years in SWS was 55.8%, lower than for NSW (60.6%) and Australia (62.4%) (CINSW, 2023). Women aged 70-74 years have the lowest participation rate among all age groups. Across SA3 areas in SWS, the participation rates were lowest in Campbelltown (36.4%) and highest in Fairfield (43.8%).

A consistent theme across the SWS region in cervical cancer screening was the preference for female GPs to conduct the PAP smear, placing female GPs in greater demand. Some male GPs mentioned they employ Practice Nurses to do the test and to increase the test uptake in their practice, however, there appears to be inconsistency between the practice receiving the Practice Nurse Incentive Payment (PNIP) and each individual GP of the practice receiving remuneration for a nurse conducting the cervical screening test. Community consultations also identified a lack of access to female nurses or GPs as a common barrier to cervical screening participation across all LGAs in SWS.

Figure 15: Cervical Cancer Screen Participation% by SA3, SWS, 2018-19(CINSW, 2021)

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The Cancer Institute NSW has funded practice nurse positions in the Well Women's Screening Course conducted by Family Planning NSW. This initiative aims to train practice nurses to conduct cervical cancer screening and increase male GPs referrals to cervical cancer screening. However, there are challenges in the accuracy of data collection to evaluate its effectiveness as the Medicare item allocation occurred without a national system in place.

GPs also mentioned the impact of the changes made to cervical screening intervals (in 2017) from every 2 years to every 5 years. Consulted community members mentioned they could not ignore reminder letters from the register to have the test, however women only receive those letters if they have had at least one test previously. Those who have never had tests are hard to reach, as well as women who change their residential address and don't update their details to receive reminder letters.

It is expected that the increased availability of self-testing options will make it easier for patients of male GPs to complete cervical screening.

### ***Bowel Cancer Screening***

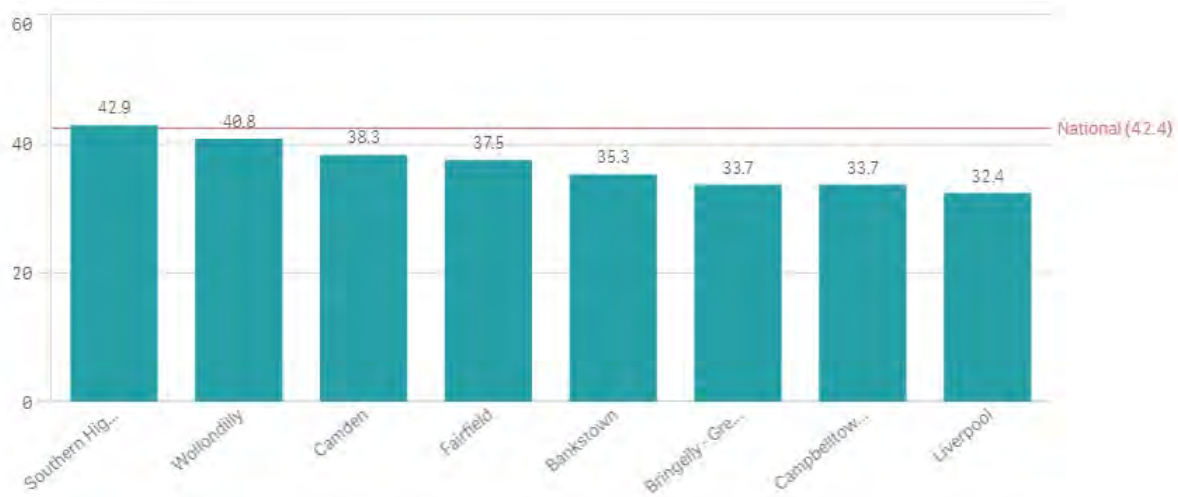
In Australia, males (9.0%) had a higher screening positivity rate than females (7.3%) in 2016. The annual bowel screening participation rate for people aged 50-74 in SWS is 32.6%, lower than NSW rate (35.4%), it's the third lowest among all LHDs in NSW. Compared with 2012, bowel screening participation rates have increased in both SWS and across NSW (CINSW, 2023).

Between 2014-15 and 2017-18, the annual bowel cancer participation rate for people aged 50-74 years in SWS increased from 32.7% to 36%. The rate for SWS was lower compared to the national rate (36% and 47.4% respectively). SWS had one of the lowest annual bowel screening participation rates in NSW. Across SA3 areas in SWS, screening participation was lowest in Liverpool (32.4%) and Campbelltown (33.7%) and highest in the Southern Highlands and Wollondilly

Community consultations revealed there is low participation in the home testing kit program. Consulted GPs suggested a high level of encouragement from GPs for their patients to participate in cancer screening, however community consultations suggest consumers believe their GP could be doing more to encourage cancer screening participation.

Figure 16: Bowel cancer screening participation rate by SA3, SWS, 2017-18 (CINSW, 2021)

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### Immunisation

Immunisation is one of the most effective ways a population can protect the community and future generations from infectious diseases. In other words, if you vaccinate, you help wipe out diseases that could spread now and into the future. Immunisation programs prevent about 2.5 million deaths globally every year.

#### Key Issue for our region

**South Western Sydney has lower immunisation coverage rates across a number of age ranges and disease types**

### Low immunisation coverage for children aged two years in SWS

In SWS, childhood immunisation coverage for all children aged 1 year and 2 years has increased compared to 2019, while the coverage for 5-year-olds has decreased slightly. For Aboriginal children, the coverage for those aged 1 year has decreased while the coverage for those aged 2 years and 5 years has increased. Across SA3 areas in SWS, Bankstown has the lowest coverage for children aged 1 year (93.8%) and 2 years (88.7%), Liverpool has the lowest coverage for children aged 5 years (94.2%) (DoH, 2021b).

Figure 17: Childhood Immunisation Coverage(%), SWS 2019-20[8](DoH, 2021c)

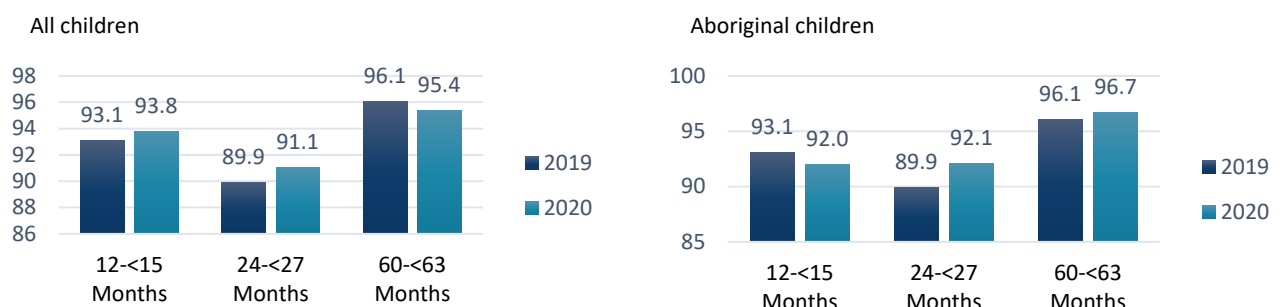
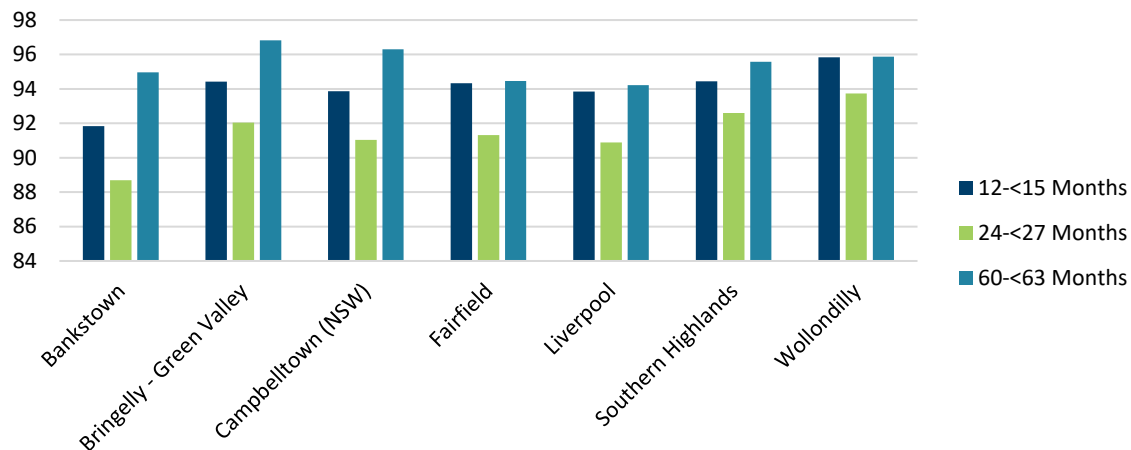


Figure 18: Childhood immunisation coverage by SA3, SWS, 2020(DoH, 2021c)



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In 2017, SWSPHN participated in a national research project to follow up immunisation overdue children with their last immunisation providers (Lauren Dalton, 2018). According to the last immunisation providers, the most common reason for children being overdue for immunisation in SWS is family have moved out of the area (35%). Often families have not updated their address with Medicare, they are still shown as living in the SWS area despite having moved elsewhere.

### **Low Pneumococcal immunisation coverage for people aged 65 years and over**

In 2018-19, there were 5,465 hospitalisations due to influenza and 29,306 hospitalisations due to pneumonia in NSW (62.7 and 309.7 per 100,000 population respectively), of which 57% (19,909) were people aged 65 years and older. Influenza immunisation uptake in adults over 65 years of age has significantly improved in SWS. The *NSW Population Health Survey* indicates that in 2018-19, 75.1% of older adults in SWS were immunised against influenza compared with 76.2% in NSW.

Consultation with GPs identified that a main reason for low uptake of pneumococcal immunisation included low awareness of pneumococcal immunisation among immunisation providers and patients, including at-risk groups.

Adult immunisation was not reported to the Australian Immunisation Register (AIR) prior to the register's expansion to record adult immunisation in 2017. GPs are reluctant to give patients the immunisation if their vaccination status is unknown.

### **Overweight and obesity**

Carrying extra weight can lead to cardiovascular disease (mainly heart disease and stroke), type 2 diabetes, musculoskeletal disorders like osteoarthritis, and some cancers. Being overweight or obese is a risk factor for colorectal, breast (in post-menopausal stage), oesophageal (adenocarcinoma), endometrial, pancreatic, liver and renal cancers (CA, 2015). By comparison, overweight and obesity contributed 8.4% of the total disease burden in Australia both in 2015 and 2018 (AIHW, 2019). Overweight (including obesity) contributed to 44% of the total burden from endocrine disorders, 31% of the total burden from kidney and urinary diseases and 22% of the total cardiovascular disease burden (AIHW, 2021c).

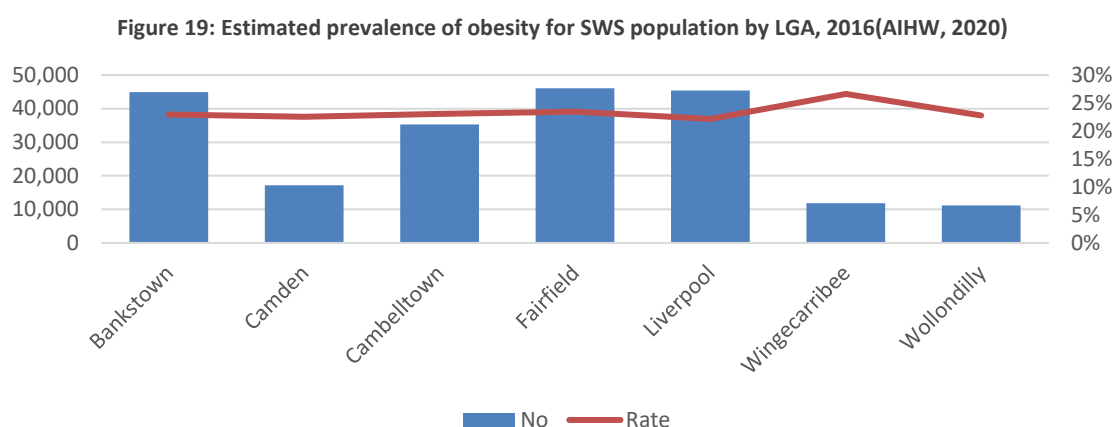
**Key Issue  
for our  
region**

**Almost a third of the South Western Sydney population are overweight and a quarter are obese**

The prevalence of overweight and obesity in both SWS and the rest of NSW has remained stable since 2010. In 2019, it was estimated 31.5% of the adult population in SWS was overweight, similar with the NSW average of 32.8%. In SWS, 23.6% of the adult population were obese, higher than the NSW average (22.4%). Women had slightly lower rate of

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obesity compared to men. The prevalence ranges from 21.5% for males in Camden to 26.6% for females in Wingecarribee (CEE, 2018). The number of obese persons in SWS increased by 34% from 212,010 in 2016 and is estimated to reach 284,575 persons by 2031 due to population growth and ageing (SWSLHD/SWSPHN, 2018).



### Overweight and Obesity among children and adolescents

In Australia (AIHW, 2020):

- In 2017–18, 25% Australian children and adolescents aged 2–17 were overweight or obese, and 8.2% were obese.
- The prevalence of overweight/obesity increased for 5–17-year-olds between 1995 (20%) and 2007–08 (25%) but has remained stable since.
- Aboriginal and Torres Strait Islander children and adolescents, those who have a disability, those who live in inner regional areas, and those who live in the lowest socioeconomic areas, are more likely to be overweight or obese.
- In 2018–19, 38% of Aboriginal and Torres Strait Islander children and adolescents aged 2–17 were overweight or obese, higher than 31% in 2012–13. The prevalence of obesity also increased, from 11% in 2012–13 to 14% in 2018–19.
- In 2017–18, children and adolescents aged 2–17 living in the lowest socioeconomic areas were more likely to be overweight or obese (28%) than those in the highest socioeconomic areas (21%). The obesity rate in this age group was 2.4 times as high for those in the lowest socioeconomic areas (11%) compared with the highest (4.4%).

The *NSW School Students Health Behaviours Survey, 2017* showed that an estimated 25.2% of SWS secondary school students aged 12–17 years were overweight or obese, much higher compared to the NSW average of 20.6% and the second highest among all LHDs in NSW (almost 5% above the state average). 18% were estimated to be overweight, compared to NSW average of 16.2% (CEE, 2016b). Overweight and obesity impacts children's physical and mental health and social wellbeing. Rising obesity rates among both adults and children contributes to the development of chronic conditions such as type 2 diabetes, CVD, CKD and musculoskeletal conditions.

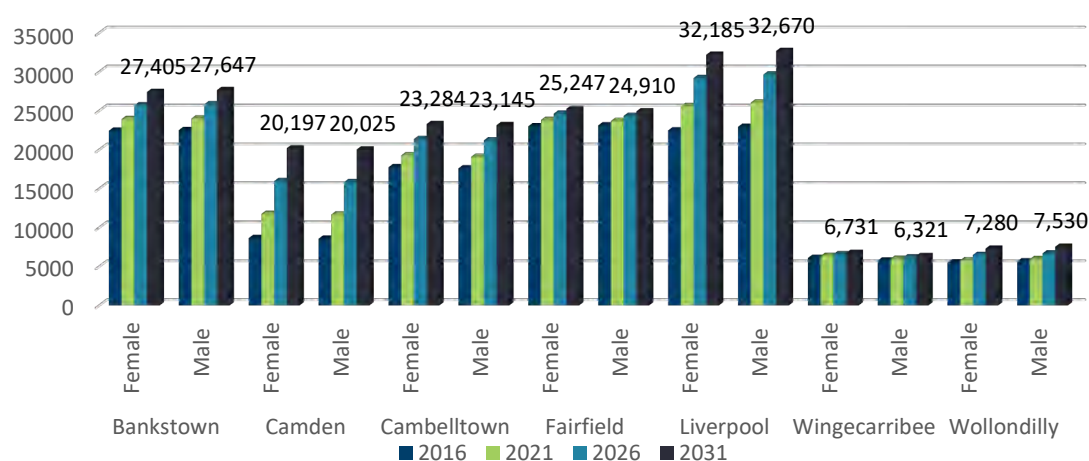
Issues raised through consultations surrounding addressing overweight and obesity issues include:

- Most common barriers to maintaining a healthy weight reported were costs of gym memberships and healthy food options, modern lifestyles including long working hours and increasing sedentary behaviour
- Navigation of services that address obesity is difficult. Lack of information about available services locally
- Need for patient resources in other languages (including pictures)
- Increase development of partnerships/relationships with GPs
- Need for community education and health promotion activities targeting shopping centres, schools and other community venues
- Gaps in availability of programs targeting youth

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- Need to reach disadvantaged people with disability, people with mental illness and Aboriginal people
- Services need to have an outreach approach and deliver to existing groups e.g., women's groups, social housing estates, schools and in community neighbourhood centres as transport is an issue to access such initiatives. Provision for language assistance and programs available in minority languages as well as more common languages
- All programs e.g. Go4Fun should have a holistic and culturally specific approach
- Lack of routine monitoring and recording height and weight measures in children and adolescents.

Figure 20: Projected number of obese persons for SWS by LGA and gender, 2016 to 2031(SWSLHD/SWSPHN, 2018)



### Potentially Preventable Hospitalisations

Potentially Preventable Hospitalisations (PPH) are those conditions for which hospitalisation is considered potentially avoidable through preventive care and early disease management, usually delivered in an ambulatory setting, such as primary health care. For SWS in 2017-18, there were 25,995 PPHs for total potentially preventable conditions (2595 per 100,000 persons) There was an average length of stay of 4.4 days (with 114, 127 bed days total) and 26.8% were same day admissions(AIHW, 2020b).

In 2017-18, potentially preventable hospitalisations for the following conditions as listed below were higher in SWS compared to NSW:

Table 16: PPH by condition per 100,000 people (age standardised), SWSPHN and NSW 2017-18

Conditions	SWSPHN	NSW
Pneumonia and influenza (vaccine-preventable)	280	240
Urinary tract infections including pyelonephritis	250	242
Ear, nose and throat infections	222	171
Asthma	139	120
Congestive cardiac failure	198	188
Diabetes complications	157	150
Convulsions	72	66
Hypertension	42	35
Pneumonia (not vaccine-preventable)	10	9
Other vaccine preventable conditions (excluding Hep B)	17	13
Perforated/bleeding ulcer	24	21

# SWSPHN NEEDS ASSESSMENT 2022 – 2025

Key Issue  
for our  
region

South Western Sydney had higher than state average rates of PPHs for a range of health conditions

A 2019 analysis conducted by Torrens University identified local hotspots for chronic disease PPHs in Australia. Below represents a heat map of SWS hotspots and the geographic variation in rates of PPH. Hotspots were defined using criteria from the Grattan Institute’s *‘Perils of Place: identifying hotspots of health inequality’* report which provided a framework to identify the existence of areas with persistently high PPH rates over time known as “PPH hotspots”.

Figure 21: Chronic Disease PPHs hotspots in SWS 2012/13 to 2016/17(Soumya Mazumdar, 2017, PHIDU, 2019)

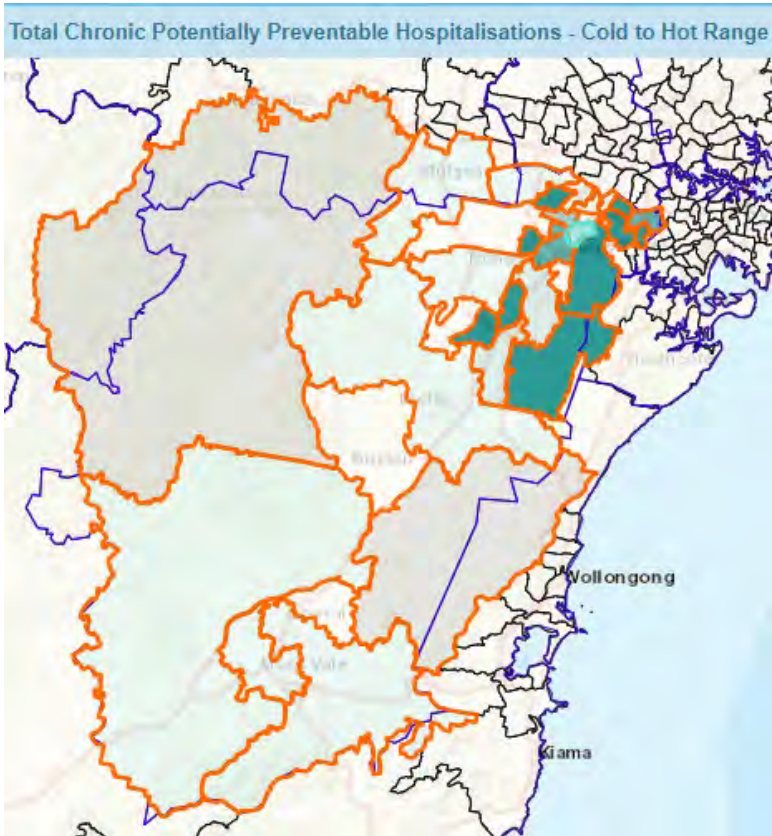


Table 17: Classification Scheme

Classification	Aggregation rule
Hot	Four and five occurrences in the 5 years
Warm-Hot	Three occurrences in the 5 years with at least one occurrence in the last two years
Warm	Two occurrences in the 5 years with consecutive values in years 2-5. Three occurrences in 5 years in only years 1-3
Cold-Warm	One occurrence in years 4 or 5 and two occurrences in the 5 years with only consecutive occurrences in year 1 and 2
Cold	Never above or only one occurrence in the years 1 to 3

Note: Occurrences were calculated based on a total of 20 thresholds selected with the lowest threshold set to 50% of the Australian rate and the highest set to four times the Australian rate for each year. NA represents admission totals not available due to either low populations or the confidentialisation of admissions which are between 1 and 4.

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Table 18: Potentially Preventable Hospitalisations 2012/13 to 2016/17, SWS areas (PHIDU, 2019)

Name	Category	Number
NSW: Greenacre - Mount Lewis/ Yagoona - Birrong	Warm-Hot	2,936
NSW: Ingleburn - Denham Court/ Minto area	Cold-Warm	2,931
NSW: Bossley Park - Abbotsbury area	Hot	2,542
NSW: Fairfield - West area	Cold	2,473
NSW: Casula/ Prestons - Lurnea	Warm-Hot	2,327
NSW: Holsworthy - Wattle Grove area	Hot	2,291
NSW: Campbelltown - Woodbine/ Rosemeadow - Glen Alpine	Cold-Warm	2,287
NSW: Bass Hill - Georges Hall/ Condell Park	Hot	2,233
NSW: Bankstown	Hot	1,873
NSW: Liverpool - Warwick Farm	Cold-Warm	1,814
NSW: Fairfield - South	Warm	1,808
NSW: Canley Vale - Canley Heights/ Fairfield	Cold	1,628
NSW: Claymore - Eagle Vale - Raby	Hot	1,265
NSW: Chester Hill - Sefton	Hot	1,227
NSW: Mount Annan - Currans Hill	Hot	1,200
NSW: Bradbury - Wedderburn/ Holsworthy Military Area	Hot	1,196
NSW: Ashcroft - Busby - Miller	Warm-Hot	1,072
NSW: Bowral/ Robertson - Fitzroy Falls	Cold	1,018
NSW: Hoxton Park - Horningsea Park	Hot	839
NSW: Douglas Park - Appin/ The Oaks - Oakdale	Cold	811
NSW: Hill Top - Colo Vale/ Southern Highlands	Cold	760
NSW: Fairfield - East	Cold	650
NSW: Penrith - South	Cold	650
NSW: Moss Vale - Berrima	Cold	593
NSW: Cobbitty - Leppington	Cold	328
NSW: Horsley Park - Kemps Creek	Cold	291

### Oral Health

Oral health contributes to overall health and wellbeing. Poor oral health can reduce quality of life and contributed 4.5% towards the total non-fatal disease burden in Australia in 2022 (AIHW, 2023).

#### Key Issue for our region

**South Western Sydney has poorer rates of oral health and higher rates of dental hospitalisations than the state average**

### Oral health in children

In NSW, children in socioeconomically disadvantaged groups, Aboriginal and Torres Strait Islander children and children living in regional and remote areas, are less likely to visit a dental professional, less likely to be free of dental caries and more likely to have decayed, missing and filled teeth (CEE, 2020d). Between 2011 and 2014, 70% of children aged 5-15 years in SWS were seen by a dental professional in the preceding 12 months, lower than NSW average of 75.7%. In 2015-16, 55% of 5 to 14 year-olds had experienced decay in their baby (deciduous) teeth and 48% of 12-year-olds had experienced decay in their permanent teeth (AIHW, 2018a).

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

Table 19: Reported rates on dental visits for children and adults, SWS, NSW and Australia, 2025 Target(AIHW, 2016a)

Indicator	SWS	Australia and NSW	2025 Target
Dentist, hygienist or dental specialist visits: adults in the last 12 months (2015-16)	43.6%	48.2% Australia	61%
Dental professional visits: children 5-15 years in the last 12 months (2011-2014)	70%	75.7% NSW	81 %
Public dental service visits: children 0-15 years in the last 12 months (2015-16)	7.7%	12.7% NSW	N/A

### Oral health in adults

It is estimated that in 2016, 168,918 people or 18% of the SWS population have deciduous teeth decayed or filled. In 2015–16, 43.6% of SWS adults reported they saw a dentist, hygienist or dental specialist in the preceding 12 months compared with 48.2% nationally.

The rate varies between 17.6% for males in Camden to 18.6% for females in Fairfield LGA. In 2018–19, around 3 in 10 adults (28%) aged 15 years and over avoided or delayed visiting a dental practitioner. Nearly 1 in 6 (18%) avoided or delayed visiting a dental practitioner due to cost. The proportion of adults avoiding or delaying visiting a dental practitioner has decreased over time from 33% in 2014–15, with those avoiding or delaying due to cost also decreasing from 20%.

The number of public dental patients waiting for assessment and treatment (excluding patients who are waiting for specialist dental services) in SWS as of 31 March 2021:

- 1,204 children waiting for assessment
- 2,333 children waiting for treatment
- 1,211 adults waiting for assessment
- 10,282 adults waiting for treatment

The number of persons forecast to have poor oral health by 2031 is expected to increase by 31.2% from 168,918 in 2016 to 221,680 in 2031.

### Dental hospitalisations

In SWS, there were 2,094 hospitalisations (211.8 per 100,000 population) recorded for acute potentially preventable dental conditions in 2016-2017. Young children have the highest rates of preventable hospitalisations due to dental conditions. In SWS, the number of persons estimated to have been hospitalised due to the poor oral health in 2016 was 26,080 and is expected to increase by 27.8% to 33,337 people.

Hospitalisation rates for the removal and restoration of teeth for dental caries in children aged (5-14) and (0-14) were higher in SWS compared with NSW, while the overall hospitalisation rate for children was similar to the state rate. Young children have the highest rates of preventable hospitalisations due to dental conditions.

Table 20: Hospitalisation for removal and restoration of teeth for dental caries in SWS and NSW, rate per 100,000 population, 2015-16(CEE, 2016a)

	0-4 years	5-14 years	0-14 years	15+ years	all ages
<b>SWS</b>	320.8	433.9	397.5	45.2	117.6
<b>NSW</b>	327.2	408.2	382.2	50.1	118.3

## Blood borne virus screening



## SWSPHN NEEDS ASSESSMENT 2022 – 2025

Harm minimisation has been a key policy of Australian state and federal governments since 1985. The Harm Reduction Program protects the community from the spread of blood borne viruses such as HIV and Hepatitis C primarily through the distribution of sterile injecting equipment to intravenous drug users and provision of information, advice and referral services. The National Drug Strategy 2017–2026 focuses on reducing harm using three approaches(DoH, 2017a):

A continued harm reduction approach combined with other complementary prevention strategies is the key to prevention efforts(MoH, 2019). This includes:

- Better detection of newly acquired hepatitis C notifications.
- Prompt appropriate education, care, referral, testing and contact tracing by diagnosing clinicians.
- Culturally appropriate harm reduction strategies for Aboriginal and Torres Strait Islander people in both community and prison settings

### Gambling Harm

The NSW Gambling Survey shows that in 2019, one in two adults in NSW gamble. Lotteries were the most common form of gambling (37%), followed by gaming machines (16%), instant scratchies (13%), and race betting (13%)(ORGNSW, 2020). It is estimated 1% of the adult population are classified as problem gamblers, 7.2% of people who gamble are at moderate risk of problem gambling(Roy Morgan, 2018).

As a result of gambling, people with gambling problems can experience harm which have negative impacts on their quality of life. Playing gaming machines presented the most risk of harm, followed by online poker machines. Young males aged 18-24, who are single and unemployed are most likely to experience gambling problems(Armstrong and Carroll, 2017). Speaking a language other than English, being of a non-Caucasian ethnicity and immigrant status have also been found to be a risk factor for gambling harm(Okuda, Liu et al., 2016).

The Fairfield community is at greater risk of gambling harm compared with the rest of SWS and NSW. Fairfield LGA has the lowest median weekly income per household in SWS, but it has the highest number of gaming machines per capital and highest net profit per capita from gaming machines. In 2019, Fairfield had 9.4 gaming machines per 1,000 population, three times of the NSW average of 3.1 per 1,000 population. The net profit from gaming machines in Fairfield was \$2,507 per capita, three times of NSW average of \$885 per capita(Liquor&Gaming, 2019).

Figure 22: Gaming machine net profit per capita, SWS, 2019(ORGNSW, 2020)



Research has found only a small proportion (<10%) of the individuals with gambling problems seek formal help(Cunningham, 2005, Slutske, Blaszczyński and Martin, 2009). Screening for gambling harm is not part of routine practice in primary health care and may indicate a lack of professional awareness and education. In a recent Victorian study of more than 300 clinicians working in mental health services, only 10.6 per cent of clinicians were aware of screening and assessment tools for gambling harm(Abbott, Stone et al., 2016). This was confirmed during SWSPHN's community consultation in 2019 as well as the additional barrier of lack of support and treatment services for gambling harm.

## 2.2.2 Chronic Disease in South Western Sydney

Many chronic diseases share common preventable risk factors. Modifying these risk factors (such as reducing tobacco use, improving physical activity and diet, etc.) can reduce the risk of developing a chronic condition, leading to large health gains in the population through the reduction in disease burden and mortality. Behavioural risk factors often occur together and may cluster particularly in disadvantaged communities and groups. These behaviours contribute to the development of biomedical risk factors, including overweight and obesity, high blood pressure, and high cholesterol levels which in turn lead to chronic disease.

### Key Issue for our region

**South Western Sydney has higher rates of chronic disease risk factors, particularly for diabetes, CVD, respiratory disease, cancer and mental health**

SWS residents on average have elevated rates of behaviours that have been linked to poorer health status and chronic disease prevalence. Diabetes, cardiovascular and respiratory diseases, cancer, and mental health conditions account for much of the burden of morbidity and mortality in SWS(SWSLHD/SWSPHN, 2018).

### Diabetes

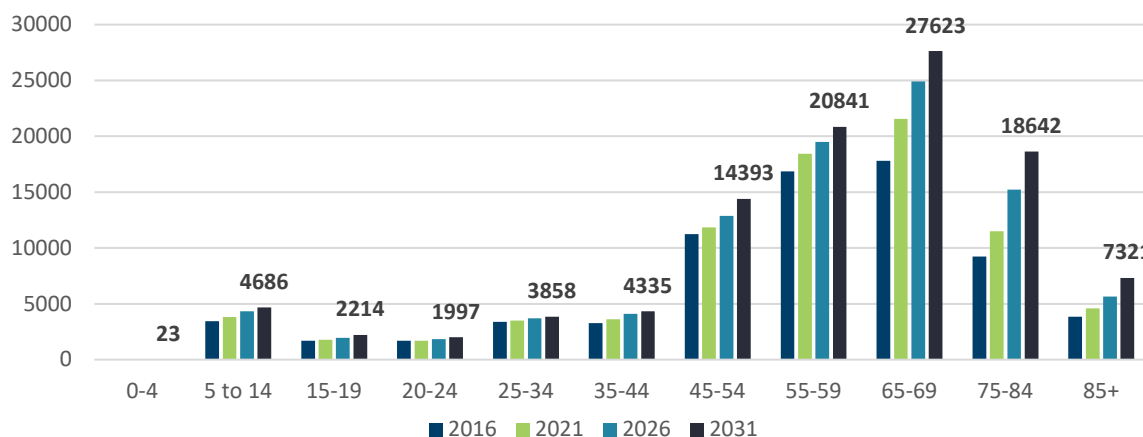
An estimated 1.2 million Australians, 4.9% of total population, had diabetes in 2017-18 in Australia (AIHW, 2020c). In NSW, diabetes is prevalent among people aged 75 years and over, males, Aboriginal people, people with lower socioeconomic status and people from a non-English speaking background. Diabetes was reported by local GPs to be the most common health issue in the community, and the second most common concern reported by the local community (CEE, 2020d).

### Key Issue for our region

**The rate of diabetes diagnoses within South Western Sydney has doubled in the past 20 years, resulting in a higher rate than the NSW average**

Between 2002 and 2019, the prevalence of diabetes has doubled in SWS (from 7% to 14.5%). In 2019, 14.5% of adults in SWS had diabetes or high blood glucose, higher than NSW rate (11.3%). Based on the prevalence for SWS from the NSW Population Health Survey 2019, it was estimated that 72,462 people had diabetes in 2016, excluding gestational diabetes. This number is expected to increase by 46.2% by 2031 to 105,933 people with almost half of it comprising of people aged 65+ (HealthStats, 2019)

Figure 23: Estimated Number of persons with diabetes in SWS by age, 2016 to 2031(CEE, 2020d, Diabetes-Australia, 2022)



Diabetes and its associated complications contribute significantly, both directly and indirectly, to mortality, morbidity,



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poor quality of life of sufferers and carers and increases the cost of health care. The number of people with type 2 diabetes is growing, as the result of rising overweight and obesity rates, lifestyle and dietary changes, and an ageing population. Type 2 diabetes accounts for about 85-90% of all diabetes cases and primarily affects people older than 40 years. Around 20% of people with type 2 diabetes use insulin. Several modifiable risk factors play a role in the onset of type 2 diabetes, including obesity, physical inactivity and poor nutrition, as does genetic predisposition and ageing. (SWSLHD/SWSPHN, 2018).

Prevalence data for diabetes is mostly collected by self-reporting methods, and less often through more accurate biomedical measures. A large proportion of the Australian population who have diabetes remains undiagnosed. It is estimated one in four people with diabetes is unaware of having the condition. This finding limits the value of self-reported data for estimating population prevalence.

In 2021, there were 72,190 people (6.6% of SWS population) registered on the National Diabetes Service Scheme (NDSS), higher than NSW average of 5.1%. Of these, 88.2% have type 2 diabetes, 7.3% have type 1 diabetes, and 3.7% have gestational diabetes (Diabetes-Australia, 2022). Across LGAs in SWS, Fairfield has the highest proportion of NDSS registrants (7.9%), followed by Campbelltown (7.2%) and Liverpool (6.6%). Diabetes Australia estimates that the NDSS covers 80%–90% of people with diagnosed diabetes.

Table 21: NDSS registrations by LGA, SWS, 2021 (Diabetes-Australia, 2022)

LGA	Number of Registrants	% Of population
Camden	4,440	4.9%
Campbelltown	13,310	7.2%
Canterbury-Bankstown	26,440	6.5%
Fairfield	18,360	7.9%
Liverpool	15,810	6.6%
Wingecarribee	2,600	4.6%
Wollondilly	2,740	4.8%

Table 22: Very High proportion of NDSS registrations Postcodes, SWS, 2021 (Diabetes-Australia, 2022)

Postcode	NDSS Registrants %	Postcode	NDSS Registrants %
2176	8.1%	2555	11.4%
2564	8.4%	2179	13.1%
2163	8.7%		
2165	8.7%	SWS	6.6%
2164	9.0%	NSW	5.4%
2174	9.8%	Australia	5.6%

Gestational diabetes (GDM) prevalence rate in SWS is higher than the state and national rate across all LGAs except Fairfield. SWS has the second highest rate of GDM registrants of all NSW PHNs (the fifth highest nationally). The high prevalence is driven by the increasing proportion of the population that is overweight and obese from a young age (SWSLHD/SWSPHN, 2018). There is also a higher proportion of NDSS registrants with GDM in SWS (3.7%) compared to the national rate (2.9%).

### Diabetes Related Hospitalisations

There were 1.2 million hospitalisations associated with diabetes in 2017-18 accounting for 11% of all hospitalisations

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in Australia. Between 2011-12 and 2018-19, type 2 diabetes hospitalisations have steadily increased in NSW, while type 1 diabetes hospitalisations have remained stable. In 2018-19, hospitalisations with diabetes as principal diagnosis were higher in SWS compared with NSW (198 and 162.5 per 100,000 population respectively).

Comparing SWS to the NSW average, type 1 diabetes hospitalisations were higher in all LGAs except for Fairfield and Canterbury-Bankstown, while type 2 diabetes hospitalisations were significantly higher in Fairfield, Liverpool, Canterbury-Bankstown and Campbelltown LGAs. For type 1 diabetes hospitalisations, people aged 0-24 have the highest rate (57.7 per 100,000 population). Type 2 diabetes hospitalisations increase with age. People aged 75 years and over have the highest rate (693.1 per 100,000 population), which is 5.5 times the rate for the general population.

**Table 23: Type 1 & Type 2 Diabetes as a principal diagnosis: Hospitalisations by LGA, SWS, 2018-19(CEE, 2020b)**

LGA	Type 1		Type 2	
	Spatially Adjusted Number of Separations per Year	Spatially Adjusted Rate per 100,000 population	Spatially Adjusted Number of Separations per Year	Spatially Adjusted Rate per 100,000 population
Fairfield	53	25.3	254	121.8
Canterbury-Bankstown	135	36	560	148.8
Liverpool	121	53.2	294	129.4
Campbelltown	90	53.3	253	148.9
Camden	55	57.9	68	72
Wingecarribee	31	63.4	41	84.5
Wollondilly	34	67.9	40	78.9
NSW		49.7		100.5

**Table 24: Type 1 and type 2 diabetes hospitalisations (rate per 100,000 population), SWS and NSW by age, 2016-17(Diabetes-Australia, 2022)**

Ages (years)		0-24	25-34	35-44	45-54	55-64	65-75	75+	All ages
Type 1	SWS	79.3	49.4	55.3	25.5	24.6	10.6	7.2	49.9
	NSW	74.3	51.8	47.7	40.5	33.3	34.0	30.0	53.1
Type 2	SWS	2.1	23.6	42.5	138.3	188.9	299.5	534.4	98.5
	NSW	2.0	13.5	35.0	87.7	168.2	328.5	530.0	88.7

### ***Potentially preventable hospitalisations for diabetes complications***

Diabetes complications are among the most common chronic conditions for which hospitalisation is considered to be potentially preventable by timely and appropriate provision of primary or community-based care(AIHW, 2018b).

In SWS in 2017-18, the age-standardised rate of potentially preventable hospitalisation (PPH) for diabetes complications was 159 per 100,000 people, lower than the national rate of 187 per 100,000. Within SWS, Campbelltown has the highest rate (193 per 100,000 people) of PPH and total bed days (2,855) (AIHW, 2020b).

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Table 25: Potentially preventable hospitalisations for diabetes complications, SWS and Australia, by SA3, 2017-18(AIHW, 2020d)

SA3 area name	PPH per 100,000 people(age-standardised)	Number of PPH	Total PPH bed days	Rate length of stay (days)
Fairfield	97	208	1672	8
Wollondilly	108	49	256	5.2
Camden	174	103	734	7.1
Bankstown	184	349	1718	4.9
Bringelly - Green Valley	193	193	1280	6.6
Liverpool	194	228	1633	7.2
Campbelltown (NSW)	198	320	2855	8.9

### Diabetes related deaths

Age-adjusted death rates for people with diabetes were almost double those for the general Australian population. The disparity in death rates was highest in people aged under 45 with type 1 diabetes (4.5 times as high), and type 2 diabetes (5.8 times as high)(SWSLHD/SWSPHN, 2018).

In 2018, the diabetes death rate in SWS was 32.2 per 100,000 population, higher than NSW rate of 27.6 per 100,000 population(AIHW, 2020b). Age-adjusted death rates for diabetes in SWS were 1.3 times higher than the NSW average. Males have a higher rate than females. At the LGA level, Canterbury-Bankstown, Campbelltown, Fairfield and Liverpool LGAs have significantly higher rates of death compared with NSW.

Table 26: Diabetes related deaths (underlying + selected associated), NSW & SWS 2018(CEE, 2018)

LGA	Spatially Adjusted Number of deaths per Year	Spatially Adjusted Rate per 100,000 population
Camden	23.3	26.1
Wingecarribee	13.4	27.2
Wollondilly	13.7	27.2
Liverpool	67.5	30.5
Canterbury-Bankstown	120.3	32.5
Campbelltown	64.8	38.9
Fairfield	84.2	40.5
NSW		27.6

### Variations between population groups

Males are 1.7 times as likely to die from diabetes complications than females. Aboriginal and Torres Strait Islander people are 2.4 times as likely to die from diabetes compared to non-Aboriginal people (69.5 and 27.5 per 100,000 population respectively). People who are socioeconomically disadvantaged are more likely to die from diabetes than those who are less disadvantaged. In 2018, people in the bottom 20% of most disadvantaged quintiles (IRSD) are 2.8 times as likely to die from diabetes complications compared to the top 20% least disadvantaged (40.6 and 14.4 per 100,000 population respectively)(CEE, 2020c).

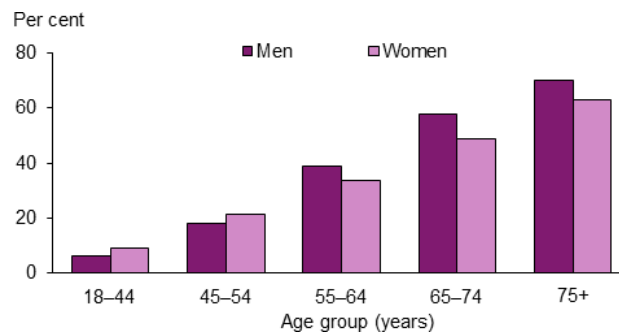
## SWSPHN NEEDS ASSESSMENT 2022 – 2025

### Cardiovascular disease

Cardiovascular (or circulatory) diseases (CVD) comprises all diseases of the heart and blood vessels. Commonly, this group of conditions is referred to under the broader term of 'heart disease' or 'cardiovascular disease' (AIHW, 2018c).

In Australia, CVD was the underlying cause of 42,300 deaths (25% of all deaths) in 2019. 6.2% of adults (1.2 million) had 1 or more conditions related to heart, stroke, or vascular disease in 2017-18. The prevalence of CVD increases with age. Aboriginal and Torres Strait Islander Australians had CVD hospitalisation and death rates at twice the rate of non-Aboriginal and Torres Strait Islander Australians (AIHW, 2018e).

Figure 24: Prevalence of CVD, among persons aged 18 and over, by age and sex, 2014–15 (AIHW, 2018e)



According to the *ABS National Health Survey* (ABS NHS), the estimated CVD prevalence in SWS is lower than the national and state prevalence (17.2% vs. 21.5% and 21.3% respectively).

The rate of coronary artery disease in SWS is 4.9% and by LGA ranges from 4.1% for persons in Camden to 8.3% for males in Wingecarribee. The rate of coronary artery disease increases strongly for those aged 45 and over and triples for individuals aged 65 and over.

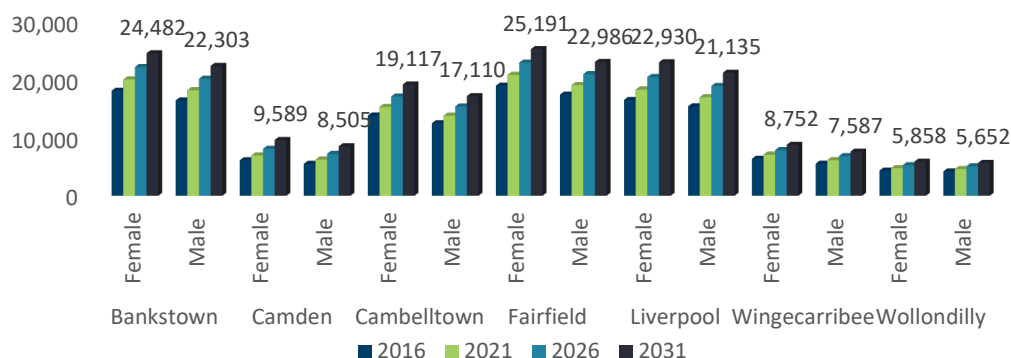
The prevalence of CVD in SWS for females is 19.1% and for males is 16.7%. The estimated prevalence rate of CVD across LGAs ranges from 13.8% for males in Camden to 27.7% for females in Wingecarribee. Fairfield and Bankstown have the highest number of persons with CVD (36,280 and 34,422, respectively). Among LGAs, Wingecarribee has the highest prevalence of 27.7% and is the only LGA with CVD prevalence above the NSW average.

#### Key Issue for our region

**While the prevalence of cardiovascular disease in South Western Sydney is lower than the state average, it is predicted to increase by 38% by 2031**

The number of residents with CVD in SWS is projected to increase by 38% by 2031 rising from 160,710 people in 2016 to 221,197 in 2031. The highest increase is expected in Camden and Liverpool LGAs (56% and 38.5% respectively) (SWSLHD/SWSPHN, 2018).

Figure 25: Projected number of persons with CVD in SWS by LGA and gender, 2016 to 2031 (SWSLHD/SWSPHN, 2018)



## SWSPHN NEEDS ASSESSMENT 2022 – 2025

### ***CVD related hospitalisations***

In SWS, The CVD hospitalisation rate slightly decreased in 2015-16 compared with 2001-02 for both males and females (CEE, 2020d). Between 2001-02 and 2018-19, CVD hospitalisations in SWS declined from 1795.8 to 1587.9 per 100,000 population. In 2017-18, hospitalisations per 100,000 was 1,729.4 and in 2018-19, it was 1587.9 per 100,000. Both were lower than the NSW rate (of 2,380.1 and 1672.4 per 100,000 population respectively) during the reference period. The hospitalisation rate for females was lower than males.

In NSW and SWS, coronary artery disease has the highest hospitalisations rate among all circulatory diseases (536 per 100,000 population). In 2018-19, it accounted for 29.4% of hospitalisations among all cardiovascular diseases in SWS(CEE, 2020c). In 2018-19, it accounted for 29.4% of hospitalisations among all cardiovascular diseases.

Table 27: Circulatory disease hospitalisations by disease type, persons, SWS 2018-19

Disease type	Number	Rate per 100,000 population
All Circulatory Disease*	17,020	1587.9
Coronary Heart Disease	5,007	463.1
Remaining circulatory diseases	4,591	434.4
Heart failure	2,218	203.2
Atrial fibrillation and flutter	1,605	149.4
Stroke	1,451	134.5
Haemorrhoids	1,234	123
Peripheral Vascular Disease	960	88
Varicose veins of lower extremities	718	70
Transient ischaemic attacks	503	46.8
Paroxysmal tachycardia	470	45.3

### ***CVD related deaths***

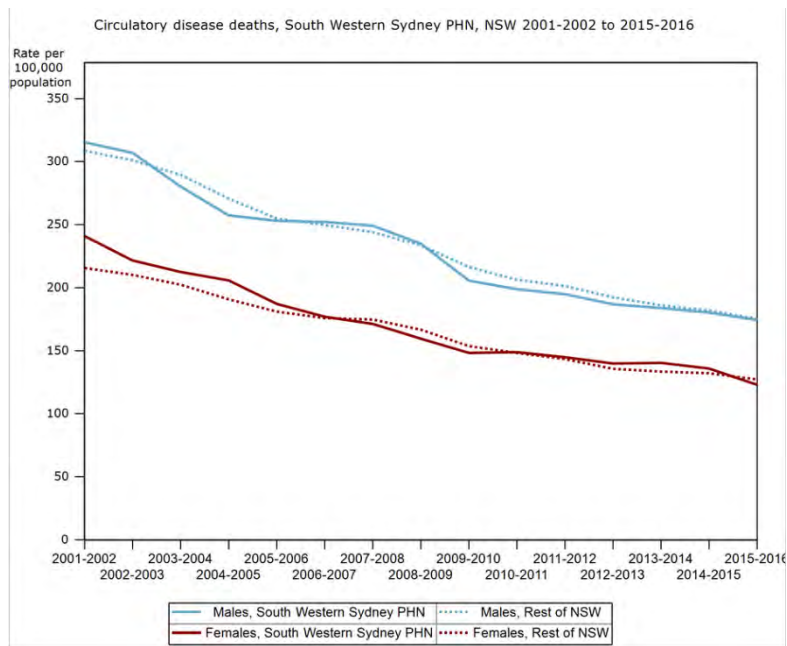
Overall, the death rates from all forms of circulatory disease have steadily decreased since 2001 due to:

- Decreased incidence, associated with reductions in some risk factors, including smoking, saturated fats in the diet, and levels of blood pressure
- Increased survival, as a result of improvements in medical and surgical treatment and follow-up care(CEE, 2020d).

In 2015-17, there were 1,478 deaths attributed to circulatory diseases in SWS. The death rates in SWS were lower for females (125.6 per 100,000) compared with males (171.4 per 100,000) (AIHW, 2021e).

Figure 26: Circulatory disease deaths, South Western Sydney PHN, NSW 2001-02 to 2016-17(CEE, 2018)

# SWSPHN NEEDS ASSESSMENT 2022 – 2025



### Variation between population groups

In NSW, males are 1.5 times as likely to die from circulatory diseases as females (173.7 and 119.2 per 100,000 population respectively). Aboriginal and Torres Strait Islander people are 1.3 times more likely to have cardiovascular related hospitalisations as non-Aboriginal people (189.0 and 144.3 per 100,000 population respectively). People who are socioeconomically disadvantaged are more likely to die from circulatory diseases than those who are less disadvantaged. In 2017-18, people in the most disadvantaged (IRSD) quintile are 1.5 times more likely to die from diabetes compared to those in the least disadvantaged quintile (163.6 and 108.5 per 100,000 population respectively)(CEE, 2020c).

### Kidney disease

Kidney disease is a subset of symptoms including problems or complaints about the kidneys, renal pain and renal colic (kidney stones). Many people do not know they have kidney disease and up to 90% of kidney function can be lost before symptoms appear. Chronic kidney disease (CKD) occurs when there is evidence of kidney damage or reduced kidney function that has lasted for at least 3 months.

CKD is largely preventable as many of its risk factors, such as high blood pressure, insufficient physical activity, overweight and obesity, and smoking, is ‘modifiable’. Diabetes and high blood pressure are two of the most common causes of CKD(SWSLHD/SWSPHN, 2018).

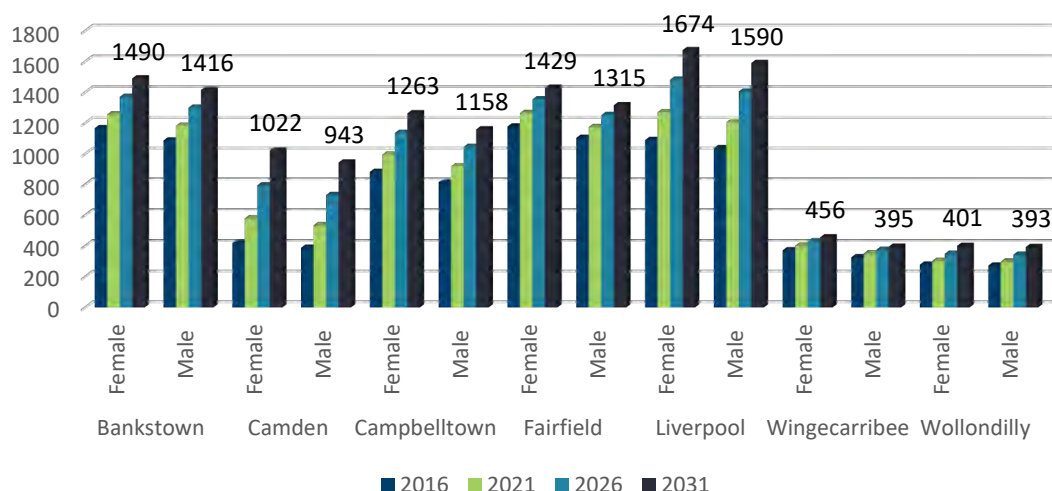
<b>Key Issue for our region</b>	<b>Sixteen percent of the state’s people with kidney disease reside in South Western Sydney</b>
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It was estimated that in 2016, 10,412 (1.1%) of SWS residents had kidney disease, representing 16% of the total state population with kidney disease. Camden and Liverpool LGAs had lower prevalence rates of 1.0% and Wingecarribee LGA had the highest rate of 1.5%. It was estimated that Fairfield and Bankstown LGAs have the highest number of people with kidney disease in SWS (2,280 and 2,252 respectively).

The number of SWS residents with kidney disease is projected to increase by 43.5% between 2016 and 2031 rising from 10,412 to 14,944 people by 2031.

Figure 27: Projected number of people with kidney disease by LGA and gender, 2016-2031(CEE, 2020d)

## SWSPHN NEEDS ASSESSMENT 2022 – 2025



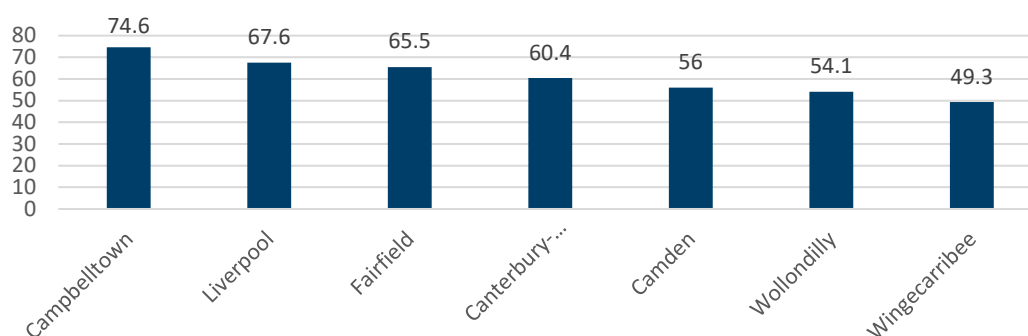
### CKD hospitalisations

In SWS, CKD hospitalisations (including dialysis) in 2018-19 was 7049 per 100,000 population, higher than NSW of 5414.1 per 100,000 population. It is the highest among all PHNs in NSW. Within SWS, five of the seven LGAs have significantly higher CKD hospitalisations compared to NSW except for Wingecarribee and Wollondilly(CEE, 2020c).

### CKD deaths

Between 2016 and 2018, there were 641 deaths per year in SWS, representing a higher death rate than the state (61.5 and 56.5 per 100,000 population, respectively). Across LGAs, Campbelltown had the highest death rate. Four out of the seven LGAs (Campbelltown, Liverpool, Fairfield, Canterbury-Bankstown) had a death rate higher than the NSW rate(CEE, 2020c).

Figure 28: Chronic Kidney Disease deaths by LGA, SWS 2016 to 2018(CEE, 2020c)



### Variations between population groups

In NSW, males are 1.77 times more likely to have CKD compared to females (7031.3 and 3970 per 100,000 population respectively). Aboriginal and Torres Strait Islander people are 2.75 times as likely to have CKD compared to non-Aboriginal people (2843.8 and 1032.8 per 100,000 population respectively). CKD prevalence increases with socioeconomic disadvantage. In 2018-19, people in the most disadvantaged (IRSD) quintile are twice as likely to die from diabetes compared to the least disadvantaged quintile (1471.2 and 729.1 per 100,000 population respectively)(CEE, 2020c).

## Respiratory disease

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Respiratory disease covers a range of respiratory-related conditions, such as asthma, COPD,

### Key Issue for our region

**The rate of hospitalisations for respiratory diseases such as asthma and COPD are higher in South Western Sydney than the state average**

### Asthma

Asthma is among the most common chronic conditions for which hospitalisation is considered to be potentially preventable (AIHW, 2018a). According to the *NSW Child Population Health Survey 2018-2019*, in SWS, 11.3% of children were reported to have current asthma. Further, 21.3% of children were reported to ever had asthma.

In SWS, asthma hospitalisation rates for people aged 5-34 years has steadily increased between 2012-13 to 2016-17. In 2016-17, the hospitalisation rate for SWS residents was higher than the NSW rate (217.3 and 180.5 per 100,000 population, respectively) (CEE, 2018). In 2015-16, the age-standardised rate of potentially preventable hospitalisation (PPH) for asthma was 148 per 100,000 people, higher than the national rate of 133 per 100,000 population. Across SWS, Merrylands-Guildford has the highest PPH (243 per 100,000), followed by Liverpool (215 per 100,000) and Campbelltown (173 per 100,000).

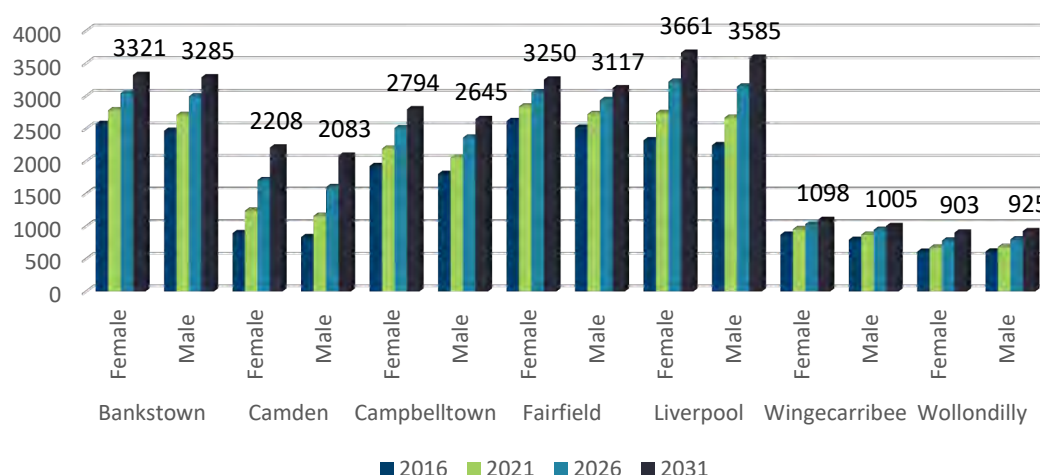
The number of persons estimated to have asthma is forecast to increase by 9% from 99,486 persons living with asthma in 2016 to 108,636 persons with asthma by 2031.

### COPD

According to the 2014–15 NHS, people with self-reported COPD were more likely to be current smokers, physically inactive, and/or obese, compared to those without COPD. In SWS, the estimated prevalence of COPD is 2.5%, with 23,068 people affected. This is similar to the national and state rate (both 2.6%). Prevalence ranges from 2.1% for males in Camden to 3.8% for females in Wingecarribee.

The number of persons with COPD in the SWS is projected to increase by 47% by 2031, from 23,069 persons in 2016 to 33,882 persons in 2031.

**Figure 29: Projected number of persons with COPD for SWS by LGA and gender, 2016 to 2031 (CEE, 2020d)**



### COPD hospitalisations

COPD is amongst the most common chronic conditions for potentially preventable hospitalisations. Hospitalisation rates for COPD in SWS for all ages were slightly lower compared with the rest of the state (248.9 and 253.1 per 100,000 population, respectively), and rates for older people over 65 years of age were higher in SWS compared with the rest of NSW (1593.5 and 1538.9 per 100,000 population, respectively) (CEE, 2020c).



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Within SWS, rates of COPD in Liverpool and Campbelltown were significantly higher than the overall rate. The total bed days were higher across SWS except in Camden and Wollondilly SA3. An average length of stay in SWS was similar to the national length of stay. Only Southern Highlands and Bankstown had higher average length of stay than the SWS and national average length of stay (7 and 6.5 days compared to 5.6 and 5.4, respectively).

**Table 28: Potentially preventable hospitalisation for COPD for SWS residents by SA3, 2015-16 (AIHW, 2020d)**

SA3 name	PPH per 100,000 people (age-standardised)	PPH per 100,000 people (crude)	Number of PPH	Number of same day PPH	Percentage of PPH that are same day (%)	Total PPH bed days	Average length of stay (days)
Southern Highlands	187	352	169	18	10.7	1,190	7
Bankstown	218	242	430	55	12.8	2,779	6.5
Camden	196	164	102	16	15.7	434	4.3
Campbelltown	309	279	448	48	10.7	2,492	5.6
Wollondilly	258	269	109	12	11	598	5.5
Merrylands- Guildford	265	264	110	6	8.4	666	6.2
Bringelly-Green Valley	189	148	143	13	9.1	664	4.6
Fairfield	236	247	473	24	5.1	2,508	5.3
Liverpool	371	321	378	35	9.3	1,829	4.8
SWS	249	251	2,362	227	9.6	13,160	5.6
National	260	302	7,1861	7,517	10.5	385,849	5.4

### ***COPD related deaths***

COPD is the fifth leading cause of death after coronary artery disease, dementia and Alzheimer's disease, cerebrovascular disease, and lung cancer. COPD mortality has declined over time; however, mortality rates are higher for people living in remote areas and for people from lower socioeconomic backgrounds. COPD mortality rates are also higher among Aboriginal Australians compared with non-Aboriginal Australians (AIHW, 2016b)

Chronic obstructive pulmonary disease, which includes chronic bronchitis and emphysema, was responsible for 2,389 deaths in NSW (91% or 2,180 in those aged 65 years and over). The number of deaths in SWS accounted for about 9.3% of NSW COPD attributed deaths. COPD death rate in SWS was similar to the state rate (23.8 and 24.4 per 100,000 population, respectively). (CEE, 2020d)

### ***Chronic pain***

In 2020, 16.1% of those aged 15 and older were reported to be living with chronic pain in Australia (Deloitte, 2019). This is projected to increase by 0.9% by 2050. NSW has the highest number of reported chronic pain cases among all Australian states, representing close to one third (32%) of all cases of chronic pain in the country.

Several factors increase the likelihood of developing chronic pain, including being female, increasing age, genetic predisposition and environmental influences, such as socioeconomic disadvantage. Behaviour risk factors including physical inactivity, smoking, and being overweight or obese have been linked to chronic pain. Several long-term health conditions are associated with chronic pain, including musculoskeletal conditions, cardiovascular diseases, diabetes, asthma, stroke, and bowel disease (AIHW, 2020e)

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### ***Chronic pain hospitalisations***

In 2017–18, 105,000 hospitalisations in Australia involved chronic pain. Hospitalisation rates were higher for women and increased with age. The average bed days for patients with chronic pain was 5 days longer than patients without chronic pain. The rate of hospitalisation is higher for people in lower socioeconomic areas (AIHW, 2020e).

### ***Treatment***

The cost of pain in Australia report by Pain Australia 2019 (Deloitte, 2019) shows that the treatment of pain management is medication dominant and varies by for people living in rural and remote areas. For example, 1 in 5 of all GP consultations are related to pain management including medication prescription, referral of diagnostic imaging and referral to a specialist. Nationwide, medications were used to manage chronic pain approximately 68.4% of GP consultations, these medications included prescription opioids, other analgesics and migraine medications.

People living in rural and regional areas are more likely to be prescribed medication, and less likely to receive a referral to a specialist (Deloitte, 2019).

In 2016, among those aged 45 and over, more than half (57%) of people with chronic pain were dispensed analgesics, compared with 1 in 5 (21%) people without chronic pain. These medications included prescription opioids, other analgesics and migraine medications.

People with chronic pain were almost 3 times as likely to be dispensed opioids, other analgesics or migraine medications as those without chronic pain (AIHW, 2020e). There is increasing evidence of harm and negative side effects, and a lack of evidence of the effectiveness of long-term opioid use for managing chronic pain (Currow, Phillips and Clark, 2016, AIHW, 2018c). Opioid misuse is of national and international concern. All opioids carry a risk of dependence, accidental overdose, hospitalisation and death (AIHW, 2018c).

Pain Australia online survey, 2022 (painAustralia, 2022) respondents identified the following action areas:

- Improve access to treatment – 59.6% of respondents reported difficulties in accessing treatment and 43.1% reported a lack of alternative treatments provided by their health professional. Chronic pain management should include access to allied health treatment, non-opioid medication, lifestyle advice, pain management clinics/programs and referral to specialists.
- Improve health professional support: Only 48.6% of respondents felt adequately support by their health professional in managing chronic pain. General practitioners should receive training to educate patients, provide holistic care and guide patients through the appropriate care pathways.
- Education and Awareness: National strategy needs to be provided at all levels to reduce stigma and increase awareness of pain, including seeking funding for a consumer engagement strategy that informs consumers to make decisions about their pain treatment, together with resources to support consumers such as a national database where consumer stories can be shared, covering the spectrum of lived experience (painAustralia, 2022).

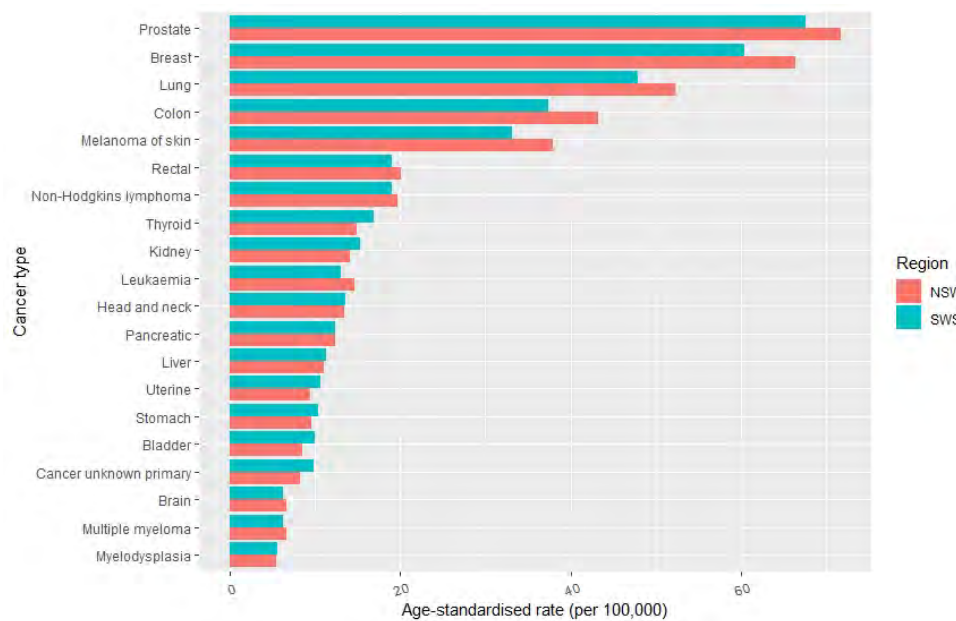
## ***Cancer***

### ***Cancer Incidence***

Between 2013 and 2017, cancer incidence was lower in SWS compared to NSW. Prostate cancer is the most diagnosed cancer, followed by breast and lung cancer in SWS. Across SWS LGAs, Camden has the highest cancer incidence rate (522.9 per 100,000 population).

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Figure 30: Cancer incidence by cancer type, age standardised, SWS and NSW, 2013-2017(CINSW, 2021)



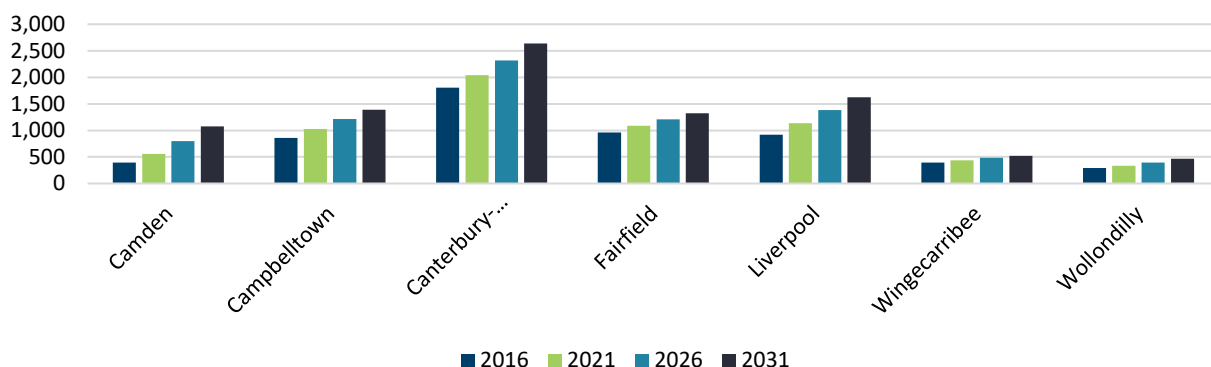
### Key Issue for our region

**South Western Sydney's incidence of cancer is expected to increase by 33-174% by 2031, depending on LGA**

Based on an understanding of the population growth, current incidence, the population profile and risk factors in the local population, the projected growth in cancer incidence by LGA between 2016 and 2031 is showing the greatest projected increase in Camden (173.7%) and Liverpool (77%) and the lowest in Wingecarribee and Fairfield (32.6% and 37.8% respectively).

The greatest increases between 2016 and 2031 are anticipated in lung cancer, myelodysplasia, upper gastrointestinal cancer and melanoma. It is expected that by 2031, SWS will have around 7,900 new cases of cancer diagnosed per year (excluding non-melanoma skin cancers) and that around 2,400 residents will die of cancer.

Table 29 : Projected number of new cases of cancer in SWS (and percent of NSW total new cases) for years 2016, 2021, 2026 and 2031, by LGA(CINSW, 2017)



Many cancers have a significant impact on multicultural communities for the following reasons:

- Lung cancer numbers are expected to increase based on high smoking rates among some CALD communities. Men born in China (20.3%), Vietnam (32.0%) and Lebanon (39.3%) have higher smoking rates compared to total NSW (14.7%).
- Primary liver cancer numbers are high due to the high rates of hepatitis B and/or C among CALD communities, which is one cause of this cancer.

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- Bowel, breast and cervical cancer outcomes are often poor due to low participation of CALD communities in the national screening programs.

### Cancer Mortality

Between 2013 and 2017, the cancer mortality rate in SWS was higher than the NSW rate (156.4 and 152.5 per 100,000 population respectively). The mortality rate for males was 1.5 times higher than females (179.3 and 119.4 per 100,000 population respectively) in SWS. Lung cancer has the highest mortality rate in SWS, followed by colon cancer and breast cancer. Within SWS, Campbelltown and Liverpool LGAs have cancer mortality rate higher than NSW (178.5 and 160.0 per 100,000 population respectively).

The Cancer Institute NSW projected that cancer deaths in SWS would overall increase by 42.3% between 2016 and 2031 from 1,923 cancer deaths in 2016 to 2,736 cancer deaths in 2031. The highest increase in death rates is expected in Camden (148%) and Liverpool (56%).

Table 30: Projected number of deaths from cancer in SWS (and percent of NSW total cancer deaths) by LGA, 2016, 2021, 2026 and 2031 (CINSW, 2021)

LGA (2016)	Cancer deaths				Cancer deaths as a percent of NSW total			
	2016	2021	2026	2031	2016	2021	2026	2031
Camden	110	150	207	273	0.7%	0.9%	1.1%	1.4%
Campbelltown	278	320	371	422	1.8%	1.9%	2.0%	2.1%
Canterbury-Bankstown	646	683	733	802	4.2%	4.1%	4.0%	4.0%
Fairfield	360	390	421	456	2.3%	2.3%	2.3%	2.3%
Liverpool	304	356	415	473	2.0%	2.1%	2.3%	2.4%
Wingecarribee	136	148	162	175	0.9%	0.9%	0.9%	0.9%
Wollondilly	89	100	117	135	0.6%	0.6%	0.6%	0.7%
<b>NSW</b>	<b>15,371</b>	<b>16,620</b>	<b>18,089</b>	<b>19,800</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

### Barriers to access cancer services

Issues raised through community consultations include:

- Increasing demand of cancer services due to population growth posed a challenge for SWSLHD cancer services
- The community views GPs as a key provider to prevent and guide patients through their cancer journey
- Service gaps were raised including transport, access to palliative care services, the cost of specialist services and the lack of services for carers
- Poor coordination/collaboration between primary care services and cancer therapy centres
- Lack of community-based palliative care dietitians
- Lack of community-based services for chronic and palliative care in Wingecarribee
- Need more resources for palliative care in all hospitals

### Cancer treatment service needs

With the increasing number of people diagnosed and surviving cancer, there is a concerted push for GPs to be more involved in shared-care follow-up, such as the CISCO Breast Cancer Shared Care Follow-Up Model. This is a clinical area in which GPs have not typically been involved in and capacity building both in terms of processes and education is required.

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The increase in the use of immunotherapy treatment methods, which often require the patient to be on immunotherapeutics for the rest of their life, will continue to add complexity for GPs to manage their patient's care due to ongoing side effects, drug interactions, etc. Further support for GPs is needed as immunotherapy becomes a more routine cancer treatment.

### *Integration of services for chronic disease management*

Local projected population growth, and growth in the number of people aged 65 years and older and increasing rates of chronic diseases will increase demand on primary care provision in the region. Patients, health professionals and other stakeholders highlighted the lack of collaboration between services and individual providers across the region, with some providers working in 'silos', and poor communication between hospitals and primary care services. Suboptimal management of chronically ill patients leads to serious complications and to an increase in hospital admissions. There is a need for better integrated and coordinated care, collaboration across a multidisciplinary team of care providers, planned care with regular follow-up and review, and support for patient self-management (SWSLHD, 2013a).

**Key Issue  
for our  
region**

**Lack of integration between primary and secondary care services**

Coordination and collaboration between services are viewed as a significant barrier to efficient health care. Consumers, service providers and GPs frequently raised the issue of a lack of collaboration and communication between services. This could be addressed by information sharing. A number of initiatives through the Integrated Care Collaboration established between SWSLHD and SWSPHN are focusing on integrated and coordinated health care between primary care and secondary care (including initiatives such as HealthPathways, Wollondilly and Fairfield Health Alliances).

In 2015, SWSLHD and SWSPHN implemented HealthPathways South Western Sydney, an online health information portal aimed at general practitioners to assist them with referrals to local specialists and services and improve care coordination between primary and secondary care services.

GP, service provider and community support for services that plan and implement activity collaboratively. A number of existing interagency networks are working well and that these models could be built on to further improve collaboration between agencies.

#### **Diabetes care**

SWSLHD has three established multidisciplinary Diabetes Centres at Bankstown-Lidcombe, Campbelltown and Liverpool Hospitals. Fairfield has a nurse-led service. The Campbelltown service provides outreach services to Camden and Bowral Hospital. Wollondilly and Wingecarribee LGAs rely largely on private providers of diabetes services, or travel to other regions.

Primary Care Clinicians require guidance and support to manage patients with type 2 diabetes and maintain good glycaemic control. This includes access to clinical guidance, care coordination with secondary care services and clinical support from relevant specialties.

In 2015, SWSLHD and SWSPHN implemented HealthPathways South Western Sydney, an online health information portal aimed at general practitioners to assist them with referrals to local specialists and services and improve care coordination between primary and secondary care services.

#### **My Care Partners**

In 2021, SWSPHN and SWSLHD implemented My Care Partners, a 'medical neighbourhood' model of care designed to address potentially preventable hospitalisations of at-risk patients in South Western Sydney. The goal of My Care Partners is to:

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- Improve coordination between the patient's medical home, primary and community services and acute care
- Improve outcomes for patients with complex and chronic conditions who are at risk of potentially preventable hospitalisations

Improve patient and provider experience by encouraging continuity of care and team-based care to reduce the risk of omission or duplication of services

## 2.2.3 Communicable Diseases in South Western Sydney

### Hepatitis B

#### Hepatitis B prevalence

In 2020 in Australia, an estimated 222,559 people were living with Chronic Hepatitis B (CHB). Of those, 162,480 (73.0%) have been diagnosed; 50,229 (22.6%) people received care (either treatment or monitoring); and 23,787 (10.7%) received anti-viral treatment (ASHM, 2020a). More than 90% of new cases of CHB in Australia are attributable to migration and cannot be prevented through local vaccination initiatives (ASHM, 2018). People born in North-East Asia and South-East Asia have the highest prevalence of 6.2% and 4.8% respectively (ASHM, 2020a)

Australia's National Hepatitis B Strategy (2018–2022) targets include:

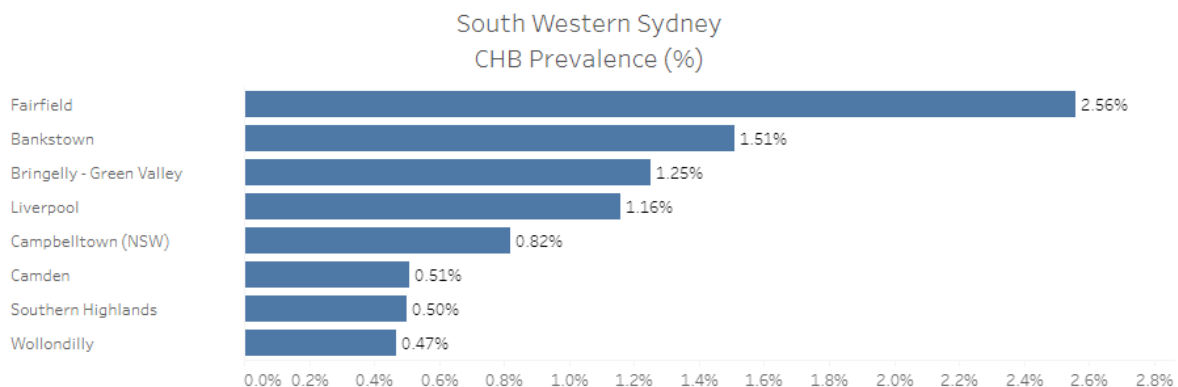
- 80% of people living with CHB diagnosed
- 50% of people living with CHB engaged in care
- 20% of people living with CHB receiving treatment.

Based on current trends in treatment uptake and changes in the number of people living with CHB, Australia is not on track to meet the National Strategy care uptake target of 50% by 2022.

<b>Key Issue for our region</b>	<b>South Western Sydney has the second highest rate of hepatitis B in Australia</b>
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In NSW, 79,526 people were living with CHB in 2020 with 26.89% care uptake and 12.86% treatment uptake. In 2020, SWS had the second highest prevalence (1.33%) out of all PHNs with 37.9% care uptake and 19.5% treatment uptake. Fairfield and Bankstown were found to have the highest prevalence of 2.5% and 1.5% respectively (ASHM, 2020b).

Figure 31 : Prevalence of Chronic Hepatitis B; SA3 areas 2020 (ASHM, 2020b)



The chronic (unspecified) hepatitis B notification rates in SWS have increased between 2014 and 2016, from 48.2 to 58.7 per 100,000 population. In 2017, SWS had the second highest CHB notifications among all PHNs in NSW of 46.8 per 100,000 population, much higher than NSW average (29.5 per 100,000). Between 2011 and 2017, CHB notification rates for SWS were 1.4 – 1.9 times higher than the NSW rate. Fairfield and Bankstown LGAs consistently had higher rates of notifications for CHB.

The high number of CHB notifications reflects the large proportion of SWS residents was born in countries with a high prevalence of hepatitis B including Vietnam, China, Cambodia, the Philippines, and Fiji.

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### Hepatitis B treatment

Due to disruptions caused by COVID-19 lockdowns and reduced international migration, there was a reduction in the number of people receiving treatment in SWS. The target was approached in SWS (19.5% uptake); however, if the static trend observed in 2020 continues, the PHN would still not reach 20% by 2022. Two LGAs in SWS have met the National Strategy treatment target of 20% – Fairfield (25.8%) and Bankstown (21.0%) (ASHM, 2020a).

GP and specialist prescribing has remained low in SWS, with plans to increase Nurse Practitioner prescribing in the future. SWS ranks first in care uptake among other PHNs with 37.9% treatment uptake (ASHM, 2020a).

CHB is a major contributing factor to the increase of liver cancer and one of the most common reasons for liver transplantation. In 2015 about 10,263 people with chronic hepatitis B in NSW were not receiving treatment, and about one quarter of them were living in SWS (2,582 people). Between 2008 and 2012, SWS had higher incidence and mortality rates of liver cancer than NSW (9.2 and 7.2 and 5.7 and 4.8 respectively).

### Hepatitis C

#### Hepatitis C prevalence

Notification rates are influenced by variations in incidence of disease, screening rates and the population at the time.

In 2016 in Australia, an estimated 188,951 people were living with CHC (viremic infection), representing 0.78% of the total population. As a result of the introduction of direct-acting antiviral (DAA) treatments and the associated high cure rates, the number of people estimated to be still living with CHC at the end of 2019 (after accounting for mortality and new infections) was 122,264.1. This coincides with reductions in hepatitis C notification rates from 52.6 per 100 000 in 2008 to 44.2 in 2017.

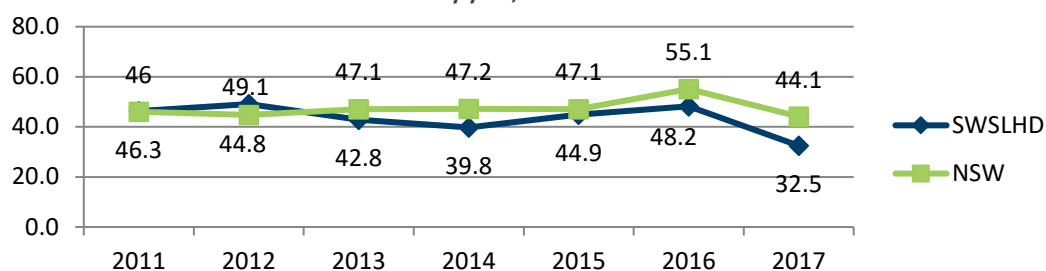
In 2017, age-standardised rates of hepatitis C notification were four times as high among the Aboriginal and Torres Strait Islander population (168.1 per 100 000) as in the non-Aboriginal and Torres Strait Islander population (38.4 per 100 000).

#### Key Issue for our region

**South Western Sydney has the highest prevalence of hepatitis C in NSW**

In NSW, there has been a steady decline in hepatitis C notification rate since 2016. Notifications for males are almost twice as high as for females (39.2 per 100,000 population and 20.2 per 100,000 population respectively) (CEE, 2020d). The majority of notifications were among people aged 25-44 years and 45-64 years (147 and 148 respectively) (MoH, 2019). The lower notification rates may be due to lower screening rates. In SWS, hepatitis C notifications declined between 2008 and 2017, from 49.8 to 33.1 per 100,000 population. Campbelltown and Fairfield LGAs have consistently had higher notification rates of chronic (unspecified) hepatitis C compared to the SWS average between 2011-2017, as well as in 2020, except for Fairfield in 2014. Bankstown had the highest notification rate in SWS in 2015 and 2016, and was overtaken by Campbelltown and Fairfield in 2017 and in 2020 (SWSLHD/SWSPHN, 2018).

Figure 32: Chronic (unspecified) hepatitis C notification rates for SWSLHD and NSW (standardised rate per 100,000 population) by year, 2011-2017





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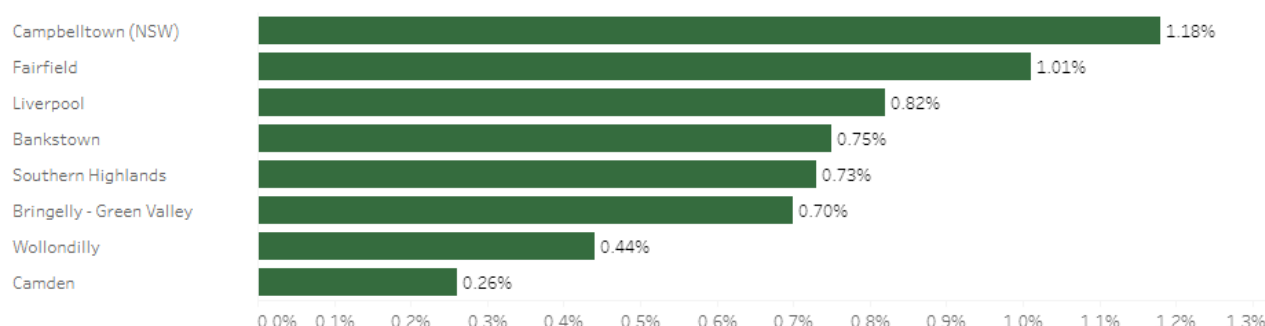
Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 24 August 2018. South Western Sydney Local Health District Public Health Unit. Sexually Transmissible Infections and Blood Borne Viruses, 2017 Annual Report. South Western Sydney Local Health District; Liverpool, NSW. October 2018.

## Prevalence and at-risk populations

Sharing or reusing other people's needles and syringes, or other drug injecting equipment, is the most common way people in Australia get hepatitis C. Tattooing and body piercing are also risks for hepatitis C (Hepatitis-NSW, 2020). The key population of CHC includes, but is not restricted to, people sharing or reusing other people's needles and syringes, prisoners with a history of injecting drug use, prison entrants and people from high-prevalence countries (Kirby Institute, 2018).

In SWS, Chronic Hepatitis C (CHC) prevalence was 0.83% in 2020, with Campbelltown and Fairfield having the highest rates (1.18% and 1.01% respectively). In 2020, an estimated 7,669 people were living in SWS with CHC, among those 42.1% were receiving treatment.

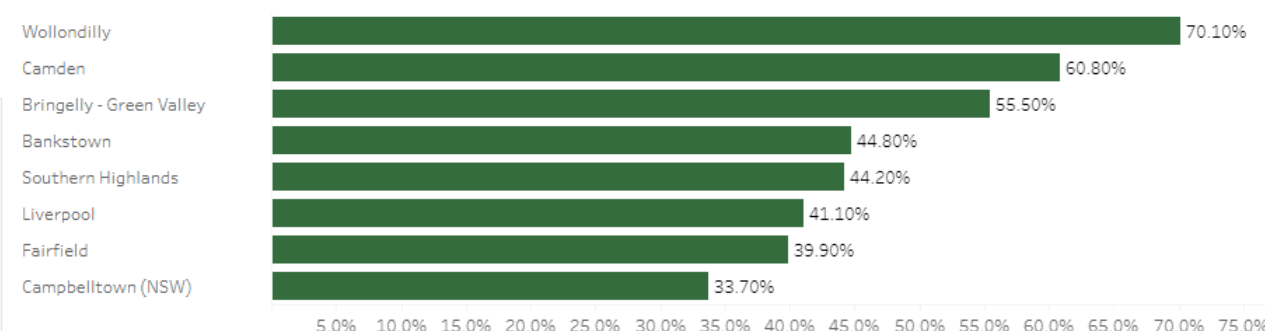
Figure 33: CHC Prevalence SA3 area in SWS, 2020 (ASHM, 2020a, ASHM, 2020b)



## Treatment

In Australia, total of 88,798 people received hepatitis C treatment between March 2016 and December 2020, 47% of the total number living with CHC at the start of 2016. The number of people who received treatment was highest in 2016 and has declined steadily over time, from 32,049 in 2016 to 8,140 people during 2020. Uptake was close to the national average of 47% in NSW (45.6%).

Figure 34: Hepatitis C Treatment SA3 areas in SWS 2020 (ASHM, 2020b)



Consultation performed with 'SWSPHN/SWSLHD Improving Hep C Testing & treatment in PHC Implementation Group' with representation of SWS GPs, specialists, Public Health units was performed in April 2021 and identified the following Hep C service needs gaps for our district:

- Access to testing / reach of testing, including routine testing for segments of our IDU population (those without access to an NSP)
- GP education regarding testing, treatment initiation and correct coding of Hep C in General Practice software

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

- Stigma regarding IDU patients in PHC
- Lack of incentive (financial/time) to provide treatment
- GP awareness of clinical support services available

### HIV

#### **Prevalence**

Between 2011 and 2016, 169 people were diagnosed with HIV infection in SWS. The number of SWS residents notified with newly diagnosed HIV infection accounted for between 5.4% to 9.4% for NSW over the period 2011- 2017.

Majority of notifications for newly diagnosed HIV infections were among males of 20-29 years and 30-39 years age groups with the latter age group accounting for approximately 38% of notifications (Health Protection NSW, 2017).

There was very little variation in the numbers of newly diagnosed HIV infection notifications received each year from 2012-2017 in SWS. However, when compared to the average for the previous five years, the number of NSW people newly diagnosed with HIV (n=206) dropped by 33% in 2020. Only 31% (n=64) of these new diagnoses showed evidence indicating their infection happened during the previous 12 months (early-stage HIV infection), a decrease of 47% from the previous five years.

Among newly diagnosed HIV infection notifications there were less than five notifications identified among Aboriginal and/or Torres Strait Islander people for the period 2011-2017.

From 2011 to 2017, SWS residents notified with newly diagnosed HIV infection reported HIV risk exposures including men who have sex with men (MSM) for 66.2% (n=131), heterosexual sex for 27.3% (n=54), and injecting drug use (PWID) for 2.0% (n=4). In 2017, 58.6% (n=17) of SWSLHD residents notified with newly diagnosed HIV infection reported male to male sex compared to 69.0% (n=216) across NSW.

Between 2011 and 2017, most newly diagnosed HIV infection notifications in SWS were acquired in Australia among persons born in Australia (average 37.2%, n=74) and persons born overseas (31.6%, n=63).

#### **Pre-exposure prophylaxis for HIV (PrEP)**

PrEP (pre-exposure prophylaxis) is a HIV prevention method in which people who do not have HIV take a pill every day to reduce their risk of becoming infected with HIV. On 1 April 2018, HIV pre-exposure prophylaxis was PBS listed as a streamlined authority item. People with a Medicare card who meet high or medium HIV infection risk criteria can purchase PrEP from community pharmacies with a GP prescription (MoH, 2018).

### Sexually transmitted infections

**Key Issue  
for our  
region**

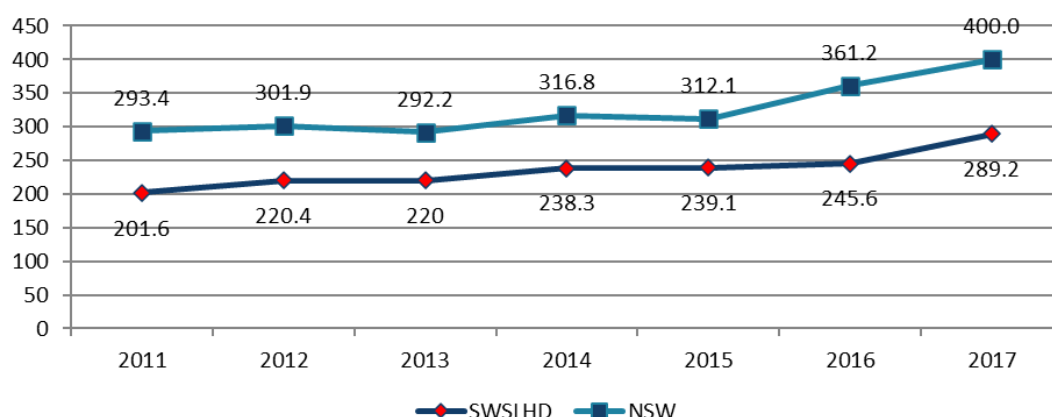
**Increasing rates of sexually transmitted infections, including medication resistant syphilis**

#### **Chlamydia**

There has been a steady increase in the rate of chlamydia notifications per 100,000 population from 2011 to 2017; however, notification rates for SWSLHD have been between one fifth to one third lower than the NSW state notification rates.

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

Figure 35: Chlamydia notifications (rate per 100,000 population) for SWS and NSW, 2011- 17



Data source: Notifiable Conditions Information Management System, Health Protection NSW. Extracted 24 August 2018. South Western Sydney Local Health District Public Health Unit. Sexually Transmissible Infections and Blood Borne Viruses, 2017 Annual Report. South Western Sydney Local Health District; Liverpool, NSW. October 2018.

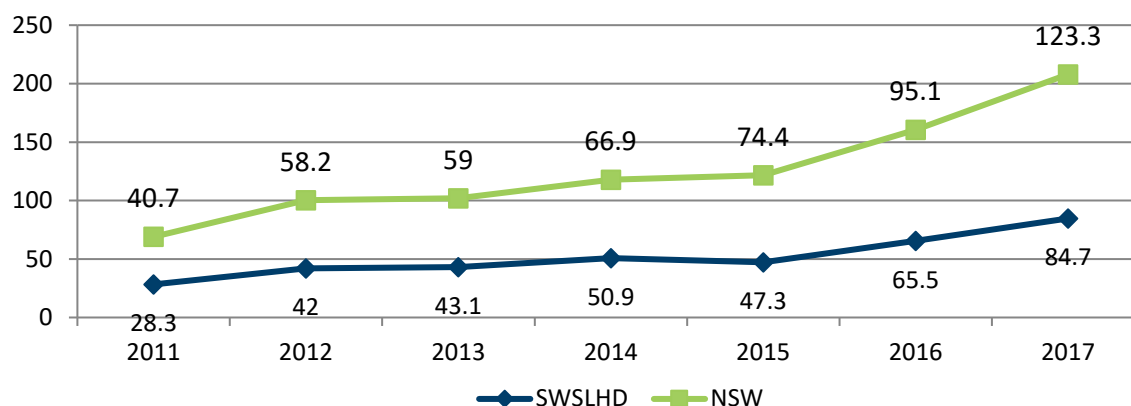
More females than males are notified with chlamydia infections annually, however both genders have shown an increase in the number of notifications over the period 2011-2017. The numbers of notifications from both genders peaked in 2016 compared to the previous five years (1,432 females and 1,296 males). Women with untreated chlamydia infections are more likely to develop pelvic inflammatory disease (PID) and in the most severe form have an increased likelihood of ectopic pregnancy and infertility. The rate of chlamydia notifications increases dramatically from the 10 to 14-year age group to the 20 to 24-year age group, after which notifications rates decline with increasing age across all years (2011-2017).

Except for Camden, chlamydia notification rates in all LGAs and in SWSLHD increased between 2011 to 2017. There was an increase in notification rates between 2016 and 2017 for all LGAs except for Wingecarribee (247.2 vs 189.4). Between 2011 and 2017, Campbelltown had the highest notification rate (range 281.8 to 347.4 per 100,000 population) which was consistently above the notification rate for SWSLHD (range 204.6 to 277.2 per 100,000 population). Liverpool also had higher notification rates than the SWSLHD from 2013-2017. Between January to June 2020, the annualised Chlamydia notification rate was 338 notifications per 100,000 population. This is 14% lower compared to 2019 when the yearly rate was 393 notifications per 100,000 population.

### Gonorrhoea

There has been a steady increase in the rate of gonorrhoea notifications in SWSLHD per 100,000 population from 2011 to 2017, with an increase from 28.8 (95% CI 25.2-32.4) in 2011 to 84.7 (95% CI 78.8-90.6) in 2017. Notification rates for SWSLHD have remained between one fifth to one third lower than the NSW state notification rates over the same period.

Figure 36: Gonorrhoea notification rates for SWSLHD and NSW (standardised rate per 100,000 population) by year, 2011-2017



Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 24 August 2018. South Western Sydney

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

Local Health District Public Health Unit. Sexually Transmissible Infections and Blood Borne Viruses, 2017 Annual Report. South Western Sydney Local Health District; Liverpool, NSW. October 2018.

Liverpool, Fairfield and Bankstown LGAs have had consistently higher rates of notification compared to other LGAs over the period 2011-2017. All LGAs reported an increase in gonorrhoea notification rates in 2017.

More males than females are notified with gonorrhoea infections annually. There was an increase in the number of notifications received for both females (23.8% increase) and males (26.5% increase) in 2017 compared with 2016.

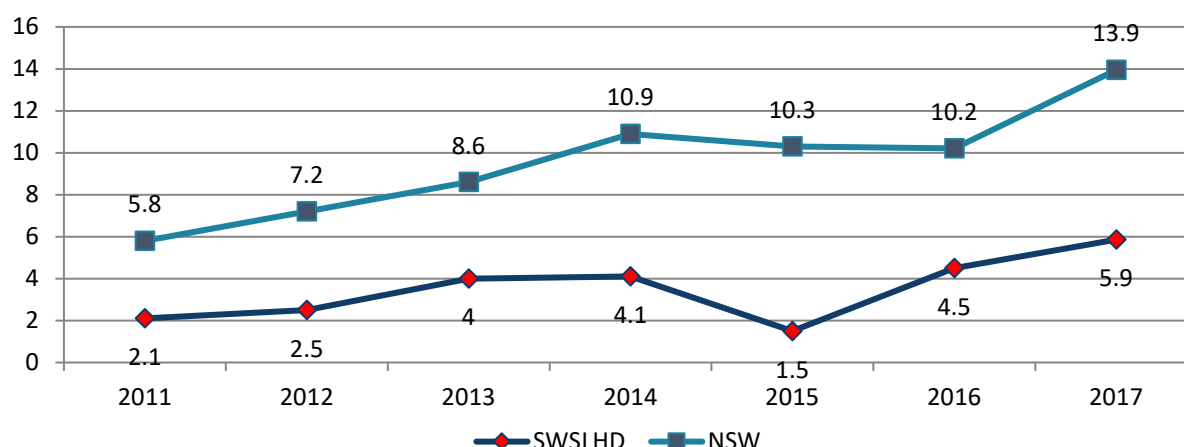
Between 2011-2017, gonorrhoea notification rates increased with age from 10-14 years until 20-24 years, after which notifications declined with increasing age. In 2017 notification rates were at an all-time high for most persons in age groups under 50 years of age.

The annualised gonorrhoea notification rate was 124 notifications per 100,000 people from January to June 2020. This is a 10% decrease from the previous year when there were 138 notifications per 100,000 people. The drop in the annualised notification rate in the first half of 2020 marks the end of a five-year trend of annual increases. However, the rate remains 1.8 times higher than in 2015, when there were 70 notifications per 100,000 people.

### Syphilis

Rates of infectious syphilis notifications for NSW have remained two to seven times higher than SWSLHD over the period 2011 to 2017 where across NSW overall rates have more than doubled.

Figure 37: Infectious Syphilis notification rates for SWSLHD and NSW (crude rate per 100,000 population) by year, 2011-2017



Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 24 August 2018. South Western Sydney Local Health District Public Health Unit. Sexually Transmissible Infections and Blood Borne Viruses, 2017 Annual Report. South Western Sydney Local Health District; Liverpool, NSW. October 2018.

In 2017, all LGAs reported lower crude rates of infectious syphilis notifications (range 1.2-9.1 per 100,000 population) compared with the NSW rate (13.9 per 100,000 population). Campbelltown LGA had the highest crude rate of infectious syphilis notifications with 9.1 per 100,000 population, followed by Bankstown and Fairfield each with 6.8 per 100,000 population. Most notifications were among men, with more than four times the number of notifications for males than females since 2014.

## 2.2.4: Violence, Abuse and Neglect in South Western Sydney

### Domestic and Family Violence

Intimate partner violence (IPV) is a specific term used to describe forms of DFV that WHO has defined as, 'behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship' (2012). In Australia, IPV is the most commonly experienced form of family violence. It takes place across all cultures and faith groups (Devries et al., 2013; Our Watch, 2018; World Health Organization [WHO], 2012).

Children are more vulnerable to family, domestic and sexual violence – it affects children's physical and mental wellbeing; development and schooling and is the leading cause of children's homelessness in Australia (Australian Institute of Health and Welfare, 2023, Family, domestic and sexual violence, AIHW, Australian Government).

#### Key Issue for our region

**South Western Sydney has the highest incidence of domestic and family violence in the Sydney metropolitan area**

In South Western Sydney, 4,293 domestic violence-related assaults occurred between January and December 2018. Domestic violence-related assault was most likely to occur in Campbelltown, with a rate of 565.3 per 100,000 people.

**NSW Recorded Crime Statistics January 2022 to December 2022)** NSW Bureau of Crime Statistics and Research, reference Domestic Violence Statistics 22Q4).

Incident Local Government Area	Number of incidents	Rate per 100,000 population
Camden	316	293.1
Campbelltown	1,016	583.6
Canterbury-Bankstown	1,348	354.4
Fairfield	909	431.3
Liverpool	1,034	447
Wingecarribee	111	214.5
Wollondilly	165	305.5

Socioeconomic factors such as alcohol consumption, education levels, employment levels and income levels are DFV risk factors. First Nations women are more likely to experience domestic violence than non-Indigenous women (Audit Office of NSW, 2011, Responding to domestic and family violence NSW Auditor-General's Report Performance Audit, Audit Office of NSW, Sydney).

IPV increased due to the of the COVID-19 pandemic, SWS experienced the toughest lockdown in Australia with wide ranging and situational stressors such as victims and perpetrators spending more time together, increased financial or economic hardship can be associated with increased severity or frequency of violence.

CALD women are particularly vulnerable to family violence due to factors such as social isolation, language and cultural barriers, and lack of knowledge about rights and available services (DSS, 2015; InTouch Multicultural Centre Against Family Violence [InTouch], 2010; Segrave, 2017; Vaughan et al., 2016).

In addition to physical and sexual violence, women from refugee backgrounds are particularly vulnerable to financial abuse, reproductive coercion and immigration-related violence. Intersecting factors relevant to the experience of IPV

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in refugee communities include migration pathways and traumatic pre-arrival experiences, as well as settlement issues such as acculturation stress and social isolation.

The primary reason people sought Specialist Homelessness Services Program (SHS) accommodation was domestic violence (30% in SWS compared with 15% for NSW).

### *Access to VAN services*

There are 19 public health and NGO violence, abuse and neglect service providers across South Western Sydney. Consultation with the community indicate access and demand issues for people requiring services. This includes limited access to emergency housing and refuges for people escaping DFV.

### 2.2.4 First Nation's Community

The analysis by AIHW into the health gap between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander Australians indicated 28% of Aboriginal and Torres Strait Islander adults were assessed to be in good health, based on the composite health measure, compared with 54% of non-Aboriginal and Torres Strait Islander adults (AIHW, 2020f).

<b>Key Issue for our region</b>	<b>Significant health inequity for First Nation's peoples</b>
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Life expectancy at birth in 2015-17 for Aboriginal people in NSW is 70.9 years for males and 75.9 years for females, compared with 80.2 years for non-Aboriginal males and 83.5 years for non-Aboriginal females.

More than half (53%) of this health gap between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander working-age adults can be accounted for by social determinants (34%) and health risk factors (19%)

Five social determinants were identified to account for 34% of the health gap and were:

- Household income (14%)
- Employment and hours worked (12%)
- Level of schooling completed (8.7%)
- Highest non-school qualification
- Housing adequacy.

Six health risk factors were identified to account for 19% of the health gap and by AIHW were:

- Smoking (10%)
- Binge drinking
- High blood pressure
- Overweight and obesity status
- Inadequate fruit and vegetable consumption
- Insufficient physical exercise.

The 47% of the health gap that remained unexplained after accounting for the selected social determinants and health risk factors can be related to other variables not able to be included in the analysis, which include differences in access to health services.

#### *Antenatal Care*

##### ***Initial antenatal visit***

Antenatal care has been found to have a positive effect on the health outcomes for both mother and baby.

<b>Key Issue for our region</b>	<b>Poorer antenatal outcomes for First Nation's mothers</b>
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Aboriginal mothers compared to non-Aboriginal mothers in SWS are:

- more likely to smoke during pregnancy than non-Aboriginal women
- less likely to present to receive antenatal care before 14 or 20 weeks of gestation
- more likely to have preterm babies compared with non-Aboriginal and Torres Strait Islander women
- have an infant mortality rate which is almost twice the rate of NSW overall

In 2019, smaller proportions of pregnant non-Aboriginal women in SWS reported their first antenatal visit before 14

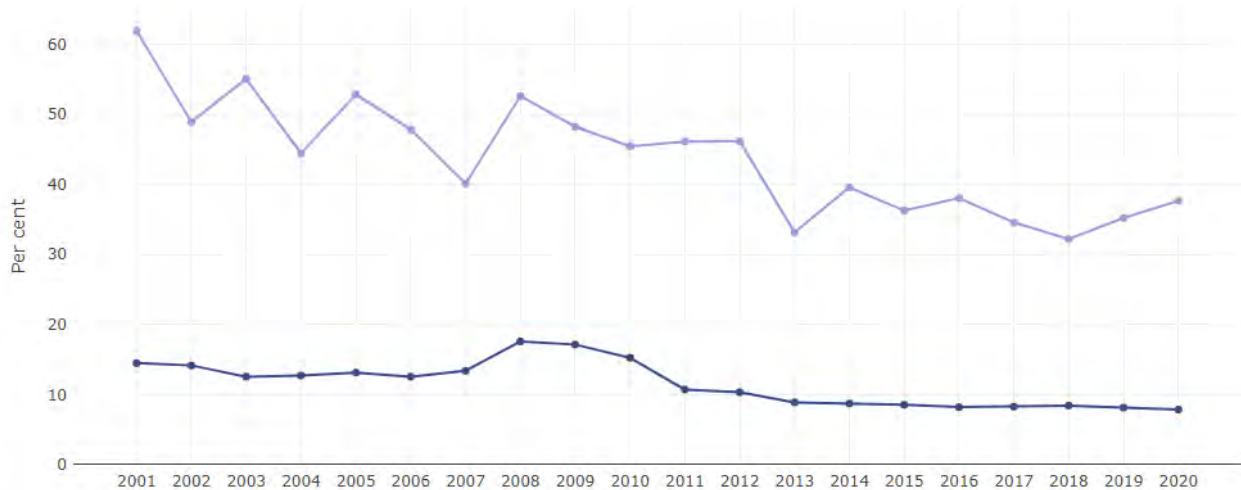
## SWSPHN NEEDS ASSESSMENT 2022 – 2025

weeks and 20 weeks of gestation compared to NSW average. The proportion of pregnant Aboriginal women in SWS who had their first antenatal visit before 14 and 20 weeks gestation was comparable with the rest of NSW(CEE, 2016a).

### **Smoking during pregnancy**

Smoking during pregnancy is associated with a wide range of complications impacting both mother and baby. In 2020, 41.7% of SWS Aboriginal and Torres Strait Islander women reported smoking in pregnancy which is higher than the NSW average of 37.7% (CEE, 2016a).

Figure 38: Smoking in pregnancy, all women vs Aboriginal women from 2001 - 2020, SWS ((SAPHaRI), 2020)



Aboriginal - South Western Sydney PHN  
Total - South Western Sydney PHN

## **Preventative health risk factors and First Nation's Peoples**

**Key Issue  
for our  
region**

**Higher rates of preventative health risk factors for First Nation's Peoples**

### **Alcohol use**

In NSW, alcohol consumption at levels posing long-term risk to health for Aboriginal people is 1.4 times of non-Aboriginal people in 2017 (41.3% and 30.7% respectively). Alcohol attributable hospitalisations for Aboriginal people is 2.2 times of non-Aboriginal people(CEE, 2018).

### **Tobacco use**

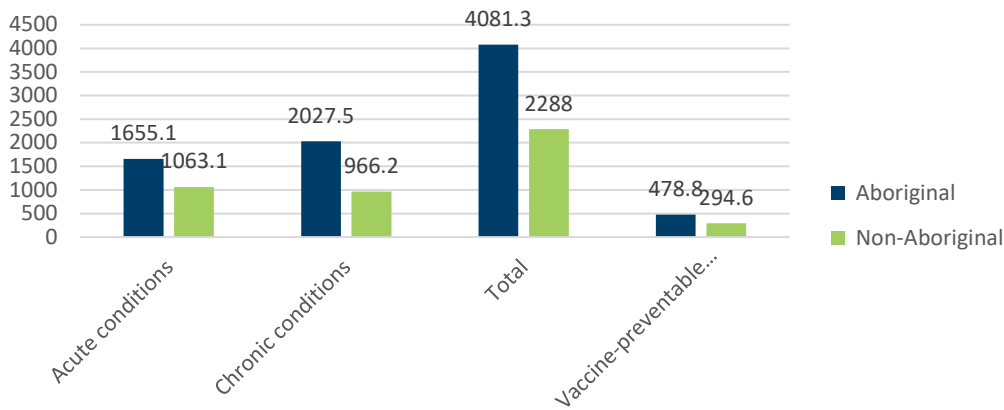
Between 2002 and 2017, smoking rates in adults have declined for Aboriginal people from 40.2% to 28.5%, however, the rate for Aboriginal people is still almost double the rate of non-Aboriginal people (14.7%)(CEE, 2020d).

### **Potentially Preventable Hospitalisations**

The rate of Potentially Preventable Hospitalisations (PPH) among Aboriginal people is 1.8 times as high as non-Aboriginal people (4081.3 and 2288 per 100,000 population respectively). The largest disparity among all PPH conditions were chronic conditions – the rate for Aboriginal people is 2.1 times as high as non-Aboriginal people (2027.5 and 966.2 per 100,000 population respectively).



Figure 39: Potentially preventable hospitalisations by Aboriginality and Condition, NSW, 2016-17[6]



## Chronic disease and First Nation's Peoples

### Diabetes

In 2017, Aboriginal people aged 16 years and over were 1.4 times as likely to have diabetes or high blood glucose compared to non-Aboriginal people in NSW. Between 2010-2017, diabetes hospitalisations among Aboriginal people had increased, while it remains the same among non-Aboriginal people in NSW. Aboriginal people were 3.3 times as likely to be hospitalised for diabetes compared with non-Aboriginal people in 2016-17(CEE, 2020d).

In 2017-18 in Australia:

- The difference in rates between Aboriginal and Torres Strait Islander Australians and non-Aboriginal and Torres Strait Islander Australians was greater for females than males—5.6 times higher for females and 3.2 times higher for males.
- The rate of type 2 diabetes hospitalisations among Aboriginal and Torres Strait Islander Australians was 4.3 times the rate for non-Aboriginal and Torres Strait Islander Australians.

Key Issue for our region	Higher rates of diabetes for First Nation's Peoples
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According to *NSW Population Health Survey*(CEE, 2020d),

- 13.7% of Aboriginal adults have diabetes or high blood glucose, compared to 11.2% for non-Aboriginal people.
- Diabetes related hospitalisations rates for Aboriginal people are 3.4 times as high as non-Aboriginal people (508.8 and 151.9 per 100,000 population respectively). Hospitalisation rates among Aboriginal people have increased from 438.8 to 508.8 per 100,000 population between 2016-17 and 2018-19.
- Aboriginal people are 2.5 times as likely to die from diabetes (total underlying + selected associated) as non-Aboriginal people (69.5 and 28.6 per 100,000 population respectively).
- Diabetes prevalence among people in the most disadvantaged quintile is 3.6% higher than the least disadvantaged quintile (12% and 8.4% respectively). The estimated diabetes prevalence in Aboriginal communities is 3.1% higher than non-Aboriginal communities (14% and 9.9% respectively)(CEE, 2016a)

In SWS, about 2.7% of the NDSS registrants are Aboriginal, lower than the NSW rate of 3.2%. Across SWS, the registration rate in Canterbury-Bankstown is higher than the state average (3.3%) compared to the NSW rate (AIHW, 2021f).

# SWSPHN NEEDS ASSESSMENT 2022 – 2025

Table 31: Number and percentage of Aboriginal NDSS in SWS by LGA, 2021(Diabetes-Australia, 2022)

LGAs	Aboriginal NDSS Registrants (n)	(%) Registrants
Canterbury- Bankstown	120	3.3
Camden	60	2.1
Campbelltown	260	3.0
Fairfield	60	2.9
Liverpool	110	2.4
Wingecarribee	30	2.1
Wollondilly	40	1.8

## Respiratory disease

### Disease burden

In NSW, Aboriginal people have higher asthma prevalence compared to non-Aboriginal people. In 2017, asthma prevalence for Aboriginal people was 1.5 times of the prevalence for non-Aboriginal people(SWSLHD, 2016c).

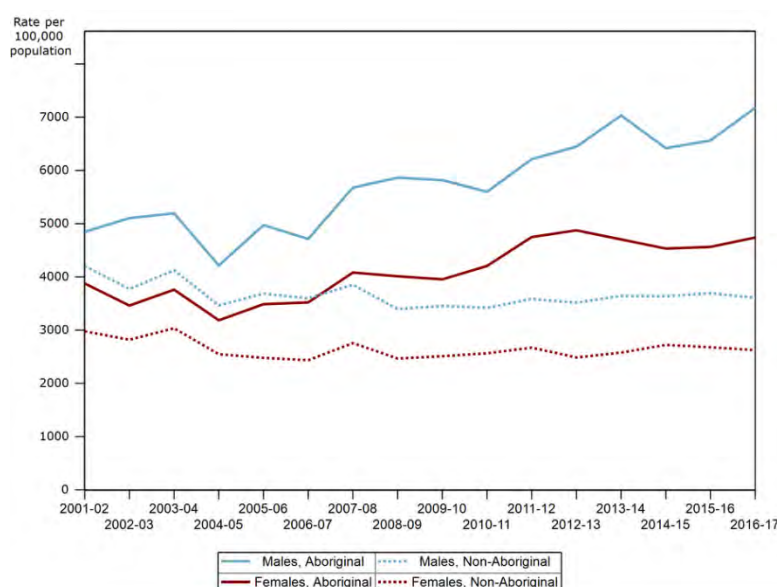
**Key Issue  
for our  
region**

**Higher rates of respiratory disease for First Nation's Peoples**

### Respiratory-related hospitalisations

Chronic obstructive pulmonary disease (COPD) hospitalisations among Aboriginal people aged 65 years and over have significantly increased between 2001 and 2017, while for non-Aboriginal people it has slightly decreased during the same period in NSW. In 2017, COPD hospitalisation rates for Aboriginal people was 4.3 times the rate for non-Aboriginal people(CEE, 2020d). There has been steady increase in hospitalisations among Aboriginal people aged 65 years and over between 2012-13 and 2018-19, from 4226.1 to 6109.6 per 100,000 population. In the same period, Aboriginal people aged 65 years and over were 4.9 times as likely to have chronic obstructive pulmonary disease related hospitalisations as their non-Aboriginal counterparts (6109.6 and 1258.6 per 100,000 population respectively).

Figure 40: Acute respiratory infection hospitalisations: All acute respiratory infection, by Aboriginality, persons aged 0-4 years, NSW 2001-02 to 2016-17(CEE, 2018)



# SWSPHN NEEDS ASSESSMENT 2022 – 2025

In NSW, acute respiratory infection hospitalisations for Aboriginal and Torres Strait Islander people have steadily increased since 2001-02, from 4378.4 per 100,000 population in 2001-02 to 5993.6 per 100,000 population in 2016-17; while the rate for all population have decreased in the same period(CEE, 2018).

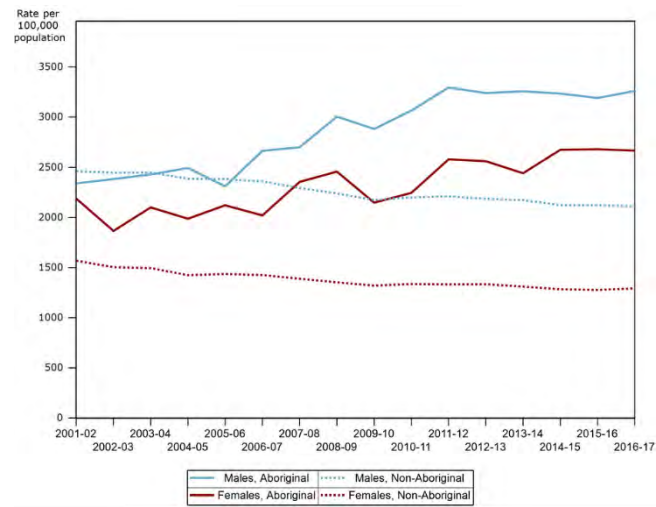
## Circulatory disease

Key Issue for our region	Higher rates of circulatory disease for First Nation's Peoples
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In NSW, Aboriginal people have higher rate of circulatory disease related hospitalisations and deaths. Between 2001 and 2017, circulatory disease-related hospitalisations for Aboriginal people have increased significantly (2251.9 and 2957.9 per 100,000 population respectively), while hospitalisations for non-Aboriginal people have decreased (1989 and 1685.5 per 100,000 population respectively)(CEE, 2020d).

- Aboriginal people are 1.6 times as likely to have circulatory disease-related hospitalisations as non-Aboriginal people (2535.4 and 1605.6 per 100,000 population respectively). There has been a steady increase in the hospitalisations rates among Aboriginal people between 2012-13 and 2018-19, from 2256.9 to 2535.4 per 100,000 population).
- Aboriginal people are 1.3 times as likely to die from circulatory disease as non-Aboriginal people (189.0 and 144.3 per 100,000 population respectively).

Figure 41: Circulatory disease hospitalisations by Aboriginality, NSW 2001-02 to 2016-17(CEE, 2020d)



## Circulatory disease related deaths

Between 2001 and 2016, circulatory disease deaths have steadily declined for both Aboriginal people and non-Aboriginal people, however, the rate for Aboriginal people is consistently higher than non-Aboriginal people(CEE, 2020d).

## Coronary heart disease

Aboriginal people are 1.7 times as likely to have coronary heart disease related hospitalisations as compared to non-Aboriginal people (795.8 and 469.3 per 100,000 population respectively).

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## Dementia

A number of studies have indicated Aboriginal and Torres Strait Islander people across urban, regional, and remote Australia have higher rates of dementia, and earlier age of onset, than comparable populations of non-Aboriginal and Torres Strait Islander people.

Key Issue for our region	Higher rates of dementia for First Nation’s Peoples
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The Koori Growing Old Well study indicates that Aboriginal people over 60 years of age, who live in urban areas, have very high rates of dementia (21%), which is three times higher than the non-Aboriginal and Torres Strait Islander population. While the reasons for this are not known, key potential associations of dementia are being explored, including age, early life factors (e.g., separation, formal/informal education; parenting; childhood trauma) and mid-life factors (e.g., social engagement, discrimination, resilience, jobs, prior stroke, vascular risks, head injury, alcohol, smoking)(Smith et al, 2010, AIHW, 2012)

In NSW, there has been a steady increase of dementia hospitalisations among Aboriginal women since 2009. Aboriginal people are 1.7 times as likely to be hospitalised for dementia compared with non-Aboriginal people in 2016-17(CEE, 2020d).

## 2.2.5: CALD Communities

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### *Chronic Disease Prevalence in CALD communities*

The prevalence of a person being diagnosed with at least one chronic disease is higher in people born in Australia than people born overseas, particularly asthma, cancer, respiratory and mental health (AIHW, 2023a). However, many countries of birth had higher prevalence of chronic diseases than the Australian-born population, including diabetes, stroke, dementia, heart disease, and kidney disease. The prevalence of these chronic diseases was particularly high in people born in regions such as Polynesia, South Asia and the Middle East.

<b>Key Issue for our region</b>	<b>People born overseas had a higher prevalence of diabetes, renal, heart disease, stroke and mental health diagnoses</b>
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The year of arrival in Australia and English-language proficiency are indicated as influencing factors according to census data. The longer a person born overseas continued to live in Australia increased the prevalence of chronic disease diagnosis, which was further exacerbated if they had low English-language proficiency.

## 2.2.5 Older Persons

### Dementia

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(AIHW, 2017b). In 2018, dementia is estimated to cost Australia more than \$15 billion. The total cost of dementia is projected to increase to \$36.8 billion by 2056(The National Centre for Social and Economic Modelling, 2016).

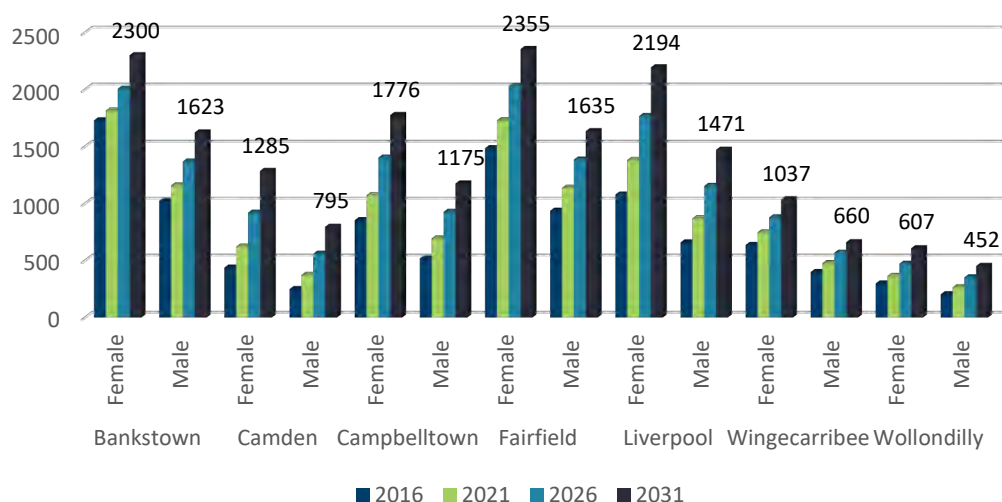
In SWS, the estimated number of people with dementia in 2016 was 10,513. The rate of dementia for the region was 1.1%, lower than the Australian rate (1.3%), and ranged from 0.6% for males in Camden to 2.8% for females in Wingecarribee LGA. Wingecarribee has the largest proportion of older people per LGA population in SWS. The prevalence was higher in females across all LGAs. It was estimated the highest number of people with dementia reside in Bankstown and Fairfield (2,755 and 2,422 respectively)(SWSLHD/SWSPHN, 2018).

#### Key Issue for our region

Based on population projections, it is expected that the prevalence of dementia will increase by 84% by 2031

Based on projections of population ageing and growth, it is estimated the number of people with dementia in SWS is expected to increase by 84.2% from 10,513 to 19,367 people by 2031. It was estimated that in 2018 about 26,443 Australians had younger onset dementia. It is expected this number will rise by 11% to 29,375 people by 2025.

Figure 42 : Projected number of persons with dementia for SWS 2016 to 2031 by LGA and gender(SWSLHD/SWSPHN, 2018)



### Dementia-related hospitalisations

In NSW, men have higher dementia-related hospitalisations than women (1818.9 and 1445.5 per 100,000 population, respectively). Aboriginal and Torres Strait Islander people are 1.5 times as likely to be hospitalised for dementia as non-Aboriginal people (2365.4 and 1560.7 per 100,000 population, respectively). People living in major cities are more likely to have dementia hospitalisations compared to people living in remote and very remote areas (1734.2 and 1303.1 per 100,000 population, respectively). People who are in the most socioeconomically disadvantaged 20% are more likely to have dementia hospitalisations compared to those who are in the least socioeconomically disadvantaged 20% (1867.9 and 1392.3 per 100,000 population respectively)(CEE, 2020c).

In 2018-19, there were 22,183 hospitalisations for dementia recorded as a principal diagnosis and/or comorbidity in NSW, 2,654 of the hospitalisations (or 12%) were in SWS. Dementia related hospitalisations (a principal diagnosis or as a comorbidity) in SWS were slightly higher compared with the NSW rate (1912.1 and 1611 per 10,000 population, respectively). Within SWS, Canterbury-Bankstown and Campbelltown LGAs have the highest rates. Most hospital

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

separations for dementia, or with dementia, were in persons aged 65 years and over.

Many people with dementia rely on health and aged care services, and often require a high level of care and support. According to the Australian Institute of Health and Welfare's [Residential aged care and Home Care 2013-14 report](#), 52% of all people in permanent government-subsidised residential aged care had a diagnosis of dementia. Compared to aged care residents without dementia, they need high care in relation to activities of daily living and behaviour.

People with dementia living in the community also depend on informal care provided by family and friends. Around 42% of primary carers of people with dementia were the spouse/partner and 44% were the child. SWS is experiencing a rapid growth in ageing population. As a leading cause of death and burden of disease, the demand dementia places on health and aged care services are expected to increase considerably.

### ***Palliative care planning for people with dementia***

Many people living with dementia struggle to access palliative care that appropriately responds to their needs and respects their wishes, due to issues around capacity for decision making, difficulties in communication and lack of community understanding of the disease(PCA, 2018). Advance care planning and engagement with palliative care for people with dementia should commence early. The demand for palliative care is expected to increase by 67.5% in the region with the number of persons requiring this type of care increasing from 2,275 in 2016 to 3,811 by 2031.

Issues raised by community care providers and residential aged care homes (RACF) include:

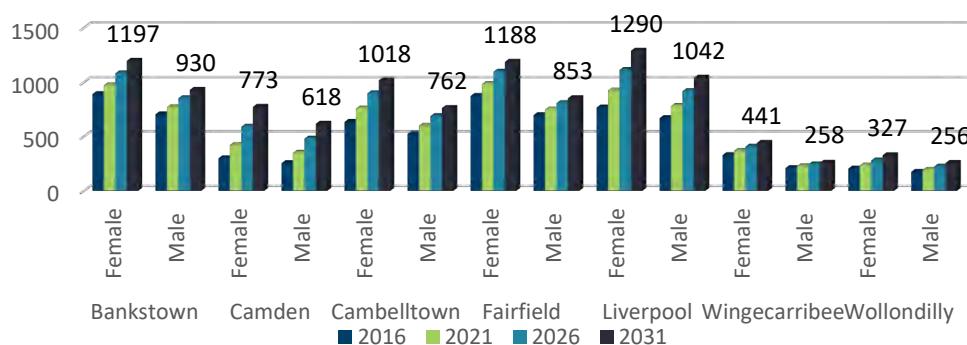
- A lack of community and health professional awareness among that dementia is a life-limiting illness and palliative care should be considered.
- RACF staff who have the most contact with residents do not have the skills to recognise deterioration towards end-of-life.
- There are structural barriers for the provision of palliative care in RACFs.
- There are limited advance care planning resources available, and do not match the literacy/reading ability/language of the SWS population.

Health professionals, community services staff and RACF staff are not comfortable or skilled at having conversations about death and dying.

### ***Falls and falls related injuries***

More than one in three people aged 65 or over fall at least once a year and many fall more often. Falls are the most identified cause of injury-related hospitalisations. Fall-related injury is a major cause of morbidity and mortality in older people. In 2015, it is estimated 20.7% people aged 65 years and over in SWS had a fall in the previous year, lower than the NSW average (22.7%)(CEE, 2017). The number of SWS residents affected by falls is expected to increase by 51.4% by 2031, from 7,232 in 2016 to 10,952 in 2031. The highest increase is expected in Camden (151%) and Liverpool (62%)(SWSLHD/SWSPHN, 2018).

Figure 43: Estimated number of SWS residents affected by falls by LGA and gender, 2016-2031(AIHW, 2015)



## SWSPHN NEEDS ASSESSMENT 2022 – 2025

### ***Fall-related injury hospitalisations***

In SWS in 2018-19, a total of 1,811 males and 3,096 females aged 65 years and older were hospitalised (overnight stay) for injury related to falls. The falls-related injury hospitalisation rate for people aged 65 years and older in SWS was lower than for the state (3519.6 and 4149.7 per 100,000 population respectively)(CEE, 2020c). Within SWS, Campbelltown has the highest fall-related injury hospitalisations. It is expected that an increase in ageing population in the region will further compound the issue.

### ***Palliative Care***

According to the latest findings from the AIHW Palliative Care Services in Australia 2017-18[202]:

- 35.8% of patients who died as admitted patients received palliative care
- The average patient age was 73.5 for palliative care and 73.8 for other end-of-life care
- Only about 1 in 10 (10.1%) of the total number of palliative care-related hospitalisations was for patients aged under 55 years
- People living in areas classified as having the lowest socioeconomic status accounted for a higher proportion of palliative care-related hospitalisations (25.0%) than those living in other areas (24.8%)
- 1.8% of residential aged care residents were assessed as requiring palliative care
- 1 in 1,000 GP encounters were palliative care-related

The ageing population and rising rates of cancer and other chronic conditions has led to a rise in the demand for palliative care services. Nationally, hospitalisations for palliative care rose by 28% over the four years to 2015-16, from 57,614 to 73,900 hospitalisations(AIHW, 2018f). In 2018-19, of the 83,430 palliative-care hospitalisations, 57.3% were for palliative care and 42.7% were for other end-of-life care (AIHW, 2021g).

<b>Key Issue for our region</b>	<b>Increasing demand for palliative care services</b>
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Palliative care-related hospitalisations were most frequently recorded for cancers of secondary/unspecified site, lung, colorectal and pancreas. Cancer incidence is projected to increase by 61% between 2016 and 2031, with an annual growth of 4%. Overall cancer deaths are expected to increase by 42.3% from 2016 to 2031 with 5,616 new cancer cases and 1,923 deaths in 2016 to 9,036 new cancer cases with 2,736 deaths in 2031[101].

In 2019-20, 1.3% of people living in residential aged care in Australia had an Aged Care Funding Instrument (ACFI) appraisal indicating the need for palliative care. Based on ACFI appraisals, the need for palliative care increased with age— from less than 10% for those aged under 70 to just over 50% of people aged 85 years and over. The most common diagnoses requiring palliative care are cancer (27.4%) and diseases of the circulatory (29.8%) and musculoskeletal (11.1%) systems. About 35.9 % of residential aged care residents assessed as requiring palliative care were diagnosed with dementia (including Alzheimer's disease) and 29.5% were diagnosed with depression, mood and affective disorders and/or bipolar disorder.

In 2016, the estimated number of persons that required palliative care in SWS was 2,275 with a prevalence rate of 0.2%. The rate in SWS ranged from 0.2% (in Bankstown and Wollondilly) to 0.4% for Wingecarribee LGA. With a predicted increase in the number of older people in SWS, the demand for palliative care is expected to increase by 67.5% in the region with the number of persons requiring this type of care increasing from 2,275 in 2016 to 3,811 by 2031.

In NSW, the rate was 21.2 per 10,000 population for palliative care and 10 per 10,000 for other end-of-life care in 2018-19, with an average length of stay of 9.4 and 11.9 respectively (AIHW, 2021g). In NSW, the number of hospitalisations for palliative care increased by 26% from 17,701 to 22,281 during the four years to 2015-16 (AIHW, 2016b).



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Figure 44: Number of SWS residents requiring palliative care by LGAs and gender, 2016 to 2031(SWSLHD/SWSPHN, 2018)



### *Increasing service demand and complexity for older people*

Issues raised through the consultations regarding service demand include:

- Population growth and ageing and an introduction of new models of care will also increase demand on GPs and other primary and secondary health care providers
- There is a shortage of private geriatricians, which impacts not only on the care afforded to the community, but also on the network of providers available to support general practitioners caring for elderly patients
- The need for better support for mental health issues in residents of aged care facilities in Liverpool area, as current support by mental health specialists close to the retirement age is deemed as inadequate
- The need for more aged care facilities, services for frail and complex care, and an increased number of chronic diseases as a consequence to an ageing population in the Camden area

The stocktake and analysis of activities at the interface between the aged care, health and disability systems report made recommendations to improve the aged care and health interface in which PHNs have lead responsibility (AIHW, 2019g):

- Create aged care health pathways for health professionals to better navigate the aged care system.
- Support proactive monitoring approaches for healthy ageing and ongoing management of long-term conditions, adapted to local needs.
- Enable virtual access to primary care and care in RACFs with a particular focus on rural and remote locations.
- Enable the provision of virtual afterhours access to urgent assessment and triage for RACFs.
- Use a standard information transfer tool between hospital and RACFs.

## Section 2.3: Mental Health / Alcohol and Other Drugs Needs and Gap Analysis

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## 2.3.1 Mental Health in the General Population

### Prevalence

In 2014-15, 11.7% Australians aged 18 years and over experienced high or very high levels of psychological distress (ABS, 2015a). In 2017, 19.2% of people aged 16 years and over self-reported high or very high levels of psychological distress in South Western Sydney, the highest rate since 2003 (CEE, 2020d).

#### Key Issue for our region

**High levels of psychological distress in South Western Sydney**

In 2018, it was estimated 165,852 (16.7%) people were likely to experience a mental illness in a 12-month period. It is also estimated a further 228,453 (23%) people could require some level of early intervention, or they could be at risk of developing mental illness over a 12-month period. It is estimated 168,926 people or 43% of those with mental illness will require treatment.

**Table 32: Prevalence and treated population by age groups and severity level, SWS, 2018 (National Mental Health Service Planning Framework, 2018)**

Population	0-4	5-11	12-17	18-64	65+	65+ BPSD	Grand Total
<b>Total population</b>	75,314	97,723	80,592	605,875	134,473	-	993,977
<b>Prevalence population</b>	16,595	28,288	21,642	284,486	37,820	5,474	394,305
<b>Early intervention</b>	4,971	13,126	9,350	105,106	14,665	-	147,218
<b>Relapse prevention</b>	-	-	-	73,040	8,195	-	81,235
<b>Mild</b>	6,642	8,656	6,885	7,193	7,790	2,692	89,858
<b>Moderate</b>	3,321	4,333	3,515	28,931	3,895	1,566	45,562
<b>Severe</b>	1,661	2,174	1,892	20,217	3,274	1,215	30,432
<b>Treated population</b>	12,609	18,420	14,675	106,984	12,424	3,815	168,926

**65+ age group is divided into two groups - BPSD: behavioural and psychological symptoms of dementia.**

Psychological distress was highest in the most disadvantaged groups. Psychological distress steadily increases across the quintiles of disadvantage with 8.8% of the least disadvantaged population reporting distress compared with 12.9% in the most disadvantaged quintile (CEE, 2020d).

More than 80% of the population in SWS reside in areas with Relative Socio-Economic Disadvantage (IRSD) Index below 5; 21.1% of the population reside in the most disadvantaged areas with score of 1 (ABS, 2018a).

#### People with mild mental illness

People with mild mental illness includes those with anxiety and depression of less than 12 months duration and minimal impact on functioning. For SWS, the estimated prevalence rate for mild mental illness in 2018 was 9.0% or

#### Key Issue for our region

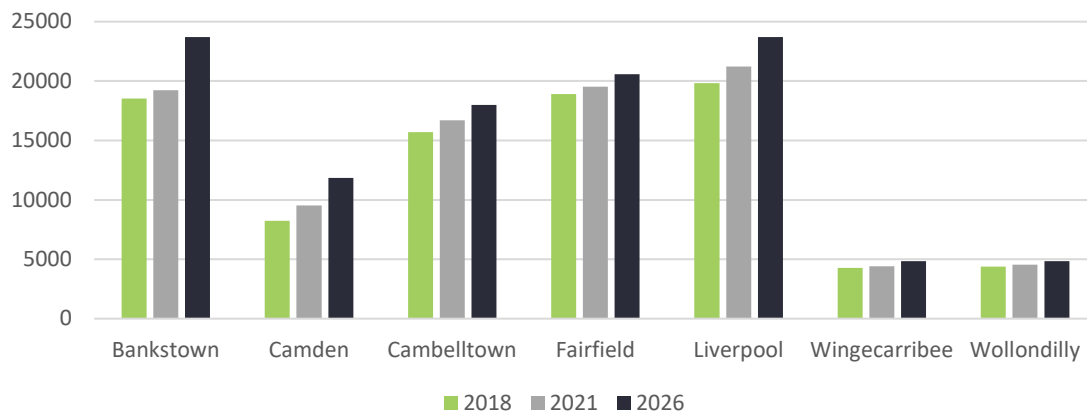
**The prevalence of mild, moderate and severe mental illness is predicted to increase significantly**

89,858 persons, with a small variation between LGAs, from 8.9% for Wingecarribee to 9.08% for Camden. People aged 18-64 years have the highest estimated prevalence of 9.4%; people aged 65 and over have the lowest of 7.8%. It is estimated 44,929 people with mild mental illness will potentially need or seek treatment (SWSLHD/SWSPHN, 2018).

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The number of people estimated to have mild mental illness in SWS is forecast to increase by 37.8% between 2018 and 2026, from 89,858 persons in 2018 to 107,487 by 2026.

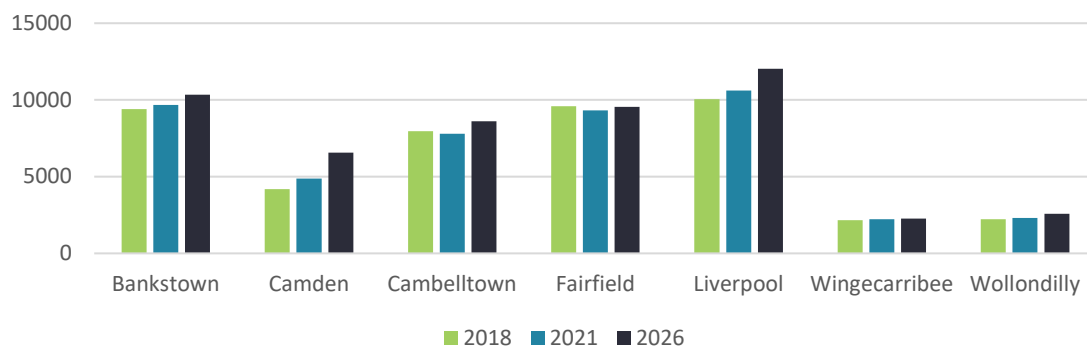
Figure 45: Projected number of SWS residents with mild mental illness by LGA, 2018 to 2026(NMHSPF, 2018)



### People with moderate mental illness

Moderate mental illness is a diagnosed mental illness of more than 12 months duration which does not meet the definition of severe or has a moderate impact of illness. The estimated prevalence of moderate mental illness in SWS in 2018 was 4.6% or 45,562 persons and with the consistently same rate across LGAs. It is estimated 36,449 persons (80%) will require treatment within 12 months. The number of people with moderate mental illness is expected to increase by 24.4% by 2031, from 45,562 people in 2016 to 56,682 by 2031(SWSLHD/SWSPHN, 2018).

Figure 46: Projected number of SWS residents with moderate mental illness by LGA, 2016 to 2026(NMHSPF, 2018)

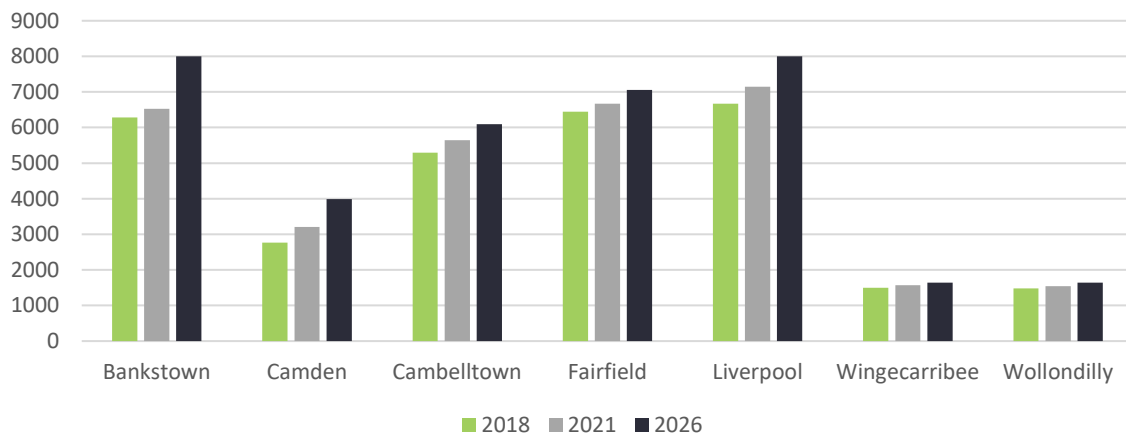


### People with severe and complex mental illness

Severe mental illnesses are defined by diagnosis, degree of disability and the presence of some abnormal behaviour. They include schizophrenia and psychosis, severe mood problems and personality disorder. Severe mental illness can cause considerable distress over a long period of time to both the person affected and his or her family and friends. The estimated prevalence of severe mental illness in SWS in 2018 was 3% or 30,432 persons. There is a small variation in the prevalence rate between LGAs, from 3.04% in Liverpool to 3.11% in Wingecarribee. It is estimated all 30,432 persons affected will need treatment, and the number of persons with severe and complex mental illness will increase by 19.7% by 2026 from 30,432 persons affected in 2018 to 36,430 persons by 2026 (SWSLHD/SWSPHN, 2018).

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

Figure 47: Projected number of SWS residents with severe mental illness by LGA, 2016 to 2026 (NMHSPF, 2018)



### Psychosocial needs

In 2018, SWSPHN conducted an online survey and face-to-face consultations with stakeholders to identify the psychosocial need for people who have a severe mental illness with an associated level of reduced psychosocial functional capacity in SWS. The survey and consultations revealed the top 5 psychosocial needs in SWS were:

- Managing daily living needs
- Social skills and friendships
- Family connections
- Physical health and wellbeing
- Finding and keeping a home

### Young People

Depression and related disorders, substance abuse, first onset psychosis and anxiety disorders are the most common mental disorders in young people. Half of all life-time mental health disorders emerge by age 18, and three quarters by age 25 (DoH, 2009).

#### Key Issue for our region

**Higher than state average rates of youth mental illness in South Western Sydney**

It was estimated that 560,000 children and adolescents aged 4–17 (approximately 14%) experienced mental health disorders in 2012–13. Attention Deficit Hyperactivity Disorder (ADHD) was the most common mental disorder (7% or 298,000), followed by anxiety disorders (7% or 278,000), major depressive disorder (3% or 112,000) and conduct disorder (2% or 83,600) (DoH, 2015).

In 2013-14, about 11% of SWS children aged 4-15 years were at substantial risk of developing a clinically significant behavioural problem compared with the 8.3% for NSW. SWS had the highest rate in metropolitan Sydney (CEE, 2016b).

The findings from Mission Australia Youth Survey 2012-16 show:

- In 2016, one in four young people aged 15-19 years who responded to the survey were at risk of serious mental illness.
- There has been a significant increase in the young people of having a probable serious mental illness between 2012 and 2016 (from 18.7% in 2012 to 22.8% in 2016).
- Aboriginal and Torres Strait Islander young people were more likely to have probable serious mental illness compared to non-Aboriginal or Torres Strait Islander peers.
- The top three issues of personal concern for young people were coping with stress, school or study problems and depression.

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- Mental illness risk increases as adolescents age and become most prevalent in the older teen years (Mission-Australia, 2016).

In 2014, 14.9% of secondary school students aged 12-17 years in SWS had experienced psychological distress, higher than the NSW average of 13.3% and highest in the Sydney metropolitan areas (CER, 2014). In SWS, young people aged 15-24 have the highest clinical psychologist and other psychologist attendance among all aged groups (AIHW, 2020g). Young people with severe mental illness that is too complex for primary mental health care services and not acute enough for SWSLHD services, often slip through the gaps in care (SWSPHN, 2019b).

### ***Other priority populations***

#### ***LGBTQIA+ community***

In 2016, the estimated number of LGBTI persons in SWS was 22,844 (comprising of 11,947 males and 10,897 females), and 183,103 persons in NSW (SWSLHD/SWSPHN, 2018). Both international and Australian studies have found LGBTI people experience mental health issues at a significantly higher rate than heterosexual people. They are twice as likely to experience depression and anxiety and have higher risk of suicidal behaviours. This is consistent amongst the LGBTI community across any age group, any residential area, income level and employment or education level. The high rate of mental illness amongst this population is caused by discrimination and exclusion (Rosenstreich, 2013).

#### ***Carers***

In 2015, almost 2.7 million Australians were carers (11.6%), with 856,100 people (3.7%) aged 15 years and older identified as primary carers. In SWS, 85,394 people (12.3%) of the population aged 15 years and older were carers (ABS, 2015b). Carers and family members often experience difficulty obtaining information regarding the status of their family members; lack of engagement in care planning, monitoring and review; lack of access to respite services and support groups are limited in flexibility (times, days of week).

Carers and family members of clients with mental illness may experience significant grief, stress and anxiety as a result of their loved one's behaviour and/or diagnosis. This can be exacerbated during acute episodes, hospitalisations and in situations where emergency services are involved. Due to their overall very complex role, carers may also experience poorer physical and mental health than the general population, with depression being a significant issue, and they may experience difficulty in maintaining employment due to their caring role.

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

In Australia (AIHW, 2017b), suicide was the leading cause of death among people aged between 15-44 years, and the second leading cause of death among those 45-54 years of age in 2018. The number of suicide deaths have continued to rise in NSW in the last decade, from 620 in 2008 to 880 in 2017. Suicide accounted for a greater proportion of all Aboriginal and Torres Strait Islander deaths (5.5%) compared with deaths of non-Aboriginal and Torres Strait Islander Australians (2.0%). Suicide is the second leading cause of death for Aboriginal and Torres Strait Islander males (ABS, 2018c). LGBTIQ people have one of the highest estimated rates of suicide of any population in Australia, with LGBTIQ young people being five times more likely to attempt suicide. The suicide rate for men is four times higher than women.

In 2016, 70 people in SWS died by suicide, accounting for around 8.7% of the state suicide deaths. Suicide rate in SWS was lower than the NSW rate (7.3 compared with 10.3 per 100,000 population, respectively). Suicide rates for males in the Southern Highlands (18.6 deaths per 100,000 population), Wollondilly (15 deaths per 100,000 population) and Campbelltown (14.8 deaths per 100,000 population) have been significantly higher than for the rest of SWS. In 2019 and 2020, 97 (9.7 per 100,000) and 71 (7 per 100,000) people died by suicide (AIHW, 2021h).

For males, the highest age-specific suicide rate was for the 85 year and older, and middle-aged males aged between 35 and 59. The median age of death due to suicide for males is 44.3 years. Deaths from intentional self-harm occur

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among males at a rate more than three times greater than that for females. Mood disorders, including depression, were the most common cause of death for intentional self-harm, followed by substance use.

In NSW(CEE, 2020e), there has been a gradual increase of suicide rate among men since 2010, from 13.1 per 100,000 population in 2010 to 17.1 per 100,000 population. In contrast, suicide rate among women has changed very little during the same period. Some characteristics include

- Suicide rate among men is almost four times as women
- In remote areas male suicide rate is 1.5 times as high as in major cities
- Suicide rate increases as socioeconomic disadvantage level increases. The most disadvantaged quintile of the population is 1.5 times as high as the least disadvantaged quintile
- Suicide by age group: Between 2015-17, suicide rate for men aged 25-34 years and 55-64 years are the highest among all age groups and have increased during this period. There has been a steady increase in suicide rate among 15-24 years between 2007 and 2017
- Suicide rate among Aboriginal males is nearly twice as high as non-Aboriginal males. It has increased from 15.9 per 100,000 population in 2003-2007 to 27.7 per 100,000 population in 2012-2016.

Research suggests majority of male suicides are not primarily linked to a mental health diagnosis. Estimates from the Black Dog Institute suggest 72% of men experiencing mental distress fail to seek help. A recent study of male farmer suicide found 78% of the suicides were predominantly associated with either relationship issues/family breakdown or a work/financial crisis [149]. Contributing factors of suicide among males include recent or pending unemployment, recent separation and relationship difficulties, having one or more existing mental health conditions, having one or more physical conditions, experiencing one or more adverse life events (e.g., relationship or financial problems) and having a history of suicidality(Leske, 2019). This information suggests that a tailored approach is required to prevent male suicides and improve men's mental health, noting that men don't seek support for their mental health in the same ways as women. There is an opportunity to develop tools and pathways to help men become proactive in not only identifying warning signs but also having the tools to proactively seek, maintain and complete support.

### ***Mental health literacy needs***

The *Co-design of Mental Health Literacy Initiatives* for SWSPHN involved co-design with the community, local services and health professionals which will inform mental health literacy activities and development of resources and tools to be implemented in the region. In May 2021, SWSPHN engaged Beacon Strategies to undertake an experience-based co-design approach to develop an understanding of the mental health literacy needs of the region and provide recommendations to guide future activities and development of resources to meet these needs.

Key recommendations emerged from the findings:

- Increased awareness and understanding of mental health
- Services and supports often do not appropriately meet the needs of people experiencing mental health challenges
- Improving the accessibility and responsiveness of mental health services and supports

### ***Mental Health Services***

There has been a steady increase in both number of services and number of patients availing mental health services through MBS since 2011-12 in SWS region, with the biggest increase in GP and Clinical Psychologist Mental Health Services. This trend has continued to 2019-21. Between 2013-17 and 2018-19, the service attendances in SWS have increased by 17.4% from 14.9 to 17.5 services per 100 people respectively in 2019-21, Campbelltown, Camden and Wollondilly had the highest percentage of people who had the service as well as the highest number of services per 100 people (AIHW, 2021b).

### Key Issue for our region

### High levels of mental health service use in South Western Sydney

The mental health service system in SWS is highly complex. It comprises all three levels of government, public and private health providers, as well as community managed sector. It becomes further complex for people with co-morbidities such as substance misuse or intellectual disability and for people who are already disadvantaged. The complexity of the mental health service system can lead to fragmentation and makes finding the most appropriate services difficult for consumers, carers and service providers.

The Living Well report recommends the use of a Collective Impact Approach involving all stakeholders, working towards a common goal, to address highly complex social issues, such as the recovery of people with a mental illness (MHCNSW, 2014).

Consultations highlighted long waiting lists for mental health support within the public system. Compared to the availability of mental health services elsewhere in NSW, SWSLHD is currently under resourced in relation to community and hospital-based services (SWSLHD, 2015b).

Publicly funded services are located in the most populous areas of the region, particularly around Liverpool, Campbelltown and Bankstown LGAs. These areas are also populated with the communities identified as being at a greater risk of psychological distress and/or socioeconomic disadvantage. Communities in the southern area of the region are shown to have poorer geographic access to inpatient services; however, levels of disadvantage and risk of psychological distress are lower. Community and stakeholder consultation revealed a shortage of psychiatrists in the Liverpool area and consequently long waiting times of up to 6 weeks which is particularly hard for people with suicidal ideation.

The number of private psychologists varies between LGAs in SWS. Considering the estimated number of population and number of psychologists, Camden residents have the best access to private psychologists in SWS, Liverpool LGA has the poorest access followed by Fairfield LGA. Consultations also identified a need for more services provided by NGOs which should be evenly distributed through the region.

The total number of services from the NGO sector providing mobile outpatient care (non-acute) in South Western Sydney is 2.17 per 100,000 residents (0.93 accounted for by the HASI program alone) (Salvador-Carulla, 2016).

### ***Access to primary care mental health services***

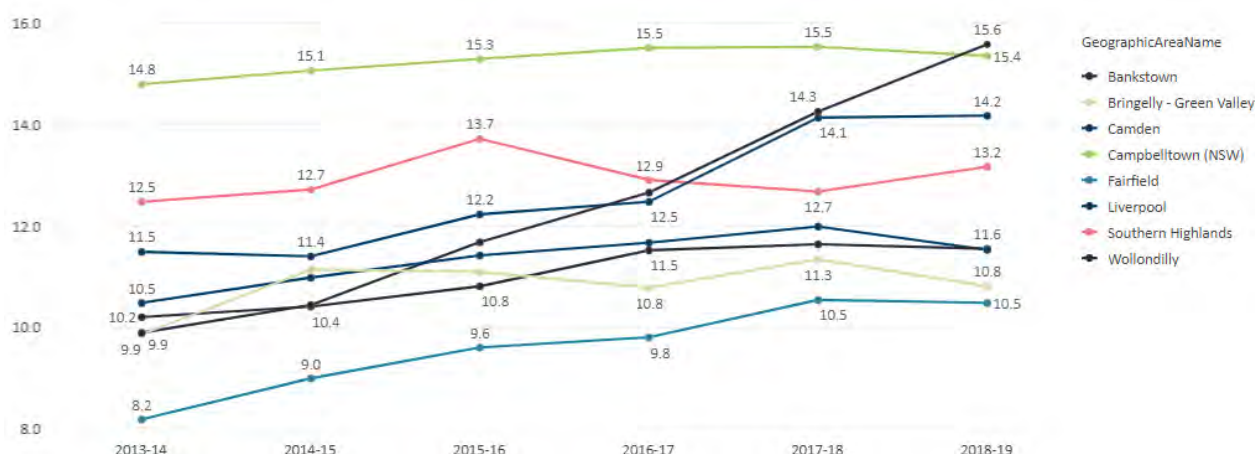
In SWS, Medicare subsidised GP mental health services have increased from 10.8 services per 100 people in 2013-14 to 12.4 services per 100 people in 2018-19. In 2020-21, it has further increased to 13.2 services per 100 people (AIHW, 2021i).

The percentage of the population who had the service increased from 6.3% to 7.6% from 2013-14 to 2018-19, whereas in 2019-20 and 2020-21, 7.7% and 8.1% of the SWS population used the service. SWS currently (2020-21) has a lower rate compared to the national rate (13.2 and 15.4 service per 100 people). Women are 1.6 times more likely to use GP mental health services compared to men (16.5 and 9.8 service per 100 people respectively). People aged 15-24 have the highest rate of encounters of all age groups (18.4 service per 100 population, or 11.5% of people who had the service), followed by people aged 25-44 years (18.2 services per 100 people, or 10.9% of people who had the service) (AIHW, 2021b).



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Figure 48: Medicare subsidised GP mental health by SA3, services per 100 people, SWS, 2013-14 to 2018-19(AIHW, 2021b)



General Practitioners are often the first point of contact for people seeking help when needing a mental health support. GPs provide a variety of services, including referral of the patient on to specialised services. The most common management of mental health-related problems was for the GP to prescribe, supply or recommend medication (62 per 100 mental health-related problems managed). The second most common form of management of mental health-related issues was counselling, advice or other clinical treatments provided by a GP (50 per 100 mental health-related problems managed) with psychological counselling (24 per 100) being the most frequently provided treatment in this category. Referrals were given at a rate of 16 per 100 mental health-related problems managed. The most common referrals given were to psychologists (8 per 100) and to psychiatrists (2 per 100).

Consultations in Fairfield and Bankstown LGAs raised issues of service/program funding structure including sector coordination; capacity building of the staff including training on evidence-based practice; collaboration/partnerships; performance indicators/health outcomes and information sharing and referral pathways.

Assisting Communities through Direct Connection reports were completed in 2022 for Cabramatta and Wollondilly LGAs (ACDC, 2022a, ACDC, 2022b). Wollondilly had a higher rate of respondents indicating they wanted to seek help for their mental health (52%) than Cabramatta (16%). However, Cabramatta reported significantly higher rates of not having their treatment needs met (70%) than Wollondilly (37%).

The NSW Mental Health Commission's foremost reform strategy focuses on 'investing in our workforce' acknowledging the importance of the availability of a skilled workforce who are diverse and have the skills to provide a range of support to people who have a severe mental illness. The suggested workforce includes Aboriginal health workers, GPs, mental health nurses, occupational therapists, psychologists, psychiatrists and social workers(MHCNSW, 2014).

SWS consumers requested access to a range of skilled staff are required to provide a range of psychosocial supports to facilitate consumers' recovery. These include group facilitators, mental health support workers and allied health professionals.

### **Mental Health Nursing**

In 2014-15, Wingecarribee, Wollondilly and Camden had the highest rate of patient engagement with mental health nurses (153, 133 and 126 per 100,000 population, respectively). The lowest rates of patient engagement were observed in Bankstown, Liverpool and Fairfield. In 2014-15 there were no Mental health nurses located in the Campbelltown, Liverpool and Fairfield LGAs under the Department of Human Services Mental Health Nurse Incentive Program.

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### Access to private mental health services

#### Private psychiatry

In 2020-21, use of Medicare-subsidised psychiatrist services was lower in SWS compared to the national rate (4 and 6.8 services per 100 people respectively). 1.2 % of the population in SWS received the service, compared to 1.6% nationally. Between 2013-17 and 2020-21, psychiatrist services attendance in SWS has remained relatively stable (AIHW, 2021b). The benefit/fee ratio is 0.76, the lowest among all Mental Health service types.

**Key Issue  
for our  
region**

**Limited access to psychiatry**

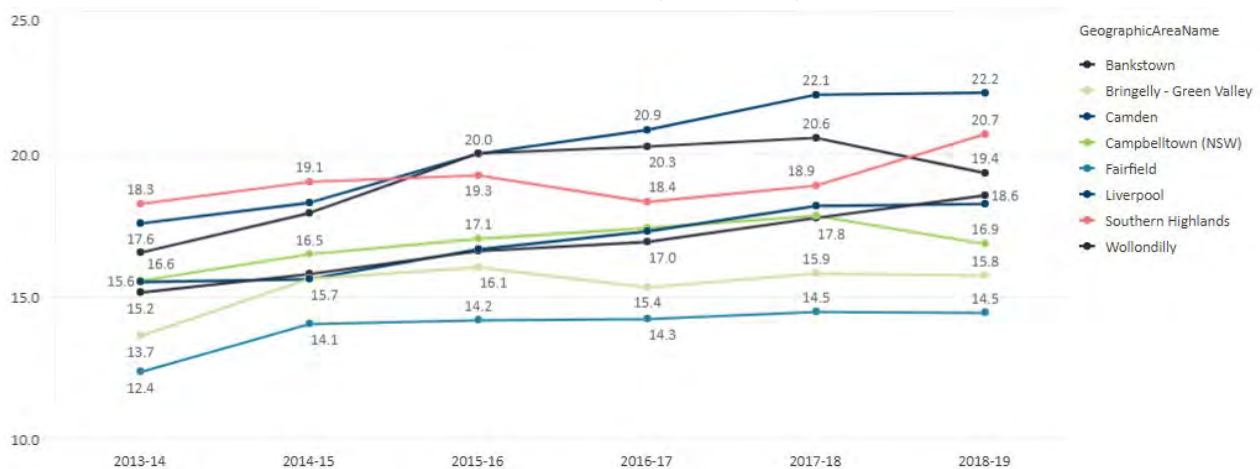
GPs tend to contact public psychiatrist services for advice as they don't have access to psychiatrist in private practice. Consultation with service providers in the Fairfield LGA identified affordability of private counselling services as an issue for the area. Services and community members highlighted a paucity of local psychiatrists, with significant gaps in access to affordable services. Lack of psychiatrists also impacted the GP workforce, with limited opportunities for mental health consultancy, which supports and empowers primary care providers to continue to oversee the management of complex patients.

Community consultations identified significant consequences associated with limited access to psychiatrists including inability to receive new scripts in time. Consultations with GPs also identified many patients with mental illness could not afford to see a psychiatrist in SWS when required as they are too expensive.

#### Private psychology

Use of Medicare-subsidised clinical psychologists and other psychologist services has increased from 2018-19 to 2020-21 (17.5 and 19.3 services per 100 people). However, it was lower than the national rate of 21.8 and 25.7 respectively. 4.2% of the population in SWS had the service, compared to 5.1% nationally. In 2020-21, clinical psychologists provided 61,464 mental health services through MBS to 12,447 patients in SWS region. Between 2013-17 and 2018-19, the service attendances in SWS have increased by 17.4% from 14.9 to 17.5 services per 100 people respectively and reached the current rate of 19.3 per 100 people. Women are 1.6 times more likely to use the service compared to men (24.2 and 14.3 services per 100 people respectively). Young people aged 15-24 have the highest attendances among all aged groups (31.6 services per 100 people) and are 1.6 times as likely to use the services compared to all ages in SWS (AIHW, 2021b).

**Figure 49: Medicare-subsidised clinical psychologist and other psychologist attendance (services per 100 people) by SA3, SWS, 2013-14 to 2018-19(AIHW, 2021b)**



## SWSPHN NEEDS ASSESSMENT 2022 – 2025

In 2020-21, Medicare-subsidised mental health service provided by other allied health professionals was lower in SWS compared to the national rate (1.3 and 2.1 services per 100 people respectively). 0.3% of the population in SWS had the service, compared to 0.4% nationally. Between 2013-17 and 2018-19, the service attendances in SWS have increased from 0.9 to 1.3 services per 100 people respectively and has been stable until 2020-21 (AIHW, 2021b).

### **Access to after-hours mental health services**

Hospital emergency departments (EDs) play a role in treating mental illness. People seek mental health-related services in EDs for a variety of reasons, often as an initial point of contact or for after-hours care.

- 3.1% (or 10,088) of ED presentations were mental health related.
- 6.5% (or 643) of the mental health-related ED presentations were Aboriginal patients.

In SWS in 2018-19(AIHW, 2021j), Campbelltown had both the highest number and rate of overnight admitted mental health-related separations (2,219 separations or 131 per 10,000 population). Wollondilly had the lowest number of separations (434), and Fairfield had the lowest rate of separations (83 per 10,000 population). Southern Highlands had the highest rate of patient days (1,601 per 10,000 population), Wollondilly had the lowest (1,024 per 10,000 population).

Consultation highlighted difficulty accessing options other than ED during the after-hours period for people experiencing a mental health crisis. There is a need for a 24hr outreach service that families or consumers can ring in crisis. According to community consultations emergency response teams are not able to respond quickly enough to meet the needs of people having an acute episode, resulting in inappropriate utilisation of ED. Police and ambulance services are used as an alternative to community-based emergency teams. There are six services providing emergency care for adults with mental health problems in SWS. Three of these teams liaise with other services at hospitals to provide psychiatric care and the other three provide acute outpatient care during business hours. It should be noted that none of these teams provide 24-hour psychiatric emergency care. This care is provided by the acute inpatient team.

### **Access to acute mental health services**

In 2015-16 in South Western Sydney there were 97 per 10,000 people age-standardised rate of mental health overnight hospitalisations in both public and private hospitals, which has slightly increased compared with 2014-15 (95 per 10,000 people). Drug and alcohol use is the most common mental health conditions requiring overnight hospitalisation, followed by schizophrenia and delusional disorders. These two conditions together represented 41% of all mental health hospitalisations and 46.8% of all mental health bed days in SWS across SWS SA3 areas, Campbelltown has the highest overnight hospitalisation for mental health, followed by Southern Highlands and Liverpool.

**Table 33: Overnight hospitalisations for mental health for SWS resident by mental health conditions, 2015-16(AIHW, 2017c)**

Mental health conditions	Hospitalisations per 10,000 people (age-standardised)	Bed days per 10,000 people (age-standardised)	No. of hospitalisations	No. of bed days
Anxiety and stress episodes	13	117	1,188	10,700
Bipolar and mood disorders	7	135	660	12,615
Depressive episodes	11	177	1,032	16,424
Drug and alcohol episodes	22	156	1,956	14,015
Dementia	7	92	660	8,650
Schizophrenia and delusional disorders	18	459	1,591	41,509
Intentional self-harm	15	85	1,429	7,918

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### ***Intentional self-harm hospitalisations***

In 2016-2017, 1,348 people (142.3 per 100,000 population) in SWS were hospitalised for intentional self-harm, similar to the NSW rate of 149.0 per 100,000 population). Of them, 457 (362.2 per 100,000 population) were aged 15-24 years. The hospitalisation rate for young people aged 15-24 years was 2.5 times as high as the rate of all population (CEE, 2017). In 2019-20 self-harm hospitalisations were higher for females (98.4 per 100,000) compared to males (63.9 per 100,000) (AIHW, 2021h).

Despite the comparatively low suicide rates and intentional self-harm hospitalisations in SWS overall, there are significant variations among SA3 areas. In 2015-16, Southern Highlands and Campbelltown had the highest rate of hospitalisation for self-harm (30 and 27 per 10,000 respectively) in SWS, significantly higher than national rate (17 per 10,000) (AIHW, 2017d).

**Table 34: Overnight hospitalisations (number per 10,000 population) for self-harm by SA3, SWS and Australia, 2015-16 (AIHW, 2017d)**

SA3	No of hospitalisations per 10,000	No of bed days	Per 10,000	SA3	No of hospitalisations per 10,000	No of bed days	Per 10,000
Southern Highlands	30	540	144	Bringelly - Green Valley	12	577	59
Bankstown	9	824	46	Fairfield	12	1,150	61
Camden	15	435	71	Liverpool	16	1,275	110
Campbelltown	27	2,527	158	SWS	15	7,918	85
Wollondilly	15	283	70	National	17	N/A	81

In 2019-20, Campbelltown and Liverpool had highest rates of intentional self-harm hospitalisations (123 and 97 per 100,000 population respectively) and Merrylands-Guildford had the lowest (41 per 100,000) (AIHW, 2021h).

### ***Post-discharge services***

The National Mental Health Consumers and Carers Forum recommends that psychosocial disability supports be integrated with health services to ensure health and mental health needs are addressed (NMHCRF, 2011). The integration of mental health services, primary care and psychosocial services are priority areas in national, state and local mental health plans. The Fifth Mental Health and Suicide Prevention Plan priority area 3 emphasises the need for coordination of treatments and supports for people with severe mental illness with focus on access to services based on the needs of the consumer to ensure a continuum of care (DoH, 2017b).

Community-based mental health service providers report the current challenge of service collaboration with concurrent market competition. The competitive nature of the sector may impair referral pathways for consumers.

SWS consumers and carers, and service providers expressed significant concerns relating to people transitioning between services. This was particularly a concern for people being discharged from the hospital, the options available to them for support/treatment within the community and the timeliness of follow up. While SWSLHD has made significant effort to improve the responsiveness of follow up care in the community within seven days of a hospital discharge there is also a need to link people to community-based services prior to discharge.

### ***Suicide prevention services***

The Living Well report recommends that suicide prevention efforts should reflect the unique needs and higher rates of suicide in particular communities and populations. The document also highlights the importance of training and education to support clinicians in assessment and management of suicidal people in community and hospital services.

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Education and resourcing for GPs including how to identify, treat and follow up with someone experiencing thoughts of suicide have been identified as an issue through the consultation (NSW Mental Health Commission, 2014).

### Key Issue for our region

**Lack of access to early intervention and support services for people experiencing suicidal ideation**

Consultations revealed a lack of early intervention and support services for people with persistent and recurring thoughts of suicide. Regarding suicide prevention in CALD communities, consultations identified the following issues: poor recognition of the need for professional care until the situation becomes a crisis, either due to lack of information, cultural stigma, or language barrier may be left untreated until the situation becomes unmanageable.

Stakeholder consultations suggested suicide in SWS is under-reported and further population growth and diversity across certain parts of the region (e.g., Oran Park: experiencing significant population growth, Liverpool/Fairfield with an influx of refugees with an experience of trauma and abuse) would potentially contribute to a rise in suicide attempts and/or suicide rates in the region. It has also been noted that several triggers such as isolation or disconnection from family or community, financial issues and drug and alcohol misuse could contribute to suicide attempts in the community.

Consultation with NGO service providers suggested women are more likely to identify and discuss the early warning signs of suicide with a friend or support service unlike men who tend to call Lifeline when distressed. It was also noted that while women engage in self-harm more frequently, men have a higher rate of death by suicide due to use of more lethal means.

A tailored approach is required to prevent male suicides and improve men's mental health, noting that men don't seek support for their mental health in the same ways as women. There is an opportunity to develop tools and pathways to help men become proactive in not only identifying warning signs but also having the tools to proactively seek, maintain and complete support.

In 2019-2020, SWSPHN codesigned Men's Pro-Active Suicide Prevention with the community to address men's suicide prevention. A total of 54 people attended the Campbelltown Workshop and 41 people attended the Mittagong workshop. A diversity of genders, ages and cultures were represented at the workshop, most notably Aboriginal peoples and Pacific Islander peoples. Initiatives proposed by participants at the codesign workshops to prevent suicide in men include:

- Media campaign across multiple media channels, including podcast, print, television, social, radio delivered throughout the day and night
- Strengths based and solution focussed podcast, featuring a range of guests and experiences and honest talks
- Men's focus groups and mentoring support
- Connect with men post-discharge
- Peer Support (people with carer and lived experience).

### ***Suicide post-vention services***

Postvention support describes the service response when someone takes their own life or attempts to take their life. International evidence documents the impact of suicide on a community, whereby a person's exposure to a suicide increases the likelihood of them viewing suicide as an option (the contagion effect).

The body of evidence that describes what the impacts are and how practitioners can respond effectively, is limited. An understanding of the responses to suicide of children and culturally diverse groups, and effective ways of resourcing families and communities to cope, has been largely ignored (Robinson, 2008).

Within SWS, there is a lack of an integrated means for delivering postvention support including inadequate support for families dealing with a family member who is suicidal and insufficient response from services once someone has

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taken their own life, related to unclear delineation of roles in response to suicide e.g., postvention response. Internationally, evidence-based models exist to deliver postvention support.

### ***Integration and transition of care***

Consumers and providers expressed significant concerns relating to people transitioning between services. This was particularly a concern for people being discharged from the hospital, the options available to them for support/treatment within the community and the timeliness of follow up. SWSLHD has made significant effort to improve the responsiveness of follow up care in the community within seven days of a hospital discharge, with services generally meeting or exceeding the target of 70% followed up within 7 days(SWSLHD, 2015b).

Evidence suggests a multi-level and multi-factorial approach to suicide prevention is more likely to have bigger effects than just individual services. Currently, the PHN's role in suicide prevention is limited to commissioning health services and primary care. For consumers and carers, a lack of integration and agreement on care pathways and service entry thresholds creates frustration and leads to poor treatment continuity, difficulty in maintaining treatment and poorer treatment outcomes. Key to success will be the involvement of consumers and carers and the building of relationships with community-managed organisations, Aboriginal and Torres Strait Islander health services, GPs and private sector providers(SWSLHD/SWSPHN, 2020).

### ***Access to NDIS supports***

There are fewer people than expected with psychosocial disability accessing the NDIS. The NDIA estimated that by full rollout of the Scheme (2019-20), there would be 460 000 participants, with 13.9% (64 000 people) expected to have a primary psychosocial disability (NDIA 2017e). As of March 2020, the NDIS had 365 000 participants, and 9.4% (34 200 people) had a primary psychosocial disability (Productivity Commission, 2020). *Source: Productivity Commission p. 852*

In March 2021 there were only 1360 people with a psychosocial disability across SWS who were receiving support through the NDIS. Only 4.46% of people with a severe mental illness in SWS received support through the NDIS. The application rates for psychosocial disability are also lower than expected (Productivity Commission, 2020). The process for testing eligibility for the NDIS can be a stressful and complicated process. Consumers often require intensive support to collect the required evidence, complete a NDIS Access Request form, and activate a NDIS plan (Productivity Commission, 2020)

In September 2020 SWSPHN conducted an online survey with 47 psychosocial support workers (PSW) in the NPSM, CoS, and NPS-T program in SWS. The data indicated the PSWs were spending considerable time preparing NDIS Access Requests for the consumers they were supporting. 21.05% of respondents reported "20+ hours"; 42.11% of respondents reported "10– 20 hours"; 15.79% of respondents reported "5 – 10 Hours"; and 21.05% of respondents reported "< 5 Hours". In summary the data of the survey also reported there were many complexities and barriers in supporting a consumer with a psychosocial disability through the NDIS process.

Transition of consumers within current psychosocial services (D2DL, PIR and PhAMS), to the NDIS presents a challenge. There are significant time delays in SWS between making an application for a NDIS package and when a decision is made. Data from former PIR program indicated that acceptance rate to the NDIS is around 50% of applications, which is below currently stated psychosocial transition estimates from DSS. In addition, a further 30% of consumers decline to apply for a NDIS package.

The National Mental Health Consumers and Carers Forum suggest specialist disability supports for people with psychosocial disabilities such as outreach home based support are likely to facilitate recovery, however availability falls short due to lack of funding and funding changes experienced by the CMOs/NGOs(NMHCRF, 2011). Currently there is limited outreach services for people who are hard to reach.



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### ***Psychosocial day programs***

There is no day care service provided by the public health sector in SWS (Salvador-Carulla, 2016). The SWS Integrated Mental Health Atlas revealed a shortage in acute day services providing a flexible alternative to acute, inpatient care. Nationally, NSW has the lowest number of residential episodes of care, with 256 episodes of care recorded in 2013-14 for 208 residents. On average, there were 154.9 care days per episode. When principal diagnosis was specified, Schizophrenia was the most common principal diagnosis for residents undergoing residential episodes of care (32%), followed by depressive episode (12%) and schizoaffective disorder (10%).

<b>Key Issue for our region</b>	<b>Lack of access to psychosocial support services</b>
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The National Mental Health Consumers and Carers Forum (2011) suggested specialist disability supports for people with psychosocial disabilities such as rehabilitation day programs and outreach home based support are likely to facilitate recovery, however availability fell short due to the lack of funding and funding changes experienced by the CMOs/NGOs (NMHCRF, 2011).

In 2015 there were three Day-to-Day Living centres, however only two remain in Liverpool and Campbelltown. These services enable social contacts in a structured way and provide workshops that aim to support the development of basic life skills.

A 2015 analysis by University of Sydney, of the needs carried out in 764 of their clients identified daytime activities and company (social life) as significant unmet needs, reported by 47% and 45% of the PIR clients. These activities, especially daytime activities and social life, could be provided by day centres (Salvador-Carulla, 2016).

### ***Psychosocial supports for people with severe and complex mental illness***

Psychosocial support programs support a consumer's mental health recovery by supporting their social, emotional, mental, and spiritual needs. The support provided to each person can vary depending on the individual needs of the person. This includes managing daily living tasks; support to participate in the community; undertaking work or study; advocacy; engaging with required services and supports; increasing social skills and capacity building; improving physical health and wellbeing; and finding or maintaining a home (National Mental Health Consumer & Carer Forum, 2011). Psychosocial support can be provided by individual, group or community-based programs and are predominately delivered by non-government organisations (NGOs) funded by the Australian (Federal) and State or Territory Governments (National Mental Health Consumer & Carer Forum, 2011).

Recent local, state, and national mental health reports (SWS Psychosocial Needs Assessment 2019 – 2021, The Royal Commission into Victoria's Mental Health System 2021, The Productivity Commission Mental Health Inquiry Report 2020) have highlighted there is a significant gap in community-based psychosocial support services for people with a severe mental illness, outside of the National Disability Insurance Scheme (NDIS).

In 2019-2020 SWSPHN had the capacity to support approximately 600 consumers in the psychosocial programs of the National Psychosocial Support Measure (Connector Hub), Continuity of Support and National Psychosocial Support – transition programs. The state government funds the community living supports, housing and support initiative programs, which provide psychosocial support to a limited number of consumers in SWS. As of March 2021, there were only 1360 people who are supported under the NDIS psychosocial disability category in SWS. This indicates there is a large service gap in psychosocial support for people with severe mental illness in SWS [140].

Estimates from the National Mental Health Service Planning Framework (NMHSPF) suggest about 690,000 people with mental illness would have benefited from some type of psychosocial support in 2019-20 (NMHSPF, 2018).

The provision of psychosocial supports, which has long been affected by inefficient and duplicative funding arrangements, is currently in a state of transition as the NDIS roll out is in progress. The transition to the NDIS, while

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providing for some, appears to have left a significant gap in service provision for many others (Productivity Commission 2020, p.827).

Co-design highlighted the following priorities:

- Access to allied mental health providers with experience and skills in tailored and targeted interventions for people with severe mental illness. Including approaches which support a recovery-oriented focus and trauma-informed care
- Service caps and session allowances which are flexible, and needs based
- Opportunities to utilise other health professionals and health workers to deliver care as a team, this included practice nurses, peer workers and allied health professionals
- Increased availability of low or no cost options for psychological and psychiatric care

Overwhelmingly there was consensus in the local data collection that SWS consumers and carers sought a range of groups: social, psychoeducation, medication, activity, interest groups, exercise groups (e.g., walking groups), and interpersonal skills (communication, self-esteem, self-confidence building). Service providers and allied health professionals also indicated the need for people with severe mental illness to access a variety of groups to assist building personal capacity and to support people with their personal goals.

Consultation within SWS identified the top five unmet psychosocial needs for the SWS region were managing daily living needs; social skills and friendships; family connections; physical health and wellbeing; and finding and keeping a home.

### ***Managing daily living needs***

The National PHaMS (2017) report indicates two areas of functional limitation for people with severe mental illness include self-care and domestic activity (AIHW website). SWS consumers and carers reported needing domestic help and in-home assistance with a range of tasks. They suggested peer or support workers were desirable to assist with medication, cooking, shopping, and paying bills, making and getting to and from appointments, and going on outings.

### ***Social skills and friendships***

The National PHaMS report indicates two areas of functional limitation including communication and interpersonal relationships (AIHW, 2017e). Additionally, the national report on psychosocial disability and the NDIS also confirmed people with severe mental illness have a strong desire for connection and friendship (USyd, 2018). Likewise, the consumer experience survey suggests “connection” was an experience which consumers desired while accessing state mental health services (SWSPHN, 2017). The National Mental Health Consumers and Carers Forum states “challenges with communication and social isolation are amongst the most pervasive of the psychosocial disabilities” (NMHCRF, 2011).

### ***Family connections***

The National PHaMS report indicates the most important need of consumers is relationships (AIHW, 2017e). Both SWS consumers and carers expressed the need for family inclusive psychosocial services where their loved ones could access support, psychoeducation and opportunities to attend activities as a family, reconnection with family after periods of loss of contact or hospitalisation, and when they experience relationship stress, and feel socially disconnected.

### ***Physical health and wellbeing***

Physical health is a key priority area across all national, state and local mental health plans. People with severe mental illness are particularly prone to cancer, cardiovascular disease, metabolic disorders and diabetes. Many experience obesity, poor nutrition and oral health, and problems with drugs and alcohol (MHCNSW, 2014).



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The National Mental Health Consumers and Carers Forum also sites consumers have a higher risk of health conditions not only due to medication and effects of their illness, but due to reduced access to health care(NMHCRF, 2011), such as needing assistance with making medical appointments, getting to appointments and financial assistance to access the specialist health services they need including dieticians and psychiatrists(SWS-PIR, 2018).

### ***Finding and keeping a home***

The second largest service gap found in the SWS Integrated Mental Health Atlas is related to the lack of supported accommodation for people with mental health problems [93]. SWS consumers described the long-term challenge of finding a home in the region and their desire to access housing support services.

One of the underlying causes linked to homelessness is severe mental illness. The data from PHaMS identified special needs groups are likely to be disadvantaged. “The data from National PHaMS programs is that consumers want three main things: secure accommodation, meaningful activity and relationships. These are rated above symptom control. We should listen to the end user of services.” Online survey respondent(AIHW, 2017e).

The National Mental Health Consumer and Carer Forum recognised the lack of housing options dominates the lives of consumers and their careers. They recommend a whole of government approach to the provision of a range of accommodation supports including safe, affordable and secure housing, support to maintain tenancy and community access(NMHCRF, 2011).

### ***Services for young people with severe and complex mental illness***

Young people with severe mental illness, that is too complex for primary mental health care services and not acute enough for SWSLHD services, often slip through the gaps in care. In 2019, SWSPHN undertook consultations involving young people with lived experience, carers, GPs, psychiatrists, and other mental health professionals to co-design the provision of services for young people with, or at risk of severe mental illness.

The key themes emerged from the consultation process include:

- Unclear referral processes
- Lack of centralised service information portal for high schools
- The need for tertiary services to have been tried prior to referral to public mental health services
- Need for service navigator / coordinator as a soft entry/referral point for the person

The co-design also identified our critical elements for the service model:

- Navigation support service which is an adjunct to a Hub and Spoke ECHO model stemming from the existing sites.
- Alignment with headspace & ReFrame sites to minimise confusion and allow for seamless ‘stepping up/down’ of young people as their needs determine. To ensure this model includes outreach to schools and other spoke sites.
- Formal service protocols, which are endorsed by each participating stakeholder organisation.
- Maximising awareness off and accessibility to services for young people, with specific promotion and workforce capacity building around the youth focussed service model.

Star4Kids is a mental health program funded by SWSPHN for children aged 3-12 years who have, or are at risk of developing, a mild to moderate mental health condition. The service provides psychological therapies delivered by mental health professionals.

In SWS, Perinatal and Infant Mental Health Services are provided through community mental health, inpatient services and Karitane/Jade House. These services provide support to women who experience a range of mental health problems during the perinatal period including depression, anxiety and difficulties with attachment.

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The district-wide Infant, Child and Adolescent Mental Health Service (ICAMHS) provides community based and inpatient services, focusing on prevention and early intervention to improve the mental health of children, young people and families.

SWSLHD Mental Health Service provides early psychosis intervention services (regular clinical and therapy programs) in partnership with headspace centres located at Bankstown, Liverpool and Campbelltown (DoH, 2018). The total number of staff in the public health sector providing non-mobile non-acute outpatient care for children and adolescents experiencing mental health problems in SWS is 2.39 per 100,000 residents. The total number of staff in NGOs providing non-mobile non-acute outpatient care for children and adolescents experiencing mental health problems in SWS is 1.20 per 100,000 population.

Non-acute, non-mobile outpatient care - child and adolescents funded by FaCS provides preventive and early intervention services for children and their families in a vulnerable situation. The direct care they provide consists of behavioural assessment and parenting education to address children's behavioural problems. Two NGOs providing non-mobile, non-acute outpatient care for children and adolescent are Miller Pathways, by Mission Australia, and the Break Thru Family Mental Health Support Service, assisting with mental/behavioural problems of children with psychosocial difficulties.

Star4Kids is a mental health program funded by SWSPHN for children aged 3-12 years who have, or are at risk of developing, a mild to moderate mental health condition. The service provides psychological therapies delivered by mental health professionals.

Within SWS, a range of mental health promotion initiatives are undertaken to improve the mental health and wellbeing of families and school-aged children and to support early identification and treatment of problems. Specific programs to support children of parents with a mental illness and young carers are also available. In terms of mental health treatment, few services provide family approaches to care (SWSLHD, 2015b).

In 2016-17, about 13.6% of all MBS Mental Health services were provided to the 0-17 aged group in SWS (DoH, 2018). Consumer and provider consultations highlighted concerns relating to service coordination between schools, NGOs and the health sector, which results in young people and children missing out.

### ***Peer support services***

Overwhelmingly SWS consumers requested more access to 1:1 support from peer workers, and/or people with a lived experience of mental illness. The importance of, and the increased need for, peer worker role is sited in national, state and local plans. The National Mental Health Consumers and Carers Forum recommends peer workers should be part of the support service workforce (NMHCRF, 2011). NSW's Living well strategic plan calls for the increase of peer workers across mental health service delivery and that all peer workers are supported and provided with resources and training to prepare and sustain them in their roles (AIHW, 2014).

Research has shown the impact and outcomes of consumer peer work in reducing depressive symptoms, reduction in hospital readmission rates, enhances hope, social functioning, and acceptance. It can also improve self-esteem and reduce stigma toward mental illness.

### ***LGBTQIA+ appropriate services***

Mental Health services working specifically with the LGBTI community are limited in SWS. However, the SWSLHD Youth Health Service provides support groups for young LGBTI people at Campbelltown and Bankstown. Clinical services including medical, nursing and social work are provided through the Sexual Health Service and the Liverpool HIV/Immunology Clinic and the HARP Health Promotion Team provide health promotion, education and referral services relevant to the LGBTI communities (SWSLHD, 2015b).

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### ***Carer support services***

Community consultations and service audits have highlighted the need to significantly increase the participation of carers in the assessment, care planning and review of care of their family members (SWSLHD, 2015b).

Carer Assist is part of the NSW Family and Carer Mental Health Program and is funded by the NSW Department of Health through the Mental Health Drug and Alcohol Office (MHDAO). Carer support services available in SWS include information, education, assistance with referrals, advocacy, carer support groups, carer events, social support activities and respite. Specific services are provided also for the children of people with mental health issues who have a caring role and there are a range of culturally diverse carer support groups available. Carer support services work closely with carers and families in inpatient and community services. However, as a result of varying funding sources, geographic boundaries, target groups, service providers and outcome requirements, there are both gaps and overlaps in carer support service availability and the system is difficult to navigate.

### 2.3.1 Alcohol and Other Drugs in the General Population

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#### *Prevalence*

##### ***Alcohol***

The impact of alcohol and other drug use, including pharmaceuticals, on individuals, families and communities is significant including quality of life, physical and mental health, family and community function and crime rates. Excessive alcohol consumption is one of the main preventable public health problems in Australia, with alcohol being second only to tobacco as a preventable cause of drug-related death and hospitalisation (NSW, 2018).

In Australia in 2018, alcohol use caused 4.5% of the total disease burden accounting for 5.6% of fatal burden and 3.4% of non-fatal burden in the same period (AIHW, 2021c). The proportion of total burden attributable to alcohol use was highest for injuries (15%), followed by mental health conditions & substance use disorders (11%).

In NSW in 2019, 32.8% of people had alcohol consumption at levels posing long-term risk to health (more than 2 standard drinks on a single occasion in the last four weeks) and 26.7% of people had alcohol consumption at levels posing immediate risk to health (more than 4 standard drinks on a single occasion in the last four weeks). Risky drinking among men is 1.7 times higher compared to women (41.2% and 22.8% respectively). Young people aged 16-25 years had the highest rate among all age groups while people aged 75+ had the lowest rate (47% and 9.1% respectively). The rate for Aboriginal adults is 1.5 times higher compared with non-Aboriginal people (48.7% and 32.5% respectively). People who were born in Australia and English-speaking countries had much higher rates compared to those who were born in non-English speaking countries (38.1%, 33.4% and 17.5%, respectively). People in outer regional and remote areas have higher rates compared to people in inner regional and those in major cities (40.4%, 36.1% and 31.4% respectively).

In SWS in 2019, 25.6% of people consumed alcohol at levels posing long-term risk to health (CEE, 2020a) and 16.7% had alcohol consumption at levels posing immediate risk to health, much lower than the NSW rate (CEE, 2020d). Men aged 16-34 years had the highest rate of alcohol consumption at levels posing long-term risk to health among all age groups.

##### ***Alcohol drinking in secondary school students***

In 2017, 46.7% of SWS secondary school students aged 12-17 years self-reported they had consumed alcohol in the past compared to 61.4% school students in NSW. Harm from alcohol-related accident or injury is experienced disproportionately by younger people; more than half of all serious alcohol-related road injuries occur among 15-24-year-olds (CEE, 2020d).

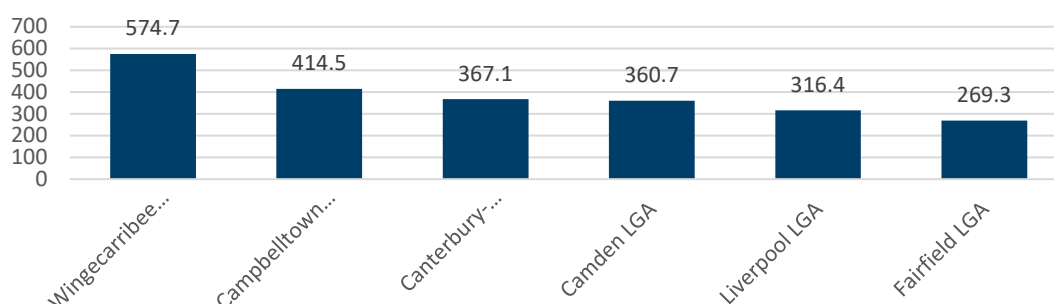
##### ***Alcohol attributable hospitalisations***

In 2014-15, 5,248 SWS residents were hospitalised for alcohol related problems. Rates for both males (717.8 per 100,000 population) and females (410.5 per 100,000 population) were lower than the state rates (797.8 and 544.7 respectively). There are variations across SWS LGAs, from 664.4 in Bankstown to 523.8 in Fairfield.

In SWS in 2018-19, alcohol attributable hospitalisations were 356.2 per 100,000 population (or 3,648 persons), lower than the NSW rate of 523.6 per 100,000 population. Between 2010-11 and 2018-19, the alcohol attributable hospitalisation rate in SWS has increased from 316.1 to 356.2 per 100,000 population. Across LGAs in SWS, Wingecarribee had the highest hospitalisation rate and is 1.6 times as high as the SWS rate (574.7 per 100,000 population) (CEE, 2020b).

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Figure 50: Alcohol attributable hospitalisations by LGA, SWS, 2017-19(CEE, 2020b)



Alcohol attributable hospitalisations among Aboriginal males are 2.4 times higher than the rate for all population in NSW. The rate of alcohol attributable hospitalisations increases with age.

### Alcohol related death

Rates for death attributed to alcohol have declined since 2001-2002 in SWS for both males and females and was similar to state rate(CEE, 2020d). In SWS in 2017-18, the rate of alcohol attributable deaths was 19.6 per 100,000 population (or 203 deaths), similar to the NSW rate (20.0 per 100,000 population). Across SWS, Wingecarribee had the highest alcohol attributable deaths rate (21.4 per 100,000 population or 11 deaths) while Canterbury-Bankstown had the highest number of deaths (63 deaths)(CEE, 2020f).

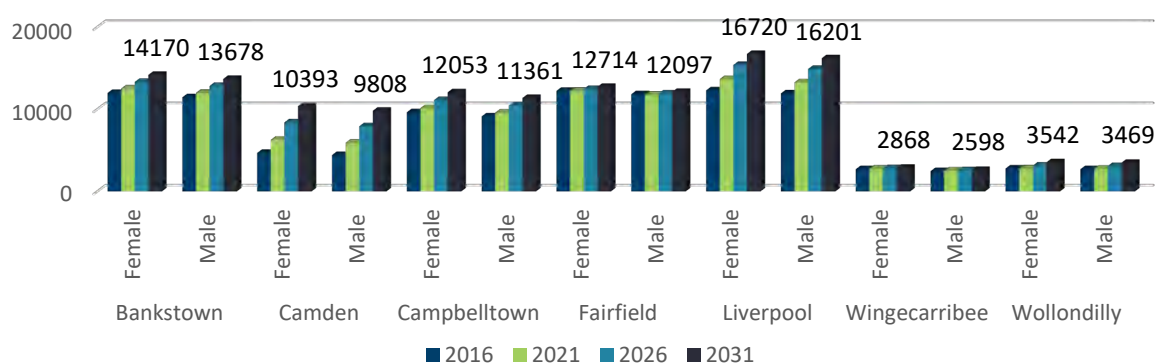
### Illicit drug use

In 2018, 3% of the total disease burden in Australia was due to illicit drug use (AIHW, 2021c). Illicit drug use includes burden from opioids, amphetamines, cocaine and cannabis and other illicit drug use, as well as their unsafe injecting practices. Illicit drug use was responsible for almost all burden associated with drug use (excluding alcohol) with 74% due to acute hepatitis C, 72% by poisoning, 27% by chronic liver disease and liver cancer, and 15% by suicide and self-inflicted injuries. Disease burden due to illicit drug use was highest in people aged between 25 and 44, peaking in ages 25–34 years. Males experienced more than twice the total burden compared to females up to the age of 84 years. Total disease burden attributable to illicit drug use was 2.1 times greater in the lowest (most disadvantaged) socioeconomic group compared with the highest (least disadvantaged) group.

According to the *AIHW Alcohol and Other Drugs Treatment Services Report (2021)*:

- When seeking treatment for their own drug use, clients most reported their principal drug of concern as alcohol (34% of treatment episodes), amphetamines (28%), cannabis (18%) and heroin (5.1%).
- Where amphetamines were reported as the principal drug of concern, over three quarters (78%) of closed treatment episodes were for methamphetamines only.

Figure 51: Projected number of persons using illicit drugs for SWS residents by LGA and gender, 2016 to 2031(AIHW, 2021h)



### ***Methamphetamine***

In 2018-19, there were 838 hospitalisations (or 112.9 per 100,000 population) in SWS, lower than the NSW rate of 142.7 per 100,000 population. In 2016-17, in SWS there were 928 methamphetamine-related hospitalisations at a slightly lower rate compared to NSW (134.3 and 136.3 per 100,000 population, respectively). However, the rate was higher for the number of persons hospitalised for methamphetamine use compared to NSW (95.1 and 92.8 per 100,000 population respectively). There has been a substantial increase of methamphetamine-related hospitalisations in SWS since 2009-10 to 2016-17(CEE, 2018). People aged 25-34 and 35-44 years had the highest Methamphetamine-related related hospitalisations among all age groups. People aged 25-44 years had the highest rate of methamphetamine-related emergency department presentations among all age groups. Between 2010-11 and 2018-19, there were significant increase in methamphetamine-related related hospitalisations in all age groups, the highest increase was among older people aged 55-64 years and 65+ years.

People aged 25-34 and 35-44 years had the highest methamphetamine-related related hospitalisations and emergency department presentations among all age groups. Between 2010-11 and 2018-19, there was an 18.5-fold increase in hospitalisations among Aboriginal people. The methamphetamine-related hospitalisation rate for Aboriginal people are 6.9 times as high as non-Aboriginal people. Aboriginal men had the highest hospitalisation rate among all demographic groups.

### ***Opioid use***

In NSW, there were 10,798 (or 171.6) opioid-related hospitalisations in 2018-19. The hospitalisations rate for men were 1.45 times as high as for women (203.6 and 140.3 per 100,000 population respectively). Young people aged 16-24 had the highest hospitalisations rate among all age groups. Between 2010-11 and 2018-19, there was a steady increase in opioid-related hospitalisations among Aboriginal people. In 2018-19, the hospitalisations rate among Aboriginal people were 5.6 times as high as non-Aboriginal people (842.8 and 151.2 per 100,000 population respectively). People living in major cities had higher hospitalisations rate (168.8 per 100,000 population) compared to those living in inner regional (175.2 per 100,000 population) and outer regional and remote areas (146.8 2 per 100,000 population). Opioid-related hospitalisations increases as socio-economic status decreases. The hospitalisations rate among people in the most disadvantaged 20% were 1.6 times as high as those in the least disadvantaged 20%(CEE, 2020e).

In 2018-19, there was 1,370 (or 180.7 per 100,000 population) opioid-related hospitalisations in SWS. It's the third highest among all PHNs in NSW, accounting for 12.7% of all opioid-related hospitalisations in NSW(CEE, 2020e).

### ***AOD Services***

Analysis of SWSPHN commissioned AOD treatment services clients in SWS in 2019-20 found that(SWSPHN, 2021b):

- 70.6% were male, compared to 29% female, and 0.4% not stated.
- The median age of clients was 23 years.
- 87.5% were non-Aboriginal, 6.9% were Aboriginal and/or Torres Strait Islander people.
- 72.1% were born in Australia. For clients born overseas, the top three countries were: Vietnam (5.3%), New Zealand (1.5%) and Cambodia (1.3%).
- The highest percentage of clients came from Liverpool (28.5%), followed by Fairfield (18.6%) and Bankstown (14.0%).
- The most common principal drug were Cannabinoids (37.2%), Methamphetamine (20.7%), and Alcohol (10.8%).
- The main treatment type was counselling (56.5%), followed by support/case management (28.2%) and rehabilitation (6.0%).
- The primary source of referral was other criminal justice setting (33.6%), followed by self-referral (26.2%) and non-residential community mental health centre (7.6%).

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Drug and alcohol abuse/dependence is a chronic and relapsing condition which exists within the social and behavioural context of the individual and society.

Community members and service providers reported a lack of integration between the multiple services clients received. These concerns related to lack of communication between services, multiple assessment processes for each service and complex referral requirement. Services may impose complex criteria as a risk management measure; however, these are reported to inhibit consumer access.

From consultations with the service providers and the communities in SWS, the following AOD treatment needs were identified:

- Significant amount of community concern relating to drug use
- Lack of a holistic, integrated care of AOD/mental health
- Limited community education and understanding of drug and alcohol issues
- Perceived overprescribing by GPs without providing enough information about medications and/or not reviewing patients' medication, in particular benzodiazepines
- Intergenerational drug abuse within Aboriginal communities raised as a concern by Aboriginal service providers
- Counselling and case management for AOD issues for vulnerable populations (CALD communities, Aboriginal and Torres Strait Islander communities, young people (including high school ages for those impacted by others use of AOD), co-morbidities with mental health, LGBTQI+ communities, people in contact with criminal justice system, people living in regional, rural and remote locations
- Treatment options across SWS region
- Preventative health interventions in primary care
- Workforce shortages
- Access to detoxification services
- Access to residential rehabilitation facilities

Other considerations impacting service delivery/perceived effectiveness of service:

- Warm referrals between providers
- Continuity of funding
- Improved reporting of experience measures (PREMs) and outcome measures (PROMs)
- Cost effectiveness (beyond cost per occasion of service) when considering complexity
- Low levels of GP referrals

GPs report limited access to support and advice to manage clients with substance misuse issues and placed a high value on GP mentor models or specialist liaison positions.

SWSPHN has gone some ways to support this, including:

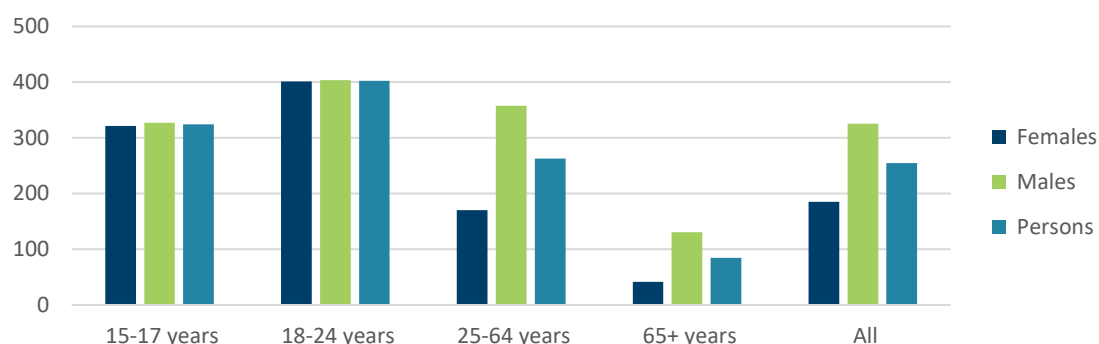
- Funding a GP Registrar training position within SWSLHD Drug Health Services
- Commissioning of drug and alcohol advice and support services to provide GPs with access to support and advice
- Incentivisation programs for GPs to complete AOD training

### ***Hospitalisations***

Drug and alcohol use, and schizophrenia and delusional disorders were the two most common mental health conditions requiring overnight hospitalisation. In 2015–16, drug and alcohol related hospitalisations represented 22% of all mental health hospitalisations and 11.6% of all mental health bed days in SWS.

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Figure 52: Alcohol problems: presentations in 84 emergency departments, Comparison by age, 15 years and over, NSW, 2018-19(CEE, 2020b)



The age-standardised rate for drug and alcohol related overnight hospitalisations was 22 per 10,000 people in both public and private hospitals in SWS, slightly higher compared to 20 per 10,000 people nationally. Within SWS, Campbelltown and Liverpool have the highest rates (29 per 10,000 people) (AIHW, 2016c).

The highest alcohol related ED presentations by ED triage category were Triage 3 - potentially life threatening. The alcohol attributable deaths rate increases with age. People aged 85 years and older are 15 times as likely to have alcohol attributable deaths compared to the rate for all population. Alcohol attributable deaths rate increases as socioeconomic status decreases. Liver cancer had the highest percentage among all alcohol attributable deaths by conditions.

### ***Detoxification services***

SWSLHD has 15 beds for inpatient detox unit in Fairfield (Fairfield Detox Corella). 501 occasions of services were reported in 2014/15. Alcohol was identified as primary drug of concern for 44% of inpatient episodes, followed by heroin which represented 13% of inpatient episodes(South Western Sydney Local Health District Drug Health Service, 2016).

Demand for drug and alcohol services will increase with population growth in South Western Sydney at approximately 10% per annum for the next 10 years(SWSLHD, 2013c).

Providers reported a limitation of current withdrawal management services to address methamphetamine withdrawal. Withdrawal treatment services have limited and set time periods for managing withdrawal. Methamphetamine withdrawal requires an extended period of withdrawal management and psycho-social support. Lack of ability to access services quickly when relapsing and challenges in linking up discharge from detox and acceptance into rehabilitation programs were reported. Services mostly tailored to crisis support, with limited availability of services to provide ongoing counselling to clients to remain abstinent.

### ***Services to support people with complex needs***

Data collected from the Magistrates' Early Referral into Treatment (MERIT) program indicates amphetamine use among program participants more than doubled from 265 in 2009/10 to 533 in 2012/13. Heroin use among the program participants nearly halved over the same period. According to the January-June 2014 Drug Court data, amphetamines have overtaken heroin as principal drug of concern for participants(MoH, 2015).

Consultation revealed challenges faced by health professionals and NGO service providers in terms of addressing the social issues within a client's life that may impact on their ability to maintain their health (e.g., Centrelink payments, court appearances, employment). There is a need for integration and coordination of care between drug and alcohol and other services and agencies. Community consultations suggested services should offer holistic programs that target physical, mental and social support.



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Stigma around drug and alcohol issues exist in the community and create obstacles in accessing treatment services. There is evidence that GPs are concerned that asking about drug use as it may adversely affect the doctor patient relationship (McAvoy B, 2008). Social and cultural barriers may lead to stigma and an unwillingness of consumers to report drug use and seek help for the issue.

### ***AOD services for pregnant women***

SWSLHD Perinatal and Family Drug Health Service (PFDHS) through its multidisciplinary service provides care to women who use substances during their pregnancy, their babies and their significant others. The team includes practitioners from Drug Health Services, Social Work, Neonatal Services, Obstetrics, Aboriginal Health Services and the Aboriginal Medical Service. Post-natal home visiting and support is available for the first two years following birth.

Providers reported challenges accessing treatment services for parents of young children. These related to limited family approaches to care, as well as fear that children would be taken away if the parent's drug problem is recorded. The wait for existing services is up to 12 weeks.

### 2.3.2 First Nation's Community

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#### ***Higher prevalence of psychological distress***

The NSW Population Health Survey identified about 19% of Aboriginal adults reported 'high' or 'very high' rates of psychological distress between 2013-2015, measured by the Kessler 10 mental health screening instrument, a rate which was twice that of the general population(HealthStats, 2019). Aboriginal people in NSW are approximately twice as likely to be hospitalised for a mental health related problem or disorder as non-Aboriginal people(CEE, 2018). The Living Well report highlighted the impact of grief and trauma as a result of the systematic removal of children and the destruction of communities(NSW Mental Health Commission, 2014).

<b>Key Issue for our region</b>	<b>Aboriginal people are hospitalized at twice the rate of non-Aboriginal people for psychological distress</b>
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#### ***Intentional self-harm hospitalisations***

Young Aboriginal people aged 15-24 years have higher intentional self-harm hospitalisations compared with non-Aboriginal people, and the gap has been increasing between 2001-02 and 2016-17. Aboriginal women are more likely to be hospitalised for intentional self-harm compared with Aboriginal men. In 2016-17, Aboriginal people aged 15-24 years are 2.5 times as likely to be hospitalised for intentional self-harm compared with non-Aboriginal people in NSW(CEE, 2020d).

#### ***Higher suicide rate among Aboriginal people***

Aboriginal people have higher suicide rates compared with non- Aboriginal people. Between 2012 and 2016, Aboriginal men were 1.8 times as likely to die as a result of suicide compared with non-Aboriginal men. Aboriginal women are 1.4 times more likely to die as a result of suicide compared with non-Aboriginal women in NSW. Between 2003 and 2016, the suicide rate has been steadily increasing among Aboriginal people in NSW(CEE, 2020d).

Consultation reveals a lack of culturally appropriate mental health services and limited integrated options for addressing social concerns concurrently with mental health concerns. A survey conducted to explore GP's barriers to referring patients with mild-to-moderate mental health problems indicated 27% of GPs surveyed reported their patients had experienced barriers such as cultural appropriateness, cost of support and general understanding of mental illnesses. 55% of the responding GPs reported they didn't have any clients who identified as Aboriginal and/or Torres Strait Islander. Based on the recent co-design prioritisation, trust, lack of culturally appropriate workers, awareness of the culturally appropriate services and the coordination between these services act as barriers for Aboriginal and Torres Strait Islander people when seeking help and support.

## 2.3.3 Culturally and Linguistically Diverse Populations

People from CALD backgrounds have a significantly lower level of access to mental health services. In Australia in 2011, 5.6% of people born overseas who spoke a language other than English at home used at least one MBS subsidised mental health-related service, compared with 8.0% of people born in Australia who spoke English at home (ABS, 2016b). In SWS in 2019-2020, 13.6% of SWSPHN commissioned mental health episodes were provided to clients of CALD backgrounds, which is disproportionately lower than the size of the CALD population in our region. Research shows the lower level of service use is due to difficulties in understanding and accessing mainstream services and lack of access to services that are culturally safe and appropriate (Henderson and Kendall, 2011). “Stigma, lack of information about mental illness and mental health services in appropriate and accessible formats, and poor communication and cultural differences between clients and clinicians have been reported as major barriers to timely access to mental health services” (Long, Pirkis et al., 1999).

### Key Issue for our region

**CALD communities have lower levels of access to mental health services**

Consultations with GPs, consumers and service providers highlighted stigma as a significant barrier for people seeking assistance in relation to a mental health issue. This stigma was noted for the entire population, as well as within specific cultural groups, including the Aboriginal community and people from culturally and linguistically diverse (CALD) backgrounds. Community consultations identified more specific issues around stigma and CALD communities. For example, people from Assyrian backgrounds may be reluctant to see a GP from their ethnic background for mental health issues as it is a taboo in their culture. Instead, people of an Assyrian background may prefer to seek help for mental health issues from a GP from a non-Assyrian background, which may result in communication barriers if an appropriate interpreter is not engaged.

Stakeholder and community consultations revealed there are significant cultural issues surrounding mental health in CALD communities in the Liverpool area. People are concerned about the shame, guilt and repercussions associated with mental health. In some cultures, with a high level of gender inequality, women don't seek help or referral for mental health issues in the presence of their husbands as the family relationships, household issues and financial difficulties, in many cases, are the cause of their distress and do not wish to discuss these with their husband present. Young women who need mental health support are also often left unsupported as their parents wouldn't approve due to the stigma. Some communities believe in help from 'cultural healers', however there is a confidentiality issue associated with accessing cultural healers. Survey responses from an elderly Macedonian community group identified that most respondents tend to go to their GP for mental health and wellbeing support and a small proportion go to church and talk to friends and family. Language barriers were also a major concern for CALD groups as they visit GPs who are not from their ethnic backgrounds to avoid the stigma around mental health within their cultural communities. This stigma extends to an unwillingness to seek support in crisis situations such as suicide, and lack of knowledge to respond appropriately when recognising suicide risk in others.

Low mental health literacy was noted as a related issue whereby community members lack the knowledge to identify mental health concerns within themselves and others in the community and lack skills to respond appropriately.

Community and provider concerns highlight a need for improvement of general mental health literacy within the wider community, with targeted and culturally appropriate approaches within the Aboriginal community and CALD groups.

### *Access to culturally appropriate mental health services*

People from culturally and linguistically diverse backgrounds have a significantly lower level of access to mental health services. In SWS in 2019-2020, only 13.6% of SWSPHN commissioned mental health episodes were provided to clients

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

of culturally and linguistically diverse backgrounds, which is very disproportionate to the CALD population in our region.

Consultations with the CALD community identified the need for:

- Community Liaison Officer in secondary schools for support to young people
- Partnership small community leaders and educate them about mental health
- Social worker from hospitals to link discharged patients with support organisations
- Staff with lived experience and training to run sessions
- Inclusion of CALD community members and leaders in co-designing services and supports should be commensurate with their needs
- Offering group supports as opposed to individual therapy is more effective in engaging the CALD community
- There is a need to utilise and increase the bilingual workforce

As part of the mental health response to the COVID-19 pandemic, the Australian Government is providing funding to support access to services for vulnerable people in the community who may be disproportionately impacted by the pandemic. This includes funding through Primary Health Networks to support the enhanced delivery of targeted mental health services to CALD communities.

SWSPHN has commissioned You in Mind psychological services targeting groups from a CALD background including refugees. The clinicians speak more than 20 languages and there are brochures of the services in 6 most spoken language other than English in SWS.

South western Sydney is one of the most culturally and linguistically diverse (CALD) regions in Australia, with about 43.3% people born overseas and about 45.3% of the population speaking only English at home, 9.9% speaks English 'not well or not at all' (ABS, 2016c). Mental health and mental illness are viewed differently by each community, based on cultural norms and expectations (mental health is often associated with shame, guilt and repercussions). Factors contributing to increased risk of mental health problems in CALD populations include low proficiency in English, separate cultural identity, loss of close family bond, stresses of migration, limited knowledge of the health system and limited opportunity to appropriately use occupational skills. Cultural and language barriers reduce the accessibility of existing services and culturally accessible services are limited in availability (Harry Minas, 2013). Research shows the lower level of service use is due to difficulties in understanding and accessing mainstream services and lack of access to services that are culturally safe and appropriate. There is a difficulty in accessing interpreters in primary care as GPs underutilise interpreters provided free of charge through the Doctors Priority Line, and appropriate translated material.

Generally, migrants and refugees have lower rates of mental health service utilisation than Australian born people due to stigma attached to mental illness and limited knowledge of mental health and available services and lack of cultural awareness of staff. Consultations with GPs, consumers and service providers also highlighted stigma as a significant barrier for people seeking assistance in relation to a mental health issue.

SWSPHN has commissioned You in Mind psychological services targeting groups from a CALD background including refugees. The clinicians speak more than 20 languages and there are brochures of the services in the six most spoken language other than English in SWS.

Eligibility for and access to services including health services can change for people seeking asylum while their refugee status is being determined (DoH, 2011). There are two refugee specific services in SWS. The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) is an affiliated state-wide health service with their main office located at Carramar in SWS, with outreach services available across NSW. The service provides counselling including early intervention and ongoing counselling, psychotherapy (individual and group) both for children and adult people. The service has several bilingual counsellors and uses interpreters for counselling sessions with refugees. In 2014/15,

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SWSLHD Health Language Service recorded 300 Occasions of Service (OOS) provided to the STARTTS. In some cases, interpreter assistance is obtained over the phone from the National Telephone and Interpreting Service (TIS). Another refugee specific health service funded by the NSW Department of Health is the NSW Refugee Health Service which aims to protect and promote the health of refugees and people of refugee-like backgrounds including asylum seekers. However, the main brief of the service is not mental health.

Some agencies such as Anglicare and Catholic Care provide some counselling to refugees. Among NGOs, New Horizons in Liverpool provides personal helpers and mentors to refugees and asylum seekers. There are a number of NGOs who are providing settlement support to migrants and refugees, and some ethnic specific organisations provide some assistance to their respective communities.

### 2.3.4 Older Person's

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Nationally there were 7,713 continuing and completed episodes of residential care in 2017–18, with 370,592 residential care days provided to an estimated 5,973 residents. Among all jurisdictions, NSW had the lowest rate for both episodes and residents (0.2 and 0.2 per 10,000 population). The highest rate of residential mental health care service use was among people aged 18–24 and 35–44 years (4.2 people per 10,000 age specific population). The top five most common principal diagnoses were schizophrenia, (26.9%), specific personality disorders (11.9%) and schizoaffective disorders (9.2%), depressive episode (8.5%), and bipolar affective disorders (6.6%)(AIHW, 2020h).

The service gaps for RACFs in SWS identified through co-design include:

- Individual programs of care, flexible to the needs of patients
- Need for programs that can decrease social isolation
- Implementation of simple referral pathways – in a timely manner
- Acute MH issues – need to go to hospital ED however OPMH services are not permitted to go to ED
- Lack of psychiatric nurses and other in-house support for acute episodes
- Early identification – associated with dementia or comorbidities e.g., bipolar or schizophrenia
- Increase the proportion of trained MH staff at RACFs
- Recruiting RNs
- Lack of timely response – in-house – rural – specialists currently travelling from Wollongong – can wait two days to a week before being seen. This is unempowering for staff and leads to burnout
- System needs to be better to support RACF staff (which in turns supports residents)

The gaps for service providers and clinicians were:

- Lack of documentation from facilities – MH issues
- Heavy reliance on medical model
- Early identification – suffering loss (independence)
- Primary carers / family / organisation space
- Getting to know the person – understanding when paralysis or stroke
- Facilities trained in MH
- Narrative style – better rapport with residents

There are 16 sub-acute inpatient beds at Braeside Hospital operated by Hammond Care. There are no acute older persons' mental health beds within SWS(SWSLHD, 2015b). Three community SMHSOP teams service the district, including one based at Braeside Hospital in partnership with Hammond Care. Community SMHSOP services provide assessment and care coordination, primarily for people who have developed or are at risk of developing a mental health disorder such as depression or psychosis, or who have severe behavioural and psychological symptoms of dementia.

## Section 2.4: Impacts of Disaster

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## 2.4.1 Bushfires

Bushfires are increasing in frequency, with longer fire seasons and fire severity, due to climate change. Record low rainfall, prolonged drought, hot temperatures and heatwaves created the conditions for the Black Summer 2019/2020 bushfires that significantly impacted NSW and areas of SWS.

The 2019-20 bushfires in Australia burned more than 17 million hectares of land, destroyed more than 3,000 homes and killed at least 33 people. In NSW, the bushfires had burnt 5.4 million hectares (6.7% of the state). In SWS, areas of Wollondilly and Wingecarribee were severely affected by the Green Wattle Creek fire. Additionally, indirect effects were seen in neighbouring LGAs such as Camden.

Significant impacts of this fire included:

- 270,700 hectares of land burnt
- 19 homes destroyed
- 18 homes damaged
- 8 facilities destroyed and 3 damaged
- 66 outbuildings destroyed and a further 45 damaged
- 270 rural landowners impacted (Leadbeater Group Pty Ltd, 2020)

**Table 35: Key facts about 2019-20 bushfires in NSW (DPC, 2020, DPE, 2020)**

5.4 million hectares of land burned in NSW	37% of all NSW National Park estate	26 lives lost in NSW
42% of all NSW state forest	4% of all NSW freehold land	2476 homes destroyed in NSW
25% of suitable koala habitat in eastern NSW	52% of heathlands in NSW	\$899m infrastructure losses in NSW
81% of the Greater Blue Mountains World Heritage Area	54% of Gondwana Rainforests of Australia World Heritage Area in NSW	601,858ha pastureland damaged in NSW
39% reduction in ecological condition in the fire ground since 2013	39% reduction in ecological carrying capacity in the fire ground since 2013	\$43m telecommunication site losses in NSW

It was estimated 80% of Australians were directly or indirectly affected by the bushfires. The scale and duration of the fires were unprecedented, and a state of emergency was declared three times.

<b>Key Issue for our region</b>	<b>Increase in short and long-term health impacts of bushfires</b>
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Bushfire smoke, like other forms of air pollution, includes gases and particulate matter (DoH, 2020) is particularly toxic as particles from soot and ash are small and penetrate deep into the lungs and can also enter the bloodstream and affect different body systems, including the heart. Particulate matter is a complex mixture of solid and liquid particles and is classified according to size:

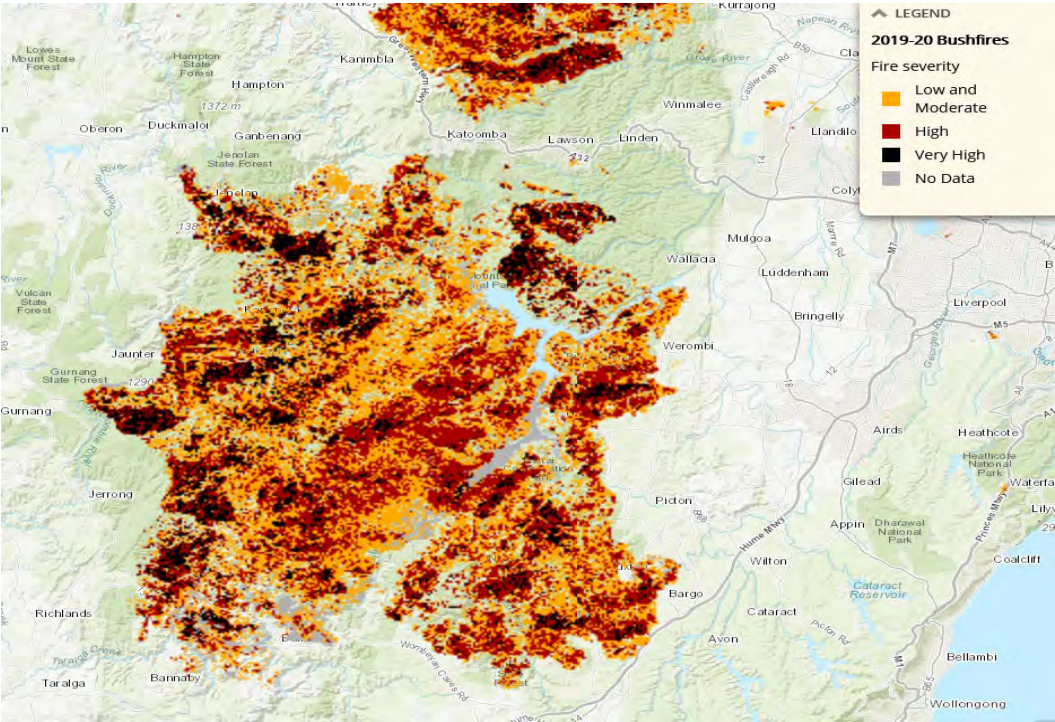
- PM<sub>10</sub> – particles smaller than 10 microns in diameter. These contribute to visible smoke haze, can irritate the eyes, throat and lungs but are too large to enter the bloodstream.
- PM<sub>2.5</sub> – particles smaller than 2.5 microns in diameter. These are too small to see and when breathed in, will penetrate deep into a person's lungs and enter the bloodstream.

Smoke from bushfires, such as the bushfires in 2019-2020, can reach levels up to 10 times the standard hazardous air quality levels

**Figure 53: 2019-20 Bushfires by severity, SWS (DPC, 2020, AIHW, 2020i)**



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Devastation of the natural environment and compromising air quality caused a rise in hospital admission and emergency department presentations and treatment, particularly for asthma and COPD.

**Table 36: Estimated number of excess deaths, hospitalisations for cardiovascular and respiratory problems, and emergency department presentations with asthma in NSW between 1 October 2019 and 10 February 2020 that could be attributed to bushfire smoke exposure (Borchers Arriagada, Palmer et al., 2020)**

Outcome	Estimated number of cases (95% confidence levels)	
	NSW	Australia
Excess deaths	219 (81-357)	417 (153-980)
Hospital admissions, cardiovascular	577 (108-1050)	1124 (211-2047)
Hospital admissions, respiratory	1050 (0-2204)	2027 (0 – 4252)
ED attendance, asthma	702 (379-1026)	1305 (705-1908)

## Respiratory effects

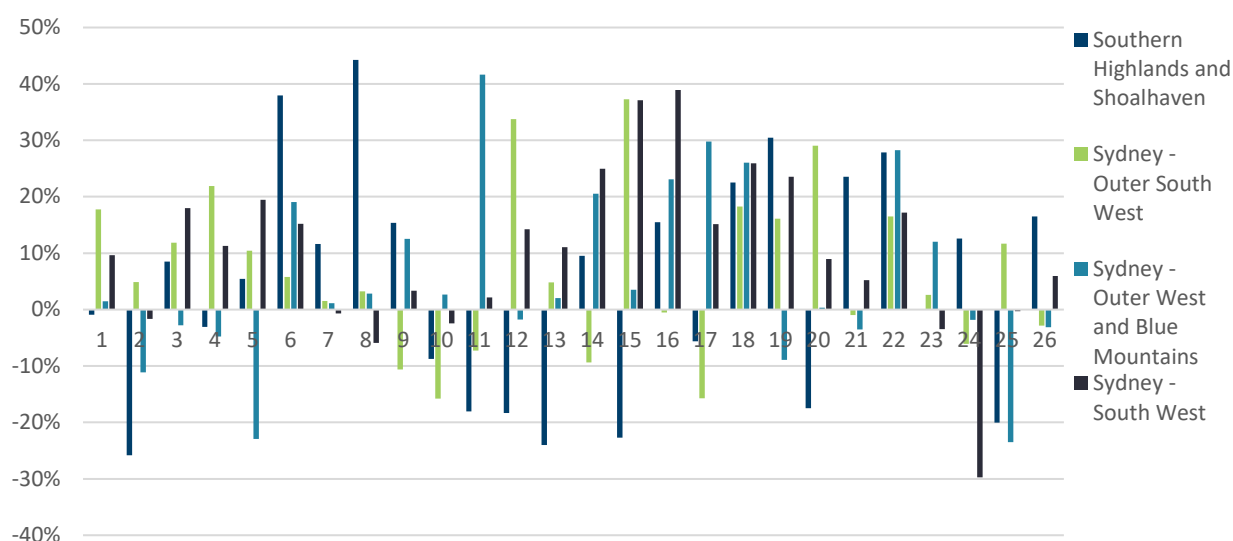
Evidence from several studies show PM<sub>2.5</sub> from bushfires is associated with respiratory effects including exacerbations of asthma, emergency department attendances and hospital admissions. Short-term exposure to PM<sub>2.5</sub> is associated with increased respiratory mortality. However, evidence of increased respiratory mortality from bushfire smoke is not consistent. Some studies have reported increased deaths, but others have not. It is likely to be dependent on the intensity and duration of the smoke event (DoH, 2020).

In SWS, the 2019-20 bushfire smoke has been related to increased risks of hospitalisation and emergency department visits due to respiratory diseases such as asthma, chronic obstructive pulmonary disease, and respiratory infections(Tham, Erbas et al., 2009). Older people, people with cardiorespiratory diseases or chronic illnesses, children, and people who work outdoors are particularly vulnerable(Morgan, Sheppeard et al., 2010). A recent study estimated the health burden attributable to bushfire smoke in NSW during the 2019-20 bushfire include: 219 deaths, 577 hospital admissions for cardiovascular disorders, 1050 hospital admissions for respiratory disorders and 702 asthma related ED attendances(Borchers Arriagada, Palmer et al., 2020).

## Emergency department presentations for respiratory health

NSW ED data shows a clear rise in presentations for respiratory problems during the bushfire season. Figure below shows the change (%) in ED presentations in SWS (including areas outside SWS) during each week of the 2019-20 bushfire season from 1 September 2019 to 29 February 2020 (week 1 to week 26). Compared with the same time in 2018-19, there is a clear increase from week 15 (8 December) to week 22 (26 January). It peaked at 60.0 per 100,000 population (or a total number of 4,946 presentations) during the 2019 Christmas week (week 17), representing an 8% increase compared with the same week in the previous year. The volume remained high for the week beginning 29 December (4,814 presentations, or 57.7 per 100,000 population—a 13% increase compared with the same week in the previous year). This rate increase ranged from 12% in the week beginning 1 December 2019 (from 44.8 to 50.3 presentations per 100,000 population) compared with the same week in 2018, to a 22% increase in the week beginning 15 December (AIHW, 2020i).

**Figure 54: Percentage of change in age-standardised rate (per 100,000) of emergency department presentations for diseases of the respiratory system by week, 2019-20 bushfire season (AIHW, 2020i)**



## Mental health effects

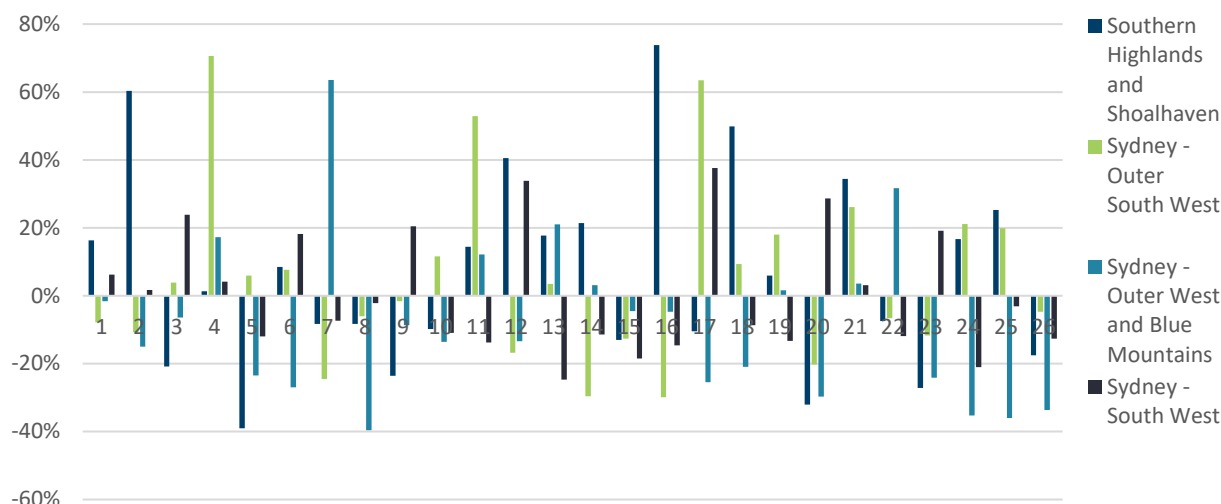
Bushfires can cause loss of life, property destruction and community disturbance, which have a significant impact on the mental health and wellbeing of affected communities and individuals. Many people experience stress-related problems, including post-traumatic stress disorder (PTSD) and depression (Norris, Friedman et al., 2002). The impact on mental health can last months or years after the bushfire. Two studies reported that 1 year after the bushfire, 42% of the affected people were distressed. Twenty months after the bushfire, 23% of the affected people were distressed (McFarlane, 1988, McFarlane, Clayer and Bookless, 1997).

Rates of presentations to NSW emergency departments for mental and behavioural problems were not notably higher in the 2019–20 bushfire season compared with the same weeks in 2018–19. As mental health impacts have been observed up to and longer than 12 months after bushfire events, it will be important to monitor mental health impacts in SWS communities.

Figure below shows the change (%) in mental and behavioural disorders related ED presentations over each week of the 2019-20 bushfire season from 1 September 2019 to 29 February 2020, compared with the same time in 2018-19.

**Figure 55: Percentage of change in age-standardised rate (per 100,000) of emergency department presentations, mental and behavioural disorders by week, 2019-20 bushfire season (AIHW, 2020i)**

## SWSPHN NEEDS ASSESSMENT 2022 – 2025



Recovery from bushfires is a long process and mental health impacts can emerge any time and the outcomes may be driven by financial strain and community recovery, rather than direct experience of the fires. The COVID-19 pandemic could exacerbate these by delaying community recovery and adding additional stress to individuals and families, for example those with businesses that have already been damaged by the fires.

### **Cardiovascular and cardiogenic effects**

- There is very good evidence that short-term exposure to PM<sub>2.5</sub> in general worsens existing cardiovascular disease and increases cardio-vascular mortality, while long-term exposure accelerates the progression of disease and also increases mortality(Pope III and Dockery, 2006).
- Evidence from bushfire smoke is less clear. However, based on the detailed assessments to the WHO and US EPA, it is likely that PM<sub>2.5</sub> from bushfires exacerbates cardiovascular disease. There is evidence from Australia and the US that bushfires are associated with an increased risk of out of hospital cardiac arrests(DoH, 2020).
- Occupational exposure to smoke as a firefighter is classified as a possible (Class 2B) carcinogen by the International Agency for Research on Cancer (IARC). Firefighters are regularly exposed to bushfire smoke (seasonally and over their working career).
- There is no evidence of a cancer risk in the general community from exposure to bushfire smoke.

### **Effects on maternal health and pregnancy outcomes**

- There is emerging evidence that exposure to PM<sub>2.5</sub> during pregnancy may be related to low birth weight and preterm birth (Breton, Park and Wu, 2011)but data from bushfire studies is limited.
- One study has shown an association between birth weight and PM<sub>2.5</sub> from bushfires. It found average birthweight was reduced by 9 grams in babies whose mothers were exposed during the second trimester of pregnancy(Vardoulakis, Jalaludin et al., 2020). Another recent study of bushfire PM<sub>2.5</sub> found average birth weight was reduced by 6 grams in babies whose mothers were exposed during the first trimester of pregnancy (Ritz and Yu, 1999).

While there is potentially a small increase in the risk of certain health effects after a period of exposure, this is likely to be extremely low in the long term for most individuals. However, as there is limited information about the long-term implications of prolonged exposure, research is ongoing to better characterise longer-term health effects, particularly across groups at higher risk, such as those with chronic conditions, very young children, pregnant women and their babies.

After the 2019-2020 bushfires, SWSPHN had been provided funding to:

- Commission immediate counselling and other mental health services to support the needs of people experiencing distress or trauma as a result of the bushfires, including emergency response personnel
- Coordinate services for people impacted by the bushfires and help them navigate access to the services they need

## SWSPHN NEEDS ASSESSMENT 2022 – 2025

- Support communities in recovery to promote resilience, social connections, and outreach by community members to individuals who may be in need

The overall aim was to increase the delivery of non-clinical supports in fire-affected communities based on the needs of the local region.

Between December 2020 and January 2021, SWSPHN had undertaken a needs assessment and consultations which included:

- An online survey to community members, government and non-government employees, emergency and frontline workers, bushfire related workers/volunteers, PHN commissioned services providers and other mental health professionals
- Interviews with key informants with experience working in the bushfire affected communities

Based on consultations, it was determined the funded activities should aim to achieve the following objectives:

- Improve awareness of and access to non-clinical and clinical bushfire related services
- Increase availability of information related to wellbeing and bushfire recovery
- Encourage coordination and communication between services
- Improve sense of connection to the community and participation through community-led engagement initiatives
- Build capacity of service providers so community members receive trauma informed care and support
- Improve sense of preparedness for service providers to respond to the mental health needs of communities affected by bushfires

### 2.4.2 Floods

Flooding is a natural process which is caused by excessive precipitation, resulting in water levels rising and inundating nearby land, leading to extensive financial and emotional losses for property, infrastructure, and people; the estimated annual economic burden of flooding in New South Wales is \$200 million. Moreover, climate change has been identified as a significant risk factor for flooding and is a major global threat to health, with an estimated 250,000 deaths each year.

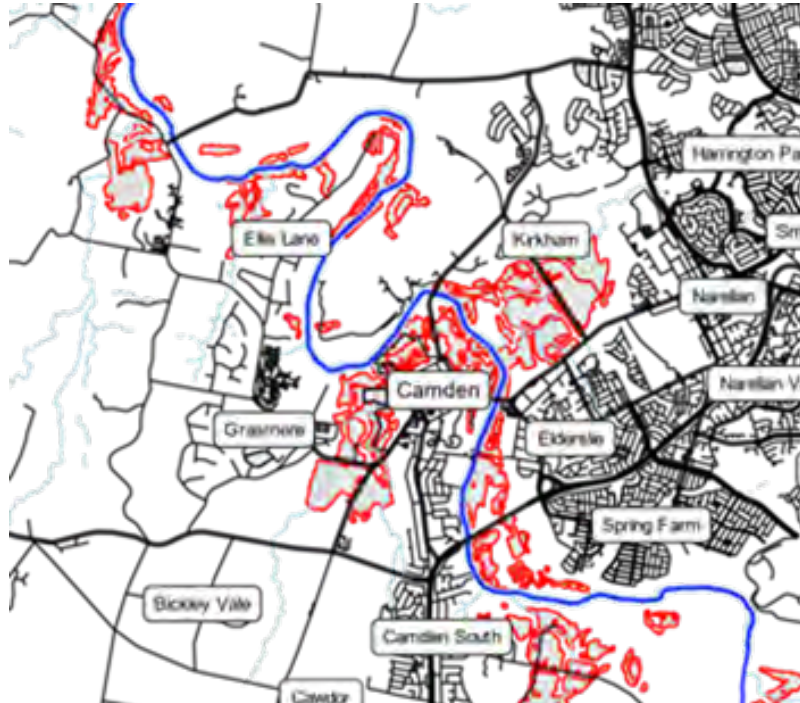
The Nepean River, located in the South Western Sydney region of New South Wales, has a history of flooding, most notably in 1867 and 1974, with the 2021 floods resulting in the submerging of Windsor Bridge and the inundation of homes and animals in the area. The peak of the floodwaters was measured to be 10 m (32.81 ft).

The floods of 2022 were the third most severe in the history of New South Wales, with the Hawkesbury River and Warragamba dam overflowing following heavy rainfall. This climate-related event had an immense impact on people and communities in the South Western Sydney region, particularly those in the Camden, Wollondilly, and Wingecarribee Local Government Areas.

An estimated 85,000 individuals were either forcibly displaced or requested to evacuate their residences by relevant authorities.

Significant impacts of this flood included:

- 150 evacuation orders and warnings
- Over 140 rescues
- 19,000 homes losing power.
- Tens of thousands of people being displaced



**Figure 58: Areas affected in SWS by floods 2021-22 [163, 164]**





Figure 57: Floodplains in Camden LGA (Source: *Nepean River Flood Plain Report, 2015*)

**Mental health effects**

Floods lead to displacement and restrict access to food, support networks, health care, and social services, thereby having a considerable effect on the psychological health and wellbeing of both affected communities and individuals.

Key Issue for our region	Increase in trauma related mental health presentations as a result of flood impacts
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A global systematic review of 83 studies has revealed that direct and indirect exposure to floods can lead to an increased risk of post-traumatic stress disorder (PTSD), psychological distress, depression, and anxiety in flood-prone areas, as compared to unaffected regions.

After the 2022 floods, SWSPHN had been provided funding to:

- Commission small community grants to fund activities that help build resilience, social connectedness and deal with loss and anxiety because of the floods.
- Coordinate access to mental health services and primary care services across the region, including administration of wellbeing grants, capacity building for general practices to support disaster preparedness, identification of those suffering adverse mental health impacts because of a disaster and link to relevant supports.
- Undertake data analysis and consultation of the impacts of July 2022 floods and improvements to support communities affected by flood and other disasters in the future.

The overall aim is to increase the delivery of non-clinical psychosocial supports in flood-affected communities based on the needs of the local region.

### 2.4.3 Heat-related impacts

2019 was Australia’s hottest year on record, with average temperatures 1.52 degrees Celsius above the long-term average (BOM, 2020). The number of extremely warm days has increased, and the increases are projected to continue (BOM, 2020).

Key Issue for our region	Increase in hospitalisations and mortality due to heat-related illness and complications expected
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Heat-related conditions can range from rashes and cramps to serious conditions such as heatstroke. Excessive heat also exacerbates a range of health conditions such as heart disease, diabetes, kidney disease and mental and behavioural conditions(AMA, 2015).

Heatwaves Increase in hospitalisation and mortality rates in Australia (Varghese, 2020) Single events can result in large numbers of additional deaths (DHHS, 2009) Built environments, including suburb design and construction requirements, also impact upon communities resilience to manage heat-related impacts (Coleman, 2017). Given the level of greenfield sites within South Western Sydney, this is predicted to be a significant population health concern in the future for our region.

## 2.4.4 COVID-19

The COVID-19 pandemic in NSW is part of the ongoing worldwide pandemic caused by SARS-CoV-2 virus. The epidemiology of COVID-19 in NSW continued to evolve since the first three cases were reported in NSW on 25 January 2020 in people who acquired their infection in China. The first locally acquired COVID-19 case in NSW was reported on 2 March 2020 and by mid-March case numbers had increased rapidly among overseas returned travellers and their contacts and within localised community outbreaks. In NSW, the number of reported daily cases peaked on 27 March 2020 at 213 cases. Public health action and the introduction of a range of stringent Federal and NSW control measures led to a decline in cases. Community transmission was interrupted by the end of May 2020. Further 2020 outbreaks occurred in November and December; however, both were interrupted by January 2021.

### Key Issue for our region

**Large numbers of COVID infections still occurring within SWS communities**

The outbreak of the highly infectious delta strain across NSW began in mid-June 2021 in Sydney's east and spread from there to SWS. Clusters developed across the state prompting NSW government to reimpose a strict lockdown in Greater Sydney, the Blue Mountains, the Central Coast and Wollongong. Cases and hospitalisations continued to rise till October 2021 reaching the peak in terms of number of cases with NSW's daily record high of 1,599 on 10 September 2021. At 30 October 2021, there had been 75,112 confirmed cases and 574 deaths in NSW since 13 January 2020 (MoH, 2021a). In SWS, there had been 22,750 cases as of 1 November 2021 (MoH, 2021a).

Figure 56: Cumulative Covid 19 cases in SWS as of 1 November 2021 (MoH, 2021a)

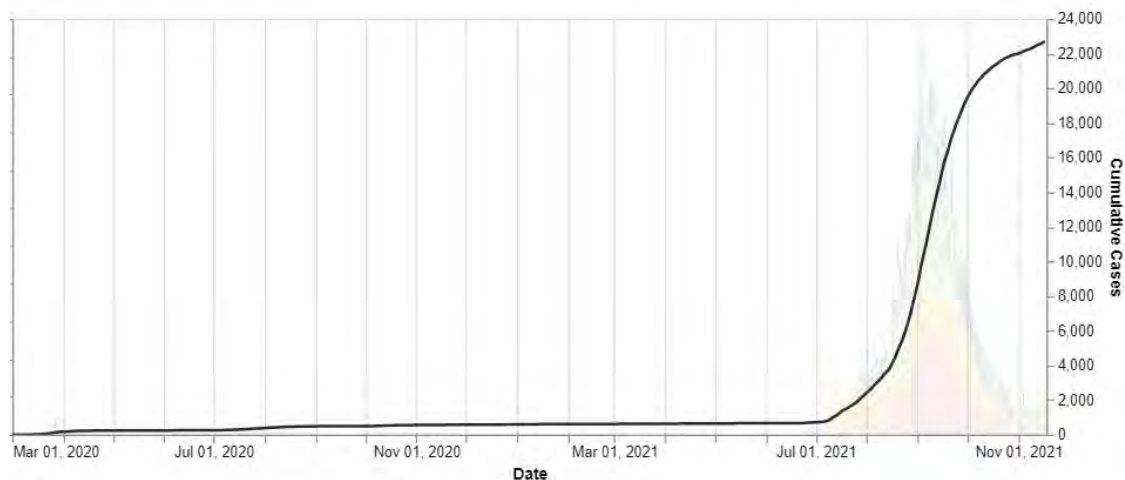
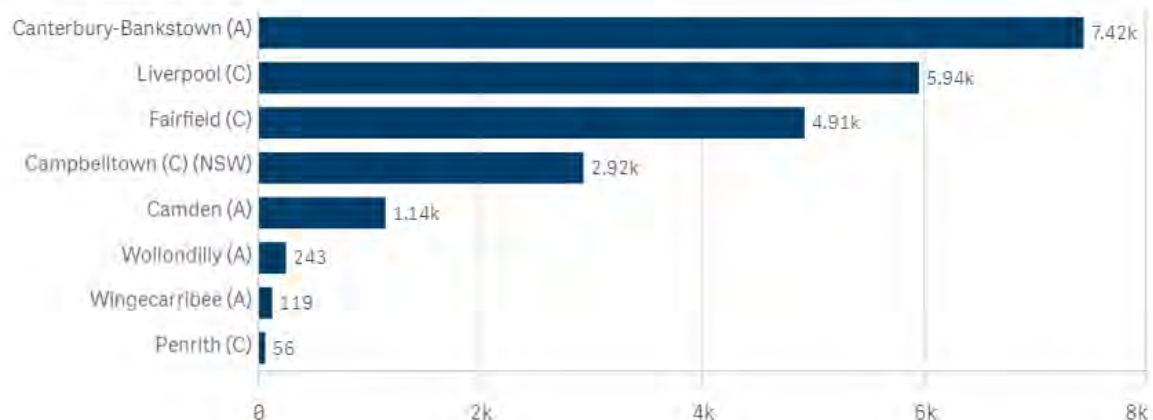


Figure 4057: Confirmed Covid 19 cases by LGA, SWS as of 1 November 2021 (MoH, 2021b)

### Confirmed cases by LGA





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Canterbury-Bankstown, Liverpool and Fairfield LGAs were most affected with 364.4, 277.5, and 238 confirmed cases per 10,000 population respectively. Overall, SWS had a rate of 235.4 cases per 10,000 population. Most affected post-codes were 2200, 2190, 2570, 2560, 2165, and 2170. At the time of writing (November 2021) Canterbury-Bankstown LGA is still reporting 7%, Liverpool and Campbelltown reporting 4% of total cases acquired in NSW.

### ***Hospitalisations and deaths***

In SWS, 22,300 cases were reported in the delta wave, and approximately 10% (2269 admissions) required hospitalisation. 16% (1.6% of all cases) of hospital admissions (363 people) required intensive care and 84% of patients recovered in the community. There were 187 COVID deaths from 22 June to 25 November 2021.

### ***The Omicron variant***

The Omicron COVID-19 variant, first reported in South Africa on 24 November 2021, caused an outbreak across Australia and NSW, forcing businesses to shut down due to virus-related staff shortages amid few Covid 19 restrictions. It caused a rapid surge in cases and hospitalisations and have led to a burnout among staff, with more than 4,000 frontline health staff having been furloughed due to Covid-19 or due to isolation needs, leading to critical staff shortages across some of the largest hospitals in Sydney. The Australian Technical Advisory Group on Immunisation (ATAGI) updated their advice and reduced the time between primary courses and booster doses to 3 months. There is a lack of Omicron specific data, but the number of Covid hospitalisations had plateaued in late January to early February 2022 in NSW.

According to NSW Mental Health Commission COVID-19 community wellbeing survey in July 2021 (MHCNSW, 2021):

- Age was significantly associated with how COVID-19 has impacted people's lives. Younger adults (18–29-year-olds) felt more negative impacts on their relationships, health, work/study, and finances, compared to older people.
- About one in two people accessed some type of formal or informal support during 2020 and it was recognised that a range of services will continue to be needed to support NSW's recovery from the impacts of the pandemic.
- Services through GPs, online advice about typical mental health issues, and guidance for supporting young people were the top preferences to ensure that mental health is supported post-COVID.

An analysis of COVID-19 mental health-related data by AIHW summarised the key impacts of COVID-19 in Australia (AIHW, 2021j): There have been temporary increases in mental health service use around lockdowns evidenced by large increases in contacts with support organisations such as Beyond Blue and Kids Helpline. It also notes an increase in self-harm presentations of children at EDs during the pandemic as well as longer term mental health effects related to COVID-19.

### ***Use of MBS subsidised mental health items***

Between 16 March 2020 and 24 January 2021, 32.1% of MBS-subsidised mental health-related services were delivered via telehealth. Use of telehealth MBS mental health services peaked at the end of April 2020 when half (49.9%) of MBS mental health services were provided remotely.

### ***Pharmaceutical Benefits Scheme (PBS) prescriptions***

The volume of mental health-related PBS prescriptions dispensed spiked in March 2020 when the first restrictions were introduced, followed by a dip in April, and a gradual uptrend to mid-December. This has been observed across all jurisdictions.

### ***Use of crisis and support organisations and online mental health information services***

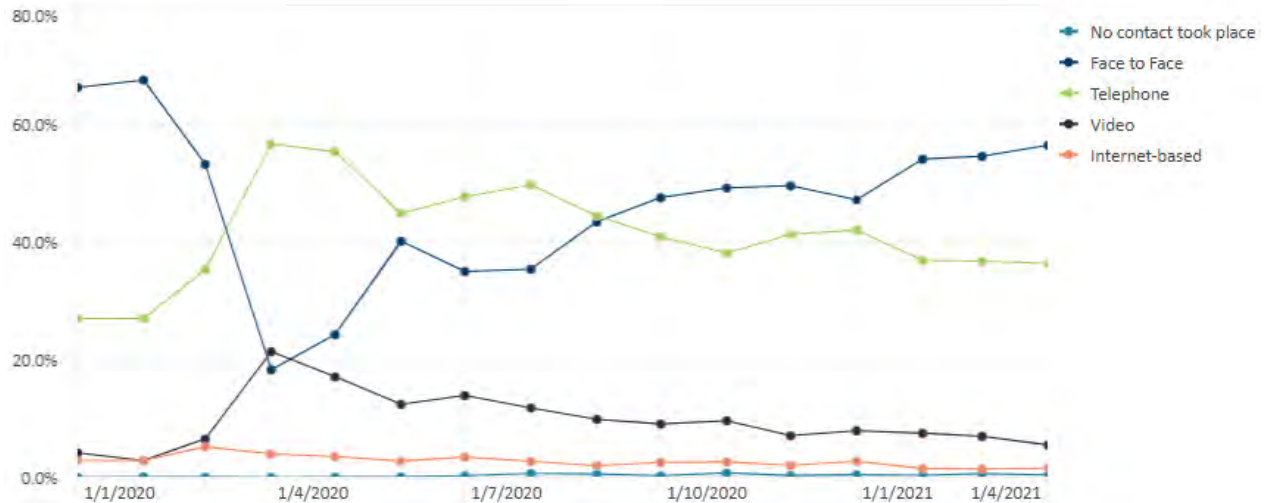
In the 4 weeks to 24 January 2021, Lifeline received over 85,000 calls (an increase of 10.0% and 21.4% from the 4 weeks to 26 January 2020 and 27 January 2019 respectively). In the 4 weeks to 24 January 2021, Beyond Blue received over 22,000 contacts (an increase of 27.2% and 29.6% from the 4 weeks to 26 January 2020 and 27 January 2019 respectively).

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### ***Increased use of telehealth and video mental health services during COVID-19 pandemic***

For SWSPHN commissioned mental health services, consultations via telephone have increased from 26.9% (of all consultations) in January 2020 to 56.5% in April 2020 at its peak, then gradually declined and maintained at around 36.8%. Consultations via video have increased from 4.1% to 21.3% during the same period and maintained at around 7%. Face-to-face consultations have seen a sharp decrease from 66.2% of all consultations in January 2020 to 18.2% in April 2020, then gradually climbed back to 56.3% in April 2021.

**Figure 58:58 SWSPHN Commissioned Mental Health services by modality, Jan 2020 - Apr 2021(SWSLHD, 2015b)**



A 2021 survey of community members living or working within SWS revealed the following:

- Top three mental health concerns impacted by COVID-19:
  - Increased feelings of loneliness/isolation
  - Increased anxiety and/or psychological distress
  - Increased prevalence of stress and burnout
- Top three most vulnerable population groups in SWS due to the impact of COVID-19:
  - Health professionals and front-line workers
  - Young people (12-25) & older adults (25+)
  - Financially disadvantaged/unemployed
- Top three most needed initiatives to improve mental health of residents in SWS:
  - Initiatives that promote mental health and decrease stigma among community
  - Psychological therapies
  - Psychosocial services and suicide prevention approaches

Extended lockdowns, isolation, managing home schooling/working from home, job losses, financial pressures, burnout, future uncertainties, not being able to visit loved ones who are sick in hospital, being with loved ones during their final days, not being able to attend funerals and being restricted from seeing family and friends has had major negative mental health effects across population groups in SWS.

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