Gold Coast Primary Health Network

Needs Assessment 2022

phn GOLD COAST

An Australian Government Initiative

Narrative

Introduction

Gold Coast Primary Health Network (GCPHN) submitted the 2021 Needs Assessment to the Department of Health and Aged Care (DoHAC) in November 2021. Following the submission, the prioritised health needs and services issues informed the GCPHN Activity Work Plans for 2022.

The 2021 Needs Assessments was approved in February 2022 and published as a resource for the local sector on the GCPHN website. Each topic area is individually uploaded to the GCPHN website to allow stakeholders and the community ease of access in viewing the information they are interested in.

GCPHN completed a review of the region's 2021 Needs Assessment with feedback from internal staff, the GCPHN board and Gold Coast Health. Areas of improvement that were identified from this review included incorporating additional data sets from primary care, particularly general practice (Primary Sense) and incorporating GCPHN funded providers' feedback into the 2022 Needs Assessment. This feedback was taken on board and has been included in the 2022 Needs Assessment submission. In addition, as the 2021 Needs Assessment was the first full scale implementation of the revised matrix style prioritisation process, it was identified that this process could be refined and simplified when next implemented, currently anticipated for 2023.

Early in 2022, GCPHN commenced scoping for an annual update of the Needs Assessment. This included consideration of feedback from internal and external stakeholders, policy drivers, DoH deliverables, and any changes to funding and Commonwealth requirements. It was determined that a light review, including data updates was appropriate for most topics. The areas that were identified as priority topics and reviewed in depth were:

- After hours
- Older people

Additionally, GCPHN was required by the Commonwealth Department of Health and Aged Care to undertake a once off supplementary Needs Assessment to identify the local health needs in relation to the Care Finder Support program.

Primary Sense

Primary Sense is a clinical decision support, population health management and data extraction tool installed in 159 eligible general practices (of a total of 208) in the GCPHN region (as of November 2022). Primary Sense currently collates comprehensive data on the primary care that has been received by over 1 million unique active patients who visit general practices in the GCPHN region.

Primary Sense analyses and manages general practice data in a confidential and safe way. It is installed onto the practice's server and de-identified data is exacted and securely transferred to the Primary Sense database in Azure for analysis. Risk assessed and prioritised patient information and insights are provided back to the general practice via the Primary Sense desktop application.

Primary Sense enhances the level and detail of service planning that PHNs can do based on historic and

current de-identified patient level, practice level, and regional level data, enabling predictive modelling, and tracking outcomes over time.

Following the decommissioning of PATCAT as the tool for extraction and analysis of general practice data for population health management on 30 June 2022, the majority of the data in the updated 2022 Needs Assessment is sourced from Primary Sense.

Consultation

During 2022, GCPHN asked the community and health professionals to provide feedback on the 2021 Needs Assessment. The feedback was promoted through:

- Social media
- Publications to General Practices and General Practitioners
- Direct emails to stakeholders
- Funded providers – Project Officers discussed health needs and services issues with providers
- Community newsletters

Questions asked in the feedback form included:

- Are there any topic areas you think are missing from the 2021 Gold Coast Needs Assessment?
- Select a needs assessment topic you would like to provide feedback on?
- Details of personal experience or knowledge of this area that highlights local health needs or service issues.
- After reading the needs assessment topic, do you agree with the identified needs?
- Is there any data you know of that should be added to the summary?
- Is the summary of the service system accurate?

GCPHN also conducted targeted engagement with numerous groups during the development of the 2022 Needs Assessment. The following groups were consulted in relation to specific topic areas to assist in the identification of health needs and service issues:

- GCPHN Clinical Advisory Council,
- GCPHN Community Advisory Council,
- Gold Coast Primary Care Partnership Council,
- Gold Coast Health Strategic and Planning Team,
- GCPHN and Gold Coast Health have established a data supply contract, and
- GCPHN and Gold Coast Health meet monthly, agenda items include data analysis, alignment of Needs Assessments and triangulation of health needs and service issues.

Process for Older people Needs Assessment Topic Area

Data: A comprehensive review of relevant data was undertaken by GCPHN. Data sources included:

- Primary Sense
- Australian Bureau of Statistics
- Health workforce data tool – Department of Health
- Australian Institute of Health and Welfare

- Public Health Information Development Unit (PHIDU)
- GEN aged care data
- GCPHN CRM tool

Service mapping: Review of existing service mapping was undertaken and updated, where needed.

Consultation: GCPHN staff reviewed the 2021 consultation with the Joint Regional plan, Primary Care Partnership Council, GCPHN Clinical Council, and GCPHN Community Advisory Council. Following this, a community facing survey was developed and disseminated to people with dementia (who were able to provide feedback), and carers of people diagnosed with dementia. Further consultation was conducted with the GCPHN Community Advisory Council in March 2022.

Process for supplementary Care Finders Needs Assessment

Data: A comprehensive review of relevant data was undertaken by GCPHN staff and contracted consultants. Data sources included:

- Primary Sense
- Australian Bureau of Statistics
- Health workforce data tool – Department of Health
- Australian Institute of Health and Welfare
- PHIDU Social Health Atlas of Australia: Primary Health Networks
- GEN aged care data
- GCPHN CRM tool

Service mapping: Was undertaken in a systematic way, commencing with the existing knowledge base that GCPHN had previously compiled. This was then assessed against a deeper level analysis via desktop research, and where possible, reviewed by key stakeholders. Service mapping focused on a breakdown of service type, number of service providers in the GCPHN region, geographic location and capacity.

Consultation: GCPHN undertook extensive consultation for the Care Finder Needs Assessment. Beginning with Assistance with Care and Housing (ACH) providers and Footprints Community and Star Community Limited, followed by consultation with GCPHN advisory groups: Community Advisory Council, Clinical Council, Primary Care Partnership Council, and Palliative and Aged Care Leadership Group. Following consultation with advisory groups a structured interview in the form of a survey was disseminated to ACH providers and identified stakeholders.

As it is a particular funding program, the Care Finders Needs Assessment is required to be published separately, however the information resulting from above has been incorporated into the Older Persons area.

Process for After hours Needs Assessment Topic Area

Data: A comprehensive review of relevant data was undertaken by GCPHN. Data sources included:

- Primary Sense
- Australian Bureau of Statistics
- Australian Institute of Health and Welfare
- 13 Health

- GCPHN CRM tool
- Gold Coast Hospital and Health Service

Service Mapping: A review of existing service mapping and feedback from key stakeholders.

Consultation: GCPHN consulted with multiple deputising services in the GCPHN region, conducted phone interviews with hinterland based general practices, Residential Aged Care Facilities and met with the Community Advisory Council. Following this consultation, a community faced survey was developed and promoted through social media channels and advisory groups. In addition, the GCPHN Community Advisory Council and Clinical Council reviewed and endorsed the identified health needs and service issues.

Consultation process for remaining topic areas

Apart from the specific topic areas noted above, the remaining modules of 2022 Needs Assessment were refreshed through:

- Identification and inclusion of updated and new emerging data,
- Review of service system by GCPHN staff and key stakeholders,
- Inclusion of a range of feedback from external stakeholders during the year through the online consultation, and
- Conducting meetings with GCPHN relevant program managers and/or project officers responsible for the Different topic areas, specifically to review and refine the identified health needs and service issues.

Data: GCPHN reviewed existing topics and looked at data to identify if any updates had been made. Staff also scanned to identify new and emerging data sources at a state, national and regional level, and where available, at the Statistical Area Level 3 (SA3). Having access to these levels of data allows for meaningful comparisons on key health indicators affecting the Gold Coast population. This level of analysis allows GCPHN to identify not only national and state health trends, but also to view the different SA3s within the Gold Coast as distinct regions, each with their own unique issues and challenges. Scoping the revision activity took account of time frames, knowledge of new data releases and resource availability. Quantitative sources to be reviewed were determined based on the ability to add value and complement existing knowledge of health on the Gold Coast. Supplementary information included in the revision was sourced from a range of sources including:

- Gold Coast Hospital and Health Service
- Australian Childhood Immunisation Register
- National Primary Health Network Secure Data Site which included Medicare Benefits Schedule Data, Pharmaceutical Benefits Scheme Data
- Australian Institute of Health and Welfare
- Australian Bureau of Statistics
- PHIDU Social Health Atlas of Australia: Primary Health Networks
- Aggregated general practice data

Service Mapping Revision: Revision of service mapping was conducted using GCPHN's CRM to determine changes in providers and number of providers. Similar activity was also used to update workforce information. In addition, information on the existing service system provided by external stakeholders through the online portal was also considered. A broad scan of the market was conducted to complement

other activities and ascertain key service gaps and issues. GCPHN staff were also engaged to validate the service mapping was accurate.

Health Needs and Service Issues

Each topic area has a list of identified health need and service issues. In 2022, these health needs and services issues were updated to align with the latest data and consultation that occurred during 2022. Where there was new data, changes to service system and/or additional consultations that related to existing topic areas (submitted to the DoHAC in 2021 and not a focus area detailed below), these were updated and where there was new or different information triangulation was reconsidered. This resulted in some minor refinement to the wording of a small number of identified health needs and service issues.

A full re-prioritisation process was not undertaken this year as this was undertaken in 2021 and this year's process involved only a 'lite' review of the other topic areas.

Additional Data Needs and Gaps

GCPHN acknowledge the significant and welcome improvement in the release of Commonwealth data to assist PHNs. The PHN data portal could be improved even further by:

- Inclusion of national and state averages for all data on the Commonwealth portal.
- Provision of information regarding funding agreements and deliverables would be beneficial to support knowledge of what type of data may be attainable through collaboration with funding receipts.
- Support to encourage key NGOs (e.g., Cancer Council, Heart Foundation) and PHNs to collaborate on data collection and reporting using SA4, SA3 or SA2 levels to enable comparison of regions.
- Social Health Atlas to include SA3 regions with the data sets to enable comparison of regions and be in conjunction with PHN data using SA3.
- Where available, Australian Institute of Health and Welfare data to include SA4 and SA3 region breakdowns in conjunction with state and national figures in Excel format. This would enable comparison of regions.

Additional comments or feedback

GCPHN undertakes undertake deep dives in key topic areas where resources and priorities indicate to continue to build on the current needs assessment. GCPHN also continues to work closely with our local hospital and health system on their Local Area Needs Assessment process to ensure that our needs assessments are built on a single comprehensive set of data for our shared Gold Coast region. As time progresses, it is intended that a comprehensive knowledge bank will be created to improve the breadth and depth of knowledge available to inform planning and service development in the GCPHN region.

Market Assessment

Population

The Gold Coast has a broad range of providers that offer services for the Gold Coast community and surrounding regions.

There is a strong public health service presence with 2 public hospitals and 7 community health service centres. More facilities are currently being planned to include one satellite hospital at Tugun and a proposed Hospital at Coomera.

In addition, there are 5 private hospitals and more than ten private organisations that offer outpatient services with day surgery and overnight facilities. There is also a 104-bed private mental health facility.

While there can be wait times to see health professionals, the Gold Coast is generally well serviced. Across most clinical professions, the Gold Coast Primary Health Network (GCPHN) region has a comparable or higher rate of health workforce than national averages as well as for rates of population accessing services.

Gold Coast mental health services across Gold Coast Health, private psychologists, allied health, and Non-Government Organisations is stretched and at capacity. This is a result on increasing need but also the Government changes to increase access to psychological services through MBS. This has significantly affected access for hard-to-reach groups with Private service providers preferring to offer services MBS clients resulting in wait-times to access NGO and GCPHN funded psychological services.

From 2013 to 2019 there was an average increase in the number of primary health care practitioners of 46.5% across health professions with the largest increases in occupational therapists, osteopaths, physiotherapists.

As at October 2022, there are currently 855 GPs working across 212 general practices in the GCPHN region. For more details, please refer to the specific Primary Health Care Workforce needs assessment topic area.

This growth in the clinical sector is likely to be at least in part due to the local university sector with nursing and allied health programs being offered at three Gold Coast universities and medicine at two of them.

Non-Government Organisations

The GCPHN region has a strong presence of non-government organisations, particularly for mental health service delivery. Additional non-government organisations continue to establish service delivery on the Gold Coast while limited organisations are ceasing Gold Coast operations in the region. These organisations are generally based in older and more established suburbs, particularly Southport, with less of a presence in the northern Gold Coast (Ormeau-Oxenford) where population continues to grow. There is significant interest in an expanded presence of non-government organisations in this area, with more services establishing service options in the northern Gold Coast every year.

Commissioning

GCPHN commission a range of services including local mental, alcohol and other drugs, suicide prevention and chronic diseases services to meet different needs of people in the GCPHN region. As part of the commissioning process, GCPHN facilitates competitive tendering processes with many different providers, including some providers from other states, submitting tenders and expressions of interest for delivery of health services or projects. GCPHN has developed a streamlined approach and supporting systems to evaluate tenders and interview potential providers as part of its competitive tendering processes.

Based on the triangulation of data, service mapping and commissioning processes, it is clear the GCPHN region has a robust local market of health services. For more details on the topic specific analysis of the local health service system please refer to each specific needs assessment topic area.

Demographics for our region

Population

The estimated resident population for the Gold Coast Primary Health Network (GCPHN) region as of 30 June 2021 was 649,659.

The Gold Coast population has grown 22.9% from 2011 to 2021 which is above the Queensland rate of 16.5%. SA3 regions with the highest annual population growth during this period were Ormeau-Oxenford (65.5%) and Surfers Paradise (22.7%).

Table 1. Estimated resident population, Gold Coast SA3 regions, 2011-2021

Region	Estimated resident population			Change growth rate (%)
	2011	2016	2021	2011-2021
Queensland	4,476,778	4,845,152	5,217,653	16.5%
Gold Coast SA4	528,766	589,933	649,659	22.9%
Broadbeach-Burleigh	60,897	64,301	67,271	10.5%
Coolangatta	52,242	55,111	58,194	11.4%
Gold Coast-North	62,272	68,258	70,111	12.6%
Gold Coast Hinterland	17,713	18,970	20,349	14.9%
Mudgeeraba-Tallebudgera	32,158	34,431	36,507	13.5%
Nerang	64,888	69,282	70,705	9.0%
Ormeau-Oxenford	97,113	124,550	160,674	65.5%
Robina	47,200	51,381	54,655	15.8%
Southport	56,993	60,937	65,430	14.8%
Surfers Paradise	37,290	42,712	45,763	22.7%

Source: ABS 3218.0, Regional Population Growth, Australia, various editions. This data set is a component of the minimum data set.

Age Breakdown

In 2021, the largest proportion of GCPHN population living in the GCPHN region was aged 25-44 years (27.2%). Children aged 14 and under accounted for 17.6% and persons aged 65 and over accounted for 17.8% of the total Gold Coast population.

The distribution of the Gold Coast population across age groups was aligned with the distribution of the total Queensland population.

Among Gold Coast SA3 regions, Ormeau-Oxenford had the largest percentage of people aged 0-14 year (23.0%), Southport had the largest percentage of people aged 15-24 (15.3%), and Gold Coast-North had the largest percentage of people aged over 65 (26.4%).

Table 2. Population by age groups, Gold Coast SA3 regions, 2021

Region	0-14		15-24		25-44		45-64		65+	
	Number	%	Number	%	Number	%	Number	%	Number	%
Queensland	964,319	18.7%	637,245	12.4%	1,389,541	26.9%	1,289,431	25.0%	875,603	17.0%
Gold Coast SA4	112,672	17.6%	77,240	12.1%	174,546	27.2%	161,960	25.3%	114,349	17.8%
Broadbeach-Burleigh	9,585	14.4%	7,030	10.6%	19,754	29.8%	16,981	25.6%	13,047	19.6%
Coolangatta	9,401	16.3%	6,000	10.4%	15,450	26.9%	15,008	26.1%	11,653	20.3%
Gold Coast-North	9,164	13.2%	7,069	10.2%	15,855	22.9%	18,975	27.3%	18,320	26.4%
Gold Coast Hinterland	3,481	17.3%	1,943	9.7%	4,238	21.1%	6,299	31.0%	4,159	20.7%
Mudgeeraba-Tallebudgera	7,982	22.2%	4,382	12.2%	8,548	23.7%	9,883	27.4%	5,240	14.5%
Nerang	13,568	19.5%	8,291	11.9%	18,242	26.2%	18,141	26.0%	11,439	16.4%
Ormeau-Oxenford	36,360	23.0%	20,523	13.0%	46,070	29.0%	36,404	23.0%	18,693	11.0%
Robina	9,232	17.1%	7,178	13.3%	14,815	27.5%	12,788	23.7%	9,887	18.3%
Southport	8,915	13.8%	9,873	15.3%	18,405	28.5%	15,373	23.8%	11,912	18.5%
Surfers Paradise	4,996	11.1%	4,940	10.9%	13,166	29.1%	12,118	26.8%	9,988	22.1%

Source: ABS Community Profiles, GO1, based on 2021 Census data

Median age

As of the 30 June 2020, the median age for the GCPHN region was 38.8 years. This was an increase of 1.2 years from the median age of 37.6 years in 2010. Within the region, Gold Coast Hinterland population had the highest median age of 46.1 years, while Gold Coast North saw the largest increase in median age by 4.0 years from 2010 to 2020.

Table 3. Median age of population, Gold Coast SA3 regions, 2010-2020

Region	2010	2015	2020	Change 2010-2020
Queensland	36.4	36.9	37.8	1.4
Gold Coast SA4	37.6	38.1	38.8	1.2
Broadbeach-Burleigh	39.5	39.8	41.1	1.6
Coolangatta	40.6	41.7	42.2	1.6
Gold Coast-North	41.7	43.5	45.7	4.0
Gold Coast Hinterland	42.4	44.3	46.1	3.7
Mudgeeraba-Tallebudgera	36.9	37.8	39.2	2.3
Nerang	36.3	37.2	39.1	2.8
Ormeau-Oxenford	33.9	33.5	33.5	-0.4
Robina	36.4	37	37.6	1.2
Southport	36.2	36.8	37.9	1.7
Surfers Paradise	38.8	39.4	41.0	2.2

Source: ABS 3235.0, Population by Age and Sex, Regions of Australia unpublished data Queensland Treasury estimates

Indigenous population

Based of 2021 Census data, 13,901 people in the Gold Coast regions identified as being of Aboriginal and/or Torres Strait Islander background, accounting for 5.9% of total population.

Almost a third of Gold Coast Aboriginal and/or Torres Strait Islander population lived in Ormeau-Oxenford SA3 region (n=4,359; 31.4% of total population).

Table 4. Population by Aboriginal and Torres Strait Islander status Gold Coast SA3 regions, 2021

Region	Aboriginal and/or Torres Strait Islander population	Proportion of Gold Coast's Aboriginal and/or Torres Strait Islander population
Queensland	237,303	
Gold Coast SA4	13,901	5.9%
Broadbeach-Burleigh	1,013	7.3%
Coolangatta	1,429	10.3%
Gold Coast-North	1,292	9.3%
Gold Coast Hinterland	432	3.1%
Mudgeeraba-Tallebudgera	750	5.4%
Nerang	1,759	12.7%
Ormeau-Oxenford	4,359	31.4%
Robina	919	6.6%
Southport	1,419	10.2%
Surfers Paradise	528	3.8%

Source: AIHW analysis of MBS data and Australian Bureau of Statistics (ABS) population data. This data set is a component of the minimum data set.

Projected population

Projected annual population growth for the Gold Coast region from 2016 to 2041 is 2.0%, which means that by 2041, Gold Coast is predicted to have a population of 961,076. The projected rate of growth is higher than for the total Queensland for this period (1.6%).

Within the region, Ormeau-Oxenford SA3 region is projected to have the fasted growth in population from 2016 to 2041, with an average annual rate of 3.2% per year.

Table 5. Projected population, Gold Coast SA3 regions, 2016-2041

Region	2016	2021	2026	2031	2036	2041	Average annual growth rate (2016-2041)
Queensland	4,848,877	5,261,567	5,722,780	6,206,566	6,686,604	7,161,661	1.6%
Gold Coast SA4	591,570	665,515	739,186	813,421	887,304	961,076	2.0%
Broadbeach-Burleigh	64,491	69,367	74,625	80,359	85,563	91,960	1.4%
Coolangatta	55,141	58,370	62,051	65,316	69,356	73,003	1.1%
Gold Coast-North	68,379	74,492	81,047	89,383	98,326	110,619	1.9%
Gold Coast-Hinterland	19,023	19,866	20,911	21,784	22,437	23,179	0.8%
Mudgeeraba-Talle-budgera	34,504	37,172	38,787	39,989	41,806	43,705	1.0%
Nerang	69,402	75,384	83,701	90,942	97,134	102,786	1.6%
Ormeau-Oxenford	125,111	160,210	191,932	222,426	250,127	273,833	3.2%
Robina	51,508	54,099	56,955	60,416	64,345	66,551	1.0%
Southport	61,128	66,422	72,455	80,287	88,973	98,478	1.9%
Surfers Paradise	42,883	50,133	56,721	62,518	69,237	76,963	2.4%

Source: Queensland Government Population Projections, 2018 edition (medium series). This data set is a component of the minimum data set.

Country of birth

In 2021, 185,278 (28.9%) of people in the GCPHN region were born overseas. Within the region, Ormeau-Oxenford had the largest number of persons born overseas with 45,496 persons, and Surfers Paradise had the largest percentage of people born overseas with 36.9%.

Table 6. Country of birth by SA3, Gold Coast and Queensland, 2021

Region	Born in Australia		Born Overseas					
	Number	%	Born in English speaking background countries		Born in non-English speaking background countries		Total	
			Number	%	Number	%	Number	%
Queensland	3,679,899	71.4%	518,523	10.1%	651,810	12.6%	1,170,333	22.7%
Gold Coast SA4	418,554	65.3%	96,634	15.1%	88,644	13.8%	185,278	28.9%
Broadbeach-Burleigh	44,825	67.5%	8,840	13.3%	8,508	12.8%	17,348	26.1%
Coolangatta	43,962	76.4%	6,402	11.1%	4,115	7.2%	10,517	18.3%
Gold Coast-North	42,463	61.2%	11,267	16.2%	11,373	16.4%	22,640	32.6%
Gold Coast Hinterland	14,502	72.1%	2,999	14.9%	1,395	6.9%	4,394	21.8%
Mudgeeraba-Talle-budgera	25,854	71.8%	5,541	15.4%	3,195	8.9%	8,736	24.2%
Nerang	47,971	68.8%	10,762	15.4%	7,932	11.4%	18,694	26.8%
Ormeau-Oxenford	104,635	66.2%	28,185	17.8%	17,311	11.0%	45,496	28.8%
Robina	33,449	62.1%	8,282	15.4%	9,797	18.2%	18,079	33.5%
Southport	37,082	57.5%	8,431	13.1%	14,206	22.0%	22,637	35.1%
Surfers Paradise	23,882	52.7%	5,912	13.1%	10,782	23.8%	16,694	36.9%

Source: ABS, Census of Population and Housing, 2021, General Community Profile-G01 and G09c. This data set is a component of the minimum data set.
Note: ESB: Based on the main English-speaking countries of UK, Ireland, Canada, USA, South Africa and New Zealand; NESB: Includes countries not identified individually, 'Inadequately described' and 'At sea' responses.

The top 5 English speaking backgrounds in the Gold Coast region in 2021 were: New Zealand (7.1%), England (4.9%), South Africa (1.4%), Scotland (0.6%), and Unites States of America (0.5%).

The top 5 non-English speaking backgrounds in the Gold Coast region in 2021 were: Mandarin (1.8%), Japanese (0.9%), Portugese (0.8%), Spanish (0.8%), and Korean (0.6%).

Migration

Tables 7 and 8 show that the 19.0% of people in the GCPHN region had a different address one year ago, and 48.4% had a different address five years ago.

Surfers Paradise SA3 region saw the largest proportion of migration in the last year (22.9%), and Ormeau-Oxenford SA3 region in the last five years (22.9%).

Table 7. Place of usual residence one year ago, Gold Coast SA3 regions, 2016

Region	Same Address	Different Address				Proportion with different address (%)	Total persons
		Within Queensland	Rest of Australia	Overseas	Total		
Queensland	3,423,989	655,524	77,129	66,975	813,045	17.5%	4,648,722
Gold Coast SA4	402,470	80,033	15,054	10,349	107,089	19.0%	563,834
Broadbeach-Burleigh	43,574	8,170	1,768	1,193	11,302	18.5%	60,998
Coolangatta	38,759	6,234	1,836	658	8,903	16.9%	52,637
Gold Coast North	46,102	9,562	1,670	1,071	12,496	19.1%	65,356
Gold Coast Hinterland	14,032	2,035	300	126	2,504	13.6%	18,360
Mudgeeraba-Tallebudgera	25,633	3,806	791	278	4,960	15.0%	33,029
Nerang	50,347	8,444	1,246	670	10,536	15.8%	66, 509
Ormeau-Oxenford	83,516	20,215	3,271	1,551	25,376	21.3%	119,123
Robina	34,929	7,068	1,385	1,100	9,697	19.8%	48,943
Southport	40,359	8,602	1,489	1,729	12,020	20.6%	58,363
Surfers Paradise	25,218	5,906	1,301	1,974	9,297	22.9%	40,526

Source: ABS, Census of Population and Housing, 2016, General Community Profile

Table 8. Place of usual residence five years ago, Gold Coast SA3 regions, 2016

Region	Same Address	Different Address				Proportion with different address (%)	Total persons
		Within Queensland	Rest of Australia	Overseas	Total		
Queensland	2,118,153	1,456,714	220,316	228,095	1,942,926	44.1	4,406,728
Gold Coast SA4	232,300	175,864	43,354	34,745	259,347	48.4	536,368
Broadbeach-Burleigh	26,112	17,982	4,914	3,850	27,318	46.7	58,488
Coolangatta	24,285	14,476	5,101	1,853	21,954	43.6	50,326
Gold Coast North	26,140	21,321	4,889	3,994	30,818	49.2	62,640
Gold Coast Hinterland	9,493	5,053	847	411	6,438	36.5	17,630
Mudgeeraba-Tallebudgera	16,099	9,444	2,507	1,137	13,323	42.7	31,230
Nerang	31,071	20,458	3,842	2,579	27,514	43.8	62,870
Ormeau-Oxenford	42,881	43,111	9,393	6,325	60,044	54.1	111,038
Robina	19,570	15,274	4,243	3,716	23,713	50.7	46,730
Southport	23,311	17,201	4,152	5,573	27,561	49.1	56,097
Surfers Paradise	13,340	11,552	3,454	5,319	20,667	52.6	39.312

Source: ABS, Census of Population and Housing, 2016, General Community Profile

The Index of Relative Socio-Economic Disadvantage

The Index of Relative Socio-economic Disadvantage (IRSD) is a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area.

Table 9 shows the distribution of population in each Gold Coast SA3 region across the five quintiles, with quantile 1 being the most disadvantaged and quantile 5 the least disadvantaged. In 2016, 9.0% of Gold Coast population was living in areas of most disadvantage and 17.6% in areas of least disadvantage.

Within the Gold Coast region, Southport SA3 had the largest percentage of population in the most disadvantaged quintile (25.9%) and Mudgeeraba-Tallebudgera SA3 had the largest percentage of people in the least disadvantaged quintile (35.8%).

Table 9. Population by Index of Relative Socio-Economic Disadvantage quintiles, Gold Coast SA3 regions, 2016

	Quintile 1 (most disadvantaged) (%)	Quintile 2 (%)	Quintile 3 (%)	Quintile 4 (%)	Quintile 5 (least disadvantaged) (%)
Gold Coast SA4	9.0%	20.1%	24.7%	28.6%	17.6%
Broadbeach-Burleigh	3.4%	14.3%	25.9%	36.3%	20.1%
Coolangatta	5.5%	30.8%	28.6%	24.0%	11.1%
Gold Coast-North	22.6%	28.1%	22.7%	14.2%	12.5%
Gold Coast-Hinterland	0.0%	5.0%	42.3%	38.7%	14.0%
Mudgeeraba-Tallebudgera	0.0%	13.7%	9.7%	40.8%	35.8%
Nerang	7.0%	17.5%	26.8%	37.3%	11.4%
Ormeau-Oxenford	4.1%	18.6%	23.8%	28.0%	25.6%
Robina	4.1%	12.6%	32.8%	32.9%	17.6%
Southport	25.9%	21.6%	24.8%	22.9%	4.8%
Surfers Paradise	10.9%	29.9%	14.4%	22.2%	22.6%

Source: ABS 2033.0.55.001 Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016, (Queensland Treasury derived). This data set is a component of the minimum data set.

Total family income

Table 10 shows the median total family income in Gold in 2016 was $104,468 per year. In this same year 11,626 or 6.7% were low-income families. Additionally, Mudgeeraba-Tallebudgera had the highest median total family income with $116,584 per year and Gold Coast North had the lowest median total family income with $89,700 per year.

Table 10. Total annual family income, Gold Coast SA3 region, 2021

	Less than $33,800		$33,800 to $77,999		$78,000 to $155,999		$156,000 or more per		Median income $/year
	Number	%	Number	%	Number	%	Number	%	
Queensland	94,168	6.9%	363,384	26.6%	464,993	34.0%	332,448	24.3%	105,248
Gold Coast SA4	11,676	6.8%	46,083	26.7%	61,701	35.8%	52,962	30.7%	104,468
Broadbeach-Burleigh	1,036	6.0%	4,294	24.8%	5,717	33.1%	5,032	29.1%	113,048
Coolangatta	957	6.3%	4,048	26.5%	5,282	34.5%	3,822	25.0%	107,536
Gold Coast-North	1,579	8.3%	6,251	33.0%	6,248	32.9%	3,585	18.9%	89,700
Gold Coast Hinterland	368	6.4%	1,568	27.5%	1,953	34.2%	1,290	22.6%	102,700
Mudgeeraba-Tallebudgera	625	6.2%	2,266	22.6%	3,399	33.9%	2,964	29.6%	116,584
Nerang	1,258	6.5%	5,117	26.2%	7,359	37.7%	4,260	21.9%	104,364
Ormeau-Oxenford	2,593	5.9%	10,475	23.9%	17,144	39.1%	10,305	23.5%	109,668
Robina	1,034	7.0%	3,981	26.9%	5,550	37.5%	3,224	21.8%	102,492
Southport	1,360	8.6%	4,933	31.1%	5,551	34.5%	2,929	18.5%	91,156
Surfers Paradise	873	7.9%	3,150	28.4%	3,485	31.4%	2,759	24.9%	99,840

Source: ABS, Census of Population and Housing, 2021, General Community Profile- G02 and G32

Australian Statistical Geography Standard

The Australian Statistical Geography Standard (ASGS) provides a framework of statistical areas used by the Australian Bureau of Statistics (ABS) and other organisations to enable the publication of statistics that are comparable and spatially integrated. First introduced in 2011, the ASGS replaced the Australian Standard Geographical Classification (ASGC) that had been in use since 1984. The ASGS provides users with an integrated set of standard areas that can be used for analysing, visualising, and integrating statistics produced by the ABS and other organisations.

Statistical Area Level

- Statistical Areas Level 4 (SA4s) are specifically designed for the output of Labour Force Survey data and reflect labour markets within each State and Territory within the population limits imposed by the Labour Force Survey sample. Most SA4s have a population above 100,000 persons to provide sufficient sample size for Labour Force estimates. In regional areas, SA4s tend to have lower populations (100,000 to 300,000). In metropolitan areas, the SA4s tend to have larger populations (300,000 to 500,000). SA4s are aggregations of whole SA3s.

- Statistical Areas Level 3 (SA3s) are designed for the output of regional data. SA3s create a standard framework for the analysis of ABS data at the regional level through clustering groups of SA2s that have similar regional characteristics, administrative boundaries or labour markets. SA3s generally have populations between 30,000 and 130,000 persons. They are often the functional areas of regional towns and cities with a population in excess of 20,000, or clusters of related suburbs around urban commercial and transport hubs within the major urban areas. SA3s are aggregations of whole SA2s.

- Statistical Areas Level 2 (SA2s) are designed to reflect functional areas that represent a community that interacts together socially and economically. They consider Suburb and Locality boundaries to improve the geographic coding of data to these areas and in major urban areas SA2s often reflect one or more related suburbs. The SA2 is the smallest area for the release of many ABS statistics, including the Estimated Resident Population (ERP), Health and Vitals and Building Approvals data. SA2s generally have a population range of 3,000 to 25,000 persons and have an average population of about 10,000 persons. SA2s are aggregations of whole SA1s.

Table 11. Gold Coast Statistical Area Level 4, 3 and 2 (2021)

Statistical Areas Level 2 (SA4)	Statistical Areas Level 2 (SA3)	Statistical Areas Level 2 (SA2)
Gold Coast	Broadbeach-Burleigh	Broadbeach Waters
		Burleigh Heads
		Burleigh Waters
		Mermaid Beach-Broadbeach
		Mermaid Waters
		Miami
	Coolangatta	Coolangatta
		Currumbin-Tugun
		Currumbin Waters
		Elanora
		Palm Beach
	Gold Coast-North	Arundel
		Biggera Waters
		Coombabah
		Labrador
		Paradise Point-Hollywell
		Runaway Bay
	Gold Coast Hinterland	Guanaba-Springbrook
		Tamborine-Canungra
	Mudgeeraba-Tallebudgera	Currumbin Valley-Tallebudgera
		Mudgeeraba-Bonogin
		Reedy Creek-Andrews
	Nerang	Carrara
		Highland Park
		Nerang-Mount Nathan
		Pacific Pines-Gaven
		Worongary-Tallai
	Ormeau-Oxenford	Coomera
		Helensvale
		Hope Island
		Jacobs Well-Alberton
		Ormeau (East)-Stapylton
		Ormeau (West)-Yatala
		Oxenford-Maudsland
		Pimpama-North
		Upper Coomera-North
		Upper Coomera (South)-Wongawallan
		Willow Vale-Pimpama (West)
	Robina	Clear Island Waters
		Merrimac
		Robina-East
		Robina-West
		Varsity Lakes

	Southport	Ashmore
		Molendinar
		Parkwood
		Southport-North
		Southport-South
	Surfers Paradise	Benowa
		Bundall
		Main Beach
		Surfers Paradise-North
		Surfers Paradise-South

Primary healthcare workforce

Local health needs and service issues

- Variability in formal education, practical experience, and resources in relation to alcohol and other drugs, mental health, and domestic violence limits capacity of general practitioners to have conversations around these issues with patients.
- Evolving service system results in general practitioners being unclear about available services and the pathways to access these services.
- High levels of burnout have negative impact on health professionals' wellbeing.
- Long waitlists to see a private psychologist have a negative impact on accessing psychology services in the Gold Coast region.
- Service providers report that it is difficult to recruit and retain doctors willing to work in the after hours for the remuneration available, which impacts the ability to deliver services to meet demand levels.
- There is a projected shortfall in the GP workforce by 2030.

Key Findings

- Registered health practitioners in the Gold Coast Primary Health Network (GCPHN) region have increased by 53.7% from 2013 to 2020. Some of those increases were for:
    - medical practitioners: 1,866 to 2,694 – 44.4% increase
    - nurses and midwives: 6,282 to 9,424 – 50.0% increase
- Guanaba-Springbrook and South Tamborine-Canungra are two GCPHN regions recognised as Distribution Priority Areas for general practitioners (GPs).
- Coolangatta, Southport and Surfers Paradise SA3 regions have limited to no shortages for specialists.
- Registered and employed health professionals in the GCPHN region are predominantly females and aged 20 to 34 years.
- Presentations related to women's health issues, pregnancy and family planning are more often reported by younger and female GPs

Overview

The health workforce in Australia is large and diverse, covering many occupations. These include health practitioners registered by the Australian Health Practitioner Agency (AHPRA) as well as other health professionals and health support workers. AHPRA is the statutory authority responsible for administering the National Registration and Accreditation Scheme (NRAS). The current list of registered health professions includes:

- Aboriginal and Torres Strait Islander health practitioners
- Chiropractors
- Chinese medicine practitioners
- Medical radiation practitioners
- Occupational therapists
- Optometrists
- Osteopaths
- Pharmacists
- Physiotherapists

Trends – total Gold Coast health workforce

Between 2013 to 2020, the number of registered health practitioners in the GCPHN region increased by 5,908 (53.7%). This increase included 2,694 medical practitioners, 9,424 nurses and midwifes, 886 physiotherapists and 727 psychologists. The highest increase between 2013 and 2020 was for occupational therapists (122.7% change).

Table 1. Key workforce statistics by health profession, Gold Coast, 2013-2020

Professions	2013	2019	2020	Change from 2012 to 2020 (%)
Aboriginal and Torres Strait Islander Health Practitioners	0	3	5	NA
Chiropractors	99	114	117	18.2%
Chinese Medicine Practitioners	118	143	151	28.0%
Dental Practitioners	478	606	634	32.6%
Medical Practitioners	1,866	2,552	2,694	44.4%
Medical Radiation Practitioners	270	387	402	48.9%
Nurses and Midwives	6,282	9,055	9,424	50.0%
Occupational Therapists	220	433	490	122.7%
Optometrists	101	128	137	35.6%
Osteopaths	32	53	57	78.1%
Pharmacists	478	629	655	37.0%
Physiotherapists	519	826	886	70.7%
Podiatrists	67	104	106	58.2%
Psychologists	466	633	727	56.0%
Paramedicine Practitioners	0	444	419	NA
Total	10,996	16,108	16,904	53.7%

Sources: Department of Health 2020; ABS 2018

Demographics – total Gold Coast health workforce

There are several demographic changes taking part in the health workforce, including an increasing proportion of females GPs; the national proportion of the female GP workforce is expected to increase from 46.3% in 2019 to 54.1% in 2030.

Health professionals in the GCPHN region are predominantly females and aged 20 to 34 years (Table 2). However, there have been some notable changes between 2013 and 2020, with more young health professionals in the workforce across male and female workers compared to previous years.

Table 2. Health care professionals, by age and sex, Gold Coast, 2013-2020

		2013	2019	2020	Change 2013-2020 (%)	Change 2019-2020 (%)
Male	20-34	819	1296	1357	65.7%	4.7%
	35-44	834	1,135	1210	45.1%	6.6%
	45-54	721	915	975	35.2%	6.6%
	55-64	495	707	712	43.8%	0.7%
	65-74	189	258	281	48.7%	8.9%
	75+	42	54	51	21.4%	-5.6%
Female	20-34	2,162	3,850	4204	94.4%	9.2%
	35-44	1,919	2,881	2995	56.1%	4.0%
	45-54	2,162	2,624	2705	25.1%	3.1%
	55-64	1,378	1,932	1941	40.9%	0.5%
	65-74	262	433	447	70.6%	3.2%
	75+	13	22	24	84.6%	9.1%

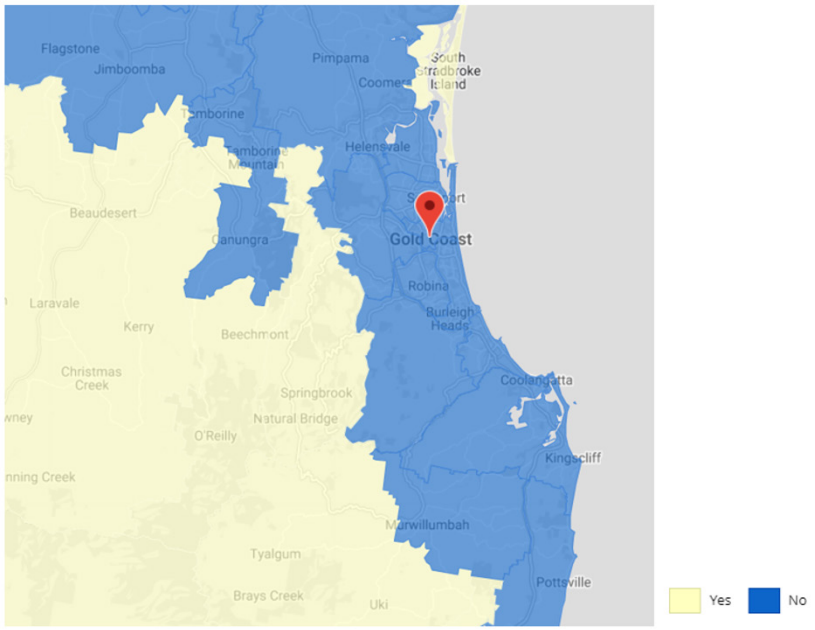
Sources: Department of Health 2020; ABS 2018, please note employed in Australia working in registered profession in all settings/job roles and job areas

General practitioner Distribution priority area (DPA) areas in the GCPHN region

Distribution Priority Area (DPA) identifies areas with limited access to doctors, based on the needs of the community. Instead of using ratio of GP to population, the DPA system considers gender, age demographics and the socio-economic status of people living in the area when determining if the area is eligible to be a DPA. The DPA classification system uses the Modified Monash Models boundaries when assessing the GP catchment benchmarks.

The Modified Monash Model (MMM) is a classification system that helps to distribute the health workforce better in rural and remote areas. The MMM tells us about the area according to its size and geographical remoteness. The scale goes from 1 to 7, with MM 1 being a major city and MM 7 very remote. Inner metropolitan areas are automatically deemed non-DPAs and areas from MM 5 to 7 are automatically deemed DPAs.

Figure 1. Distribution Priority Area, Gold Coast, 2022



Source: Health workforce locator

DPA areas designated in the GCPHN region include:

- Guanaba-Springbrook is classified as a DPA
- Tamborine – Canungra is classified as a partial DPA (North Tamborine – Canungra is not a DPA while South Tamborine – Canungra is a DPA)

Shortages in primary healthcare workforce

Specialist Medical Practitioners

The District of Workforce Shortage (DWS) classification is a health workforce classification for specialist medical practitioners. A DWS is an area where people have poor access to specialist medical practitioners. Population and Medicare billing data is used to determine the ratio of specialist to population in each Statistical Area Level (SA3) region. An area is classified as DWS if:

- ratio of specialist to population is less that the national average, and
- has an Australian Statistical Geography Standard – Remoteness Area classification of RA3-RA 5.

There are eight specialties under DWS:

- anesthetics
- cardiology
- diagnostic radiology
- general surgery
- obstetrics and gynecology
- ophthalmology
- medical oncology
- psychiatry

Table 3. District Workforce Shortage per speciality, Gold Coast, as of May 25, 2022

Region	Anaesthetics	Cardiology	Diagnostic radiology	General surgery	Obstetrics Gynaecology	Ophthalmology	Medical oncology	Psychiatry
Coolangatta								
Mudgeeraba-Tallebudgera	√	√	√	√	√	√	√	√
Broadbeach-Burleigh	√	√	√	√	√	√	√	
Robina	√	√		√	√		√	
Nerang	√	√	√	√	√	√	√	√
Guanaba-Springbrook	√	√	√	√	√	√	√	√
Tamborine-Canungra	√	√	√	√	√	√	√	√
Southport								
Surfers Paradise						√	√	
Gold Coast-North	√	√	√	√	√	√	√	
Ormeau-Oxenford	√	√	√	√	√	√	√	√

Source. Health Workforce Locator. Please note, Table 3 shows Coolangatta, Southport and Surfers Paradise as having no shortage across the eights specialist fields which may be due to two hospitals located in Southport and one in Coolangatta SA3 region.

General practitioners

GPs plays a central role in the delivery of healthcare to the Australian community. In Australia, GPs:

- are most likely the first point of contact in matters of personal health,
- coordinate the care of patients and refers patients to specialists,
- care for patients in a whole-of-person approach and in the context of their work, family, and community,
- care for patients of all ages and sexes across all disease categories,
- care for patients over a period of their lifetime,
- provide advice and education on healthcare, and
- perform legal processes such as certification of documents or provision of reports in relation to motor transport or work accidents.

The Gold Coast SA4 region has 1.5 GP FTE per 1,000 residents which is above both the national (1.2 per 1,000) and Queensland (1.3 per 1,000) average.

In 2021, Gold Coast region also had the highest rate of MBS services provided by GPs per capita (9.0 per 1,000 residents) compared to the national (7.5 per 1,000) and Queensland averages (7.8 per 1,000)[1].

[1] Headsupp, 2021

Number of general practitioners in general practice

Table 4. Number of general practices and GPs, Gold Coast SA3 regions, as of 5 October 2022

Region	Number of general practices	Number of GPs	Average number of GPs per general practice
Broadbeach-Burleigh	29	149	5.1
Coolangatta	19	86	4.5
Gold Coast-North	22	84	3.8
Gold Coast Hinterland	7	33	4.7
Mudgeeraba-Tallebudgera	7	22	3.1
Nerang	16	74	4.6
Ormeau-Oxenford	41	181	4.4
Robina	21	92	4.4
Southport	28	131	4.7
Surfers Paradise	20	67	3.4

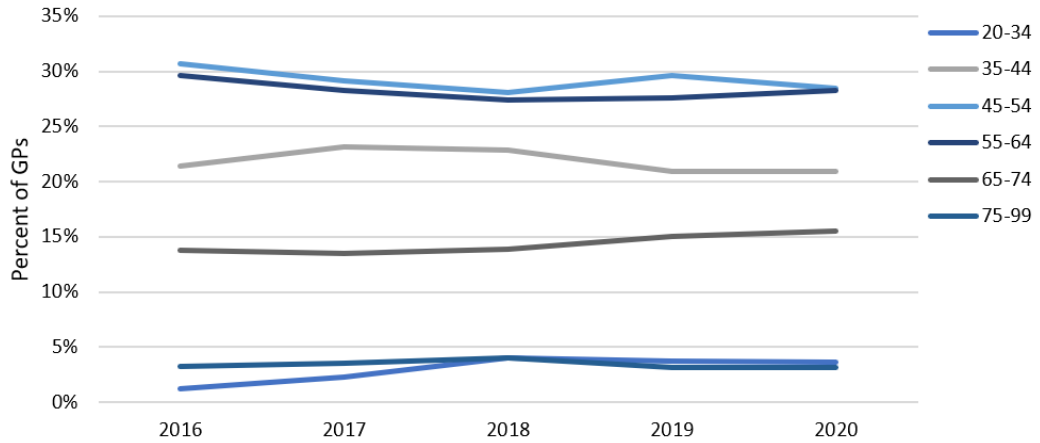
Source: GCPHN Client Relationship Management System. This data set is a component of the minimum data set. Note: the number of GPs listed in Table 5 includes GPs who may work at more than one general practice.

There are currently 855 GPs working across 212 general practices in the GCPHN region. In October 2022, the average number of GPs per general practice was 4.0.

General practitioners by age group

Between 2016 and 2020, the highest percentage of GPs working in the Gold Coast region were aged 45-54 years, followed by the 55-64 age group. GPs aged 34 or under, or 75 or more accounted for less than 5% of the total workforce. These trends are aligned with national patterns.

Figure 2. GPs by age group, Gold Coast, 2016-19



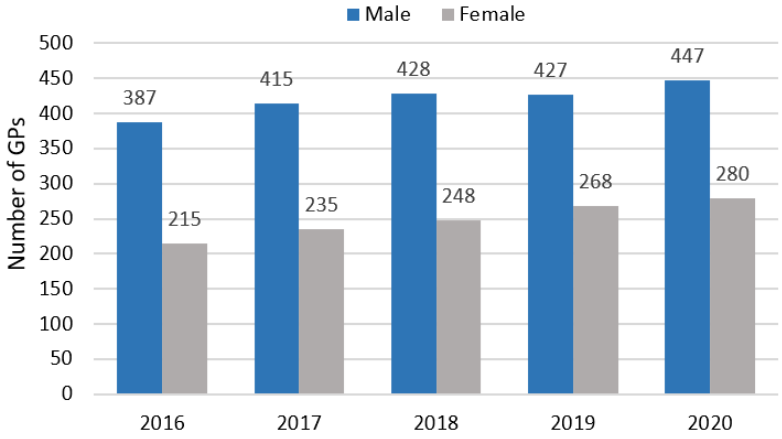
Source: Health Workforce Data tool, data is mapped to medical practitioners who primary specialty is general practice and in labor force in Australia

General practitioners by sex

There was a higher number of male GPs compared to female GPs in the GCPHN region from 2016 to 2020. In 2020, there was 45.9% more male GPs compared to female GPs (447 males vs 280 females).

There was a 30% increase in female GPs from 2016 to 2020 compared to 16% increase of male GPs in the same period.

Figure 3. Sex of general practitioners in the GCPHN region, 2016-2020



Source: Health Workforce Data tool, data is mapped to medical practitioners who primary specialty is general practice and in labor force in Australia

General practitioners trained in Australia and overseas

Due to a sustained increase in the number of GPs from 2016 to 2020, the number of overseas-trained GPs exceeded those trained domestically. In 2020, there were 380 GPs trained overseas and 318 GPs trained in Australia.

The trend of increasing overseas trained GPs with a primary specialty of general practice exceeding the number of Australian trained GPs is not seen nationally. Nationally in 2020 15,244 GPs were trained in Australia, compared to 10,911 overseas trained GPs.

An increase in the overseas trained GPs percentage was smaller between 2018 and 2020, dropping to 4% from the 10% observed in 2016-17. In the same period, Australian trained GPs rose from 3% to 15%. This can be attributed to Australia's border closures due to the COVID-19 pandemic with a 90% decline in total immigration to Australia during that period[2].

Table 5. General practitioners trained in Australia and overseas, Gold Coast, 2016-2020

Location trained	2016	2017	2018	2019	2020
Australia	271	279	276	286	318
New Zealand	28	29	27	25	27
Other overseas	298	329	364	379	380
Not stated	5	13	9	5	0

Source: Health Workforce Data tool, data is mapped to medical practitioners who primary speciality is general practice and in labour force in Australia

[2] RACGP, General Practice Health of the Nation 2021

Common health presentations in general practice

Psychological issues, including depression, anxiety, and sleep disturbance continue to be the most common presentations in general practice, with 70% of GPs reporting those to be the most frequent reasons for patient presentations[3]. This number has been steadily rising from 2017 to 2022.

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Common health presentations in general practice

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There was a significant shift in preventative health presentations, which accounted for 56% of presentations in 2020; this can be explained by the flu vaccinations provided compared to previous years[4]. In 2021, there has been a return back towards the 2019 numbers of preventative health presentations.

Musculoskeletal, circulatory, endocrine and metabolic presentations have increased from the 2020 decline, but presentations are still lower than the previous year's percentages.

Commonly managed health issues according to practitioners' personal characteristics

Through the RACGP survey, GPs identified commonly managed health issues they had with their patients, this was split by GP characteristics (sex and age). Women's health issues, pregnancy and planning, and psychological presentations are more likely to be reported by GPs aged under 45 years and female. Male GPs are more likely to report consultations for musculoskeletal and respiratory issues, as shown in Tables 6 and 7.

[3] EY Sweeney, RACGP GP Survey, May 2021

[4] Communicable Diseases Intelligence 2021 - Influenza vaccination uptake in Australia in 2020: impact of the COVID-19 pandemic? (health.gov.au)

Table 6. Commonly managed health issues vary according to a practitioner's personal characteristics

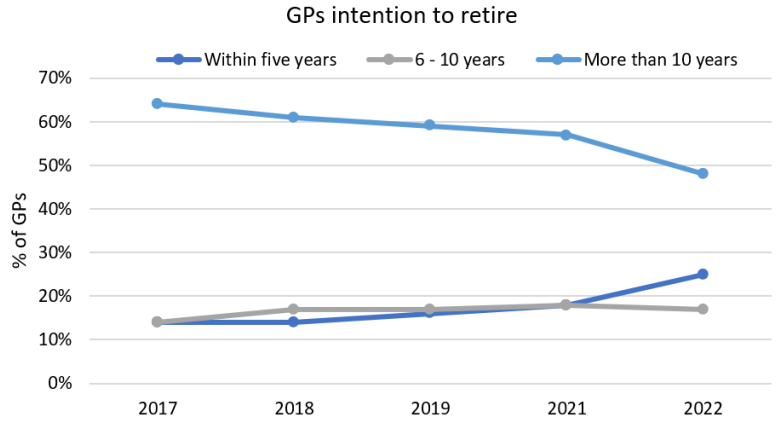
	GPs aged ≥45 years	GPs aged ≤44 years
Psychological	78%	66%
Preventive	22%	21%
Respiratory	33%	29%
Musculoskeletal	33%	42%
Endocrine and metabolic	26%	33%
Undifferentiated illness	18%	18%
Pregnancy and family planning	12%	6%
Circulatory	15%	30%
Women's health	37%	26%
Skin	8%	10%

Source Health of the nation (EY Sweeney, RACGP GP Fellow Survey, May 2021) GP responses to the question 'During the COVID-19 pandemic, what are the three most common reasons for patient presentations? Total survey respondents, n = 1386

GPs choosing to leave the profession

In 2022, the sixth edition of the General Practice: Health of the Nation report 2022 surveyed 3,219 GP and identified that more GPs are planning for early retirement than in the past. In 2022, 25% GPs reported intentions to retire within the next five years, an increase from 18% in 2021 (Figure 5). Fewer than half of GPs (48%) intend to still be practising in 10 years' time.

Figure 5. Proportion of GP responses to the question 'When do you intend to retire from practising as a GP?'



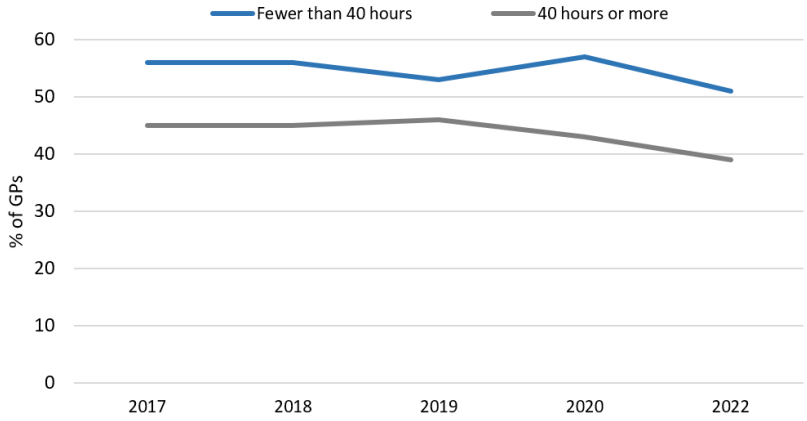
Source: The Navigators, RACGP Health of the Nation survey April/May 2022

Retirement trends are not solely explained by an ageing workforce. Younger GPs are also reporting their intentions to leave the profession at an earlier age. The proportion of GPs who still intend to be practicing in 10 years' time has decreased among those aged under 45 years from around 90% in 2017 to below 80% in 2022.

GPs moving away from full-time work

GPs also appear to be reducing the volume of hours they practice, with a shift towards more GPs working fewer than 40 hours (Figure 6). In 2022, 61% of GPs were working less than 40 hours, compared to 53% in 2019. It is unclear whether GPs are picking up hours in other employment sectors to supplement income, or reducing working hours to avoid burnout.

Figure 6. Proportion of GP responses to the question, 'Approximately how many hours do you spend at work during a typical week?'



Source: The Navigators, RACGP Health of the Nation survey April/May 2022. Note the question was not asked in 2021.

The future workforce

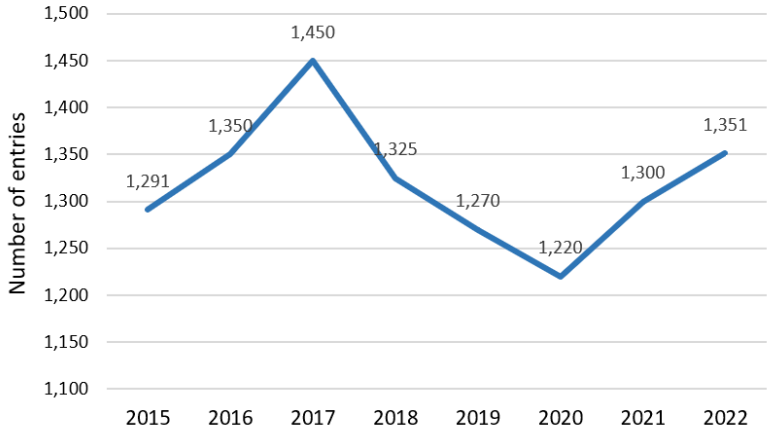
In 2022, only 13.8% of medical students consider general practice as a preferred career path, a decrease from 16.1% in 2021[5].

With fewer GPs choosing to recommend general practice as a career, and other issues emerging associated with chronic underfunding, this in unlikely to improve without significant increase in GP private billing.

[5] Medical Deans Australia and New Zealand. National data report 2021. 2021. Available at https://medicaldeans. org.au/md/2022/06/MSOD-National-Data-Report-2021_ correction-May-2022.pdf

The number of GPs entering the Australian General Practice Training (AGPT) Program saw a significant decline from 2017 to 2020, causing concern regarding the future of the profession. While 2021 and 2022 have seen an increase in the number of GPs starting the RACGP Australian General Practice Training Program (Figure 7), this has not yet flowed through to increased number of GPs entering the profession.

Figure 7. Entry into general practice training, Australia, 2017- 2020



Data source: RACGP training data

Demand for GPs and projected shortfall in the GP workforce by 2030

A report by Deloitte in 2022 highlighted that in Australia the demand for GP services is forecast to outpace supply, resulting in a widening shortfall of FTEs from 2022 onwards. The report found:

- With an ageing and growing population, demand for GP services is projected to increase by 38% by 2032 (and by 47% in cities).
- Despite this significant increase, supply of GPs will decrease by 15% in cities and 4% overall, which will result in a shortfall of 11,392 GPs by 2032.
- In per capita terms, the average Australian in 2021 demanded 2.1 hours of GP care per annum. This is forecast to grow to 2.5 hours per annum by 2032. Meanwhile, supply of GP clinical hours per person is estimated to decline to 1.8 hours per annum by 2032 from 2.2 hours per annum in 2021. This indicates an average annual shortfall for Australians of 40.9 minutes of GP care per year by 2032[6].

[6]General Practitioner workforce report 2022, Prepared for Cornerstone Health Pty Ltd, Deloitte

Nurses

Primary healthcare is often the first level of contact that individuals, families, and communities have with the healthcare system in Australia. Primary healthcare nurses work in a range of settings, such as:

- general practice
- residential aged care
- community settings
- domiciliary settings
- educational settings
- occupational settings

Scope of practice for nurses is determined by professional registration (registered nurse or enrolled nurse), educational background, nursing experience and clinical specialisation.

General practice nursing

A general practice nurse is a registered nurse or enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice. Nationally, there are approximately 14,000 nurses working within general practice, with around 63% of general practices employing at least one nurse.

In the GCPHN region, 83% of general practices employ at least one nurse. There is a total of 421 nurses of which some may work across more than one general practice.

Table 7. Number of general practices with one or more nurses, GCPHN region, as of 5th October 2022

GCPHN SA3 regions	Number of general practices	Number of nurses	Average number of nurses per practice
Broadbeach-Burleigh	25	77	3.1
Coolangatta	16	39	2.4
Gold Coast-North	19	45	2.4
Gold Coast Hinterland	7	19	2.7
Mudgeeraba-Tallebudgera	6	10	1.7
Nerang	10	34	3.4
Ormeau-Oxenford	39	92	2.4
Robina	18	43	2.4
Southport	24	60	2.5
Surfers Paradise	13	23	1.8

Source: GCPHN Client Relationship Management System. This data set is a component of the minimum data set.

Impact of COVID-19 on nurses

The Australian Primary Healthcare Nurses Association (APNA) undertook a sample survey of primary healthcare nurses (772 responses) in April 2021 and a follow up survey in August 2021 (500 responses). The survey collected feedback from nurses on the impact of the pandemic on their work, and their views in relation to the COVID-19 vaccine rollout.

[7] Australian Primary Health Care Nurses Association COVID-19 'Pulse Check' Survey – April 2021
[8] Australian Primary Health Care Nurses Association COVID-19 'Pulse Check' Survey – August 2021

The survey showed that nurses involved in the vaccine rollout:

- are most commonly educating patients about the COVID-19 vaccine and discussing vaccine hesitancy (90%), with a significant majority (86%) feeling confident or very confident providing this education;
- 19% reported being 'tired and burnt out';
- see the low supply of COVID-19 vaccines as the main issue hampering their work (28%);
- in August 2021, 30% of primary healthcare nurses reported not working to their full scope of practice (a 10% increase from April 2021 survey); and
- 1 in 5 respondents reported intending to cease working as a nurse in the next 2 to 5 years.

Among nurses whose organisations are not involved directly in the vaccine rollout, a significant majority (90%) provide general education to patients about the COVID-19 vaccine and/or discussing vaccine hesitancy.

This survey highlighted that primary healthcare nurses are taking a lead in educating patients about the COVID-19 vaccine and potential vaccine hesitancy, regardless of whether they are directly involved in the vaccine rollout.

The sample surveys also identified the wider impact of COVID-19 on the health of Australians:

- of those respondents who indicated that their role had changed as a direct result of the pandemic, 46% reported doing less preventative health and screening activities, and chronic disease and healthy ageing management compared to pre-COVID.
- of those respondents doing less preventative health and chronic disease management, more than a quarter (27%) reported that their general practice does not have a process in place to support patients with routine care.

This is a significant concern as the reduced focus on preventative health and chronic disease management will likely cost the community and government more in health and treatment costs in future years.

Wellbeing of health workforce

Burnout and psychological distress

A 2018 study found Australian doctors have higher rates of psychological distress and suicidal thoughts compared to the Australian general population and other Australian professionals. In particular, levels of very high psychological distress were found to be much higher in doctors aged 30 years and below than in individuals aged 30 years and under in the Australian general population and other professions (5.9% vs. 2.5% vs. 0.5%)[9].

Physician burnout is an under-recognised and under-reported problem and is characterised by a state of mental exhaustion, depersonalisation, and a decreased sense of personal accomplishment[10]. While

[9] National Mental Health Survey of Doctors and Medical Students, Beyond Blue

[10] Lacy BE, Chan JL. Physician Burnout: The Hidden Health Care Crisis. Clin Gastroenterol Hepatol. 2018 Mar;16(3):311-317. Doi: 10.1016/j.cgh.2017.06.043. Epub 2017 Jun 30. PMID: 28669661

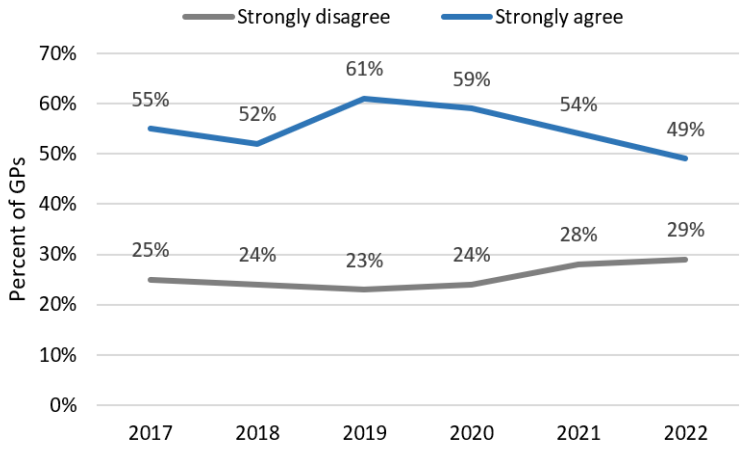
doctors and medical students have good understanding of the larger health system and have access to services, they may experience barriers to seeking treatment for mental health problems, including:

- perceptions of stigmatising attitudes regarding medical professionals with mental health conditions,
- lack of confidentiality and privacy,
- concerns about career progression and potential impacts on patients and colleagues,
- embarrassment, and
- concerns regarding professional integrity[11].

Maintaining a healthy work–life balance is important for GP's wellbeing, and to encourage continuing engagement in the profession. GP work–life balance has declined annually since 2019, and for the first time since the survey began, in 2022, fewer than half of GPs reported having a good work– life balance (Figure 8).

Burnout and poor work–life balance appears to be linked to earlier exit from the profession. GPs who indicated intention to retire early are significantly more likely to report experiencing burnout in the previous 12 months, and more likely to report that they are unable to maintain a good work–life balance[12].

Figure 8. GP responses to the question, 'I am able to maintain a good work–life balance', 2017-2022



Source: The Navigators, RACGP Health of the Nation survey April/May 2022.

Psychological impacts of disasters on healthcare workers

The COVID-19 pandemic has had a profound impact on healthcare workers and their mental health, with emerging evidence suggesting potential long term ramifications[13]. In May 2020, one in two GPs reported at least one negative impact of the COVID-19 pandemic on their wellbeing. The most frequently reported impact was to their work-life balance (33%), although more than one in four (27%) reported a deterioration in their mental health state. One in three GPs ranked their own wellbeing as one of the top three challenges that impacts their ability to provide care to patients during COVID-19[14]. This can decrease safety and quality of care for patients and negatively affect workforce retention and engagement[15].

[11]National Mental Health Survey of Doctors and Medical Students, Beyond Blue
[12]The Navigators, RACGP Health of the Nation survey April/May 2022.
[13]Smallwood, N, Harrex, W, Rees, M, Willis, K, Bennett, CM. COVID-19 infection and the broader impacts of the pandemic on healthcare workers. Respirology. 2022; 1– 16.
[14]Health of the Nation, RACGP, 2020
[15]Smallwood, N, Harrex, W, Rees, M, Willis, K, Bennett, CM. COVID-19 infection and the broader impacts of the pandemic on healthcare workers. Respirology. 2022; 1– 16. 8

Furthermore, recent observations from the COVID-19 pandemic have found that the Australian healthcare workforce are struggling to regain their mental and physical health back to pre-pandemic levels since starting to recover from the height of the pandemic[16].

Need for continuous learning

Medical practice and health policy are changing rapidly. While the adopting of changes is not new for physicians, the pace of change in standards of care, marked by medical advances has accelerated over the past 20 years. GPs must simultaneously absorb new processes in the healthcare system brought about by the Commonwealth Department of Health, while also staying up to date with the latest research to offer the best care to their patients.

The rapid advancements in medical information are mirrored by the 3% annual increase in new scientific journals from 1900 to 1996[17] and nearly two million scientific research articles published in 2012[18]. This has resulted in exponential growth of medical knowledge, increased complexity of medical practice and greater medical specialisation. The role of GPs is increasing each year and their level of knowledge is expected to be very high in numerous different domains. GPs are expected to have high levels of knowledge in:

- preventative medicine
- mental health
- alcohol and other drugs
- family and domestic violence
- chronic disease management
- complex multi-comorbidity
- sensible use of limited medical resources
- coordination of the healthcare team
- digital health
- use of telehealth

In recent years, there has been an increase in the number of consultations with GPs for mental health, alcohol and other drugs and family and domestic violence. Not only do GPs require additional training on patient care, so do other general practice staff and health professionals. This training can include business management and development, continuity, systems, and professional development.

Upskilling the mental health and suicide prevention workforce

The mental health workforce, and wider health workforce, are the most critical component of Australia's mental health system. The Productivity Commission on Mental Health Inquiry report identified numerous issues with the mental health and suicide prevention workforce including:

[16]Stubbs, J.M., Achat, H.M. & Schindeler, S. Detrimental changes to the health and well-being of healthcare workers in an Australian COVID-19 hospital. BMC Health Serv Res 21, 1002 (2021).

[17]Mabe M, Amin M. Growth dynamics of scholarly and scientific journals. Scientometrics. 2001; 51:147–162.

[18]Hughes DA, Bagust A, Haycox A, Walley T. The impact of non-compliance on the cost-effectiveness of pharmaceuticals: a review of the literature. Health Econ. 2001.

- low number of nurses, psychologists and allied health practitioners working in mental health settings,
- low number of Psychiatrist actively working in Australia,
- underrepresentation of Aboriginal and Torres Strait Islander people in the mental health workforce,
- need to boost mental health peer workforce, and
- additional mental health training for GPs working in aged care.

The National Mental Health and Suicide Prevention Plan is the Federal Government's response with key initiatives announced in the 2021-22 Federal Budget to address the above issues.

Service system

Services	Distribution	Information
RACGP GP Support Program	Online	Offers free, confidential specialist advice to help cope with professional and personal stressors impacting mental health and wellbeing, work performance and personal relationships.
DRS4DRS	Online	• Independent program providing confidential support and resources to doctors and medical students across Australia. • The DRS4DRS website provides coordinated access to mental health and wellbeing resources, training on becoming a doctor for doctors.
Lifeline	Online	Lifeline provides all Australians experiencing a personal crisis with access to 24-hour crisis support and suicide prevention services
beyondblue	Online	beyondblue's support service is available 24 hours /7 days a week by phoning
Royal Australian College of General Practitioners (RACGP)	Online	RACGP is the professional body for general practitioners in Australia, and is responsible for maintaining standards for quality clinical practice, education and training, and research.

General Practice and Primary Care

Local health needs and service issues

- Care coordination/clinical handover is challenging, particularly to general practice on discharge from hospitals.
- There is a high number of people requiring chronic wound management services in general practice and Residential Aged Care Facilities (RACF).
- My Health Record is not yet embedded to support team-based care.
- Challenges for general practices and pharmacies in adopting digital health include:
    - New systems that need to be integrated in general practice system and workflow,
    - Lack of interoperability with new systems,
    - Initially low uptake of video conferencing under telehealth.
- 7 out of 10 Quality Improvement (PIP QI) measures in the GCPHN region are below the national rate.
- GCPHN's rate of potentially preventable hospitalisations is above the national rate. Top conditions included Urinary tract infections, Iron deficiency anemia, Dental conditions, Cellulitis, and Ear, nose and throat infections.
- Low uptake of free translation services by general practitioners, specialist, pharmacy, and nurse practitioners in the GCPHN region is potentially limiting access and quality of care.

Key findings

There are currently 212 general practices and 855 general practitioners in the GCPHN region.

- 78% of general practices in the GCPHN region have data extraction tools (Primary Sense or CAT Plus).
- 93% of GCPHN general practices that are eligible (accredited or in process of being accredited) are registered for the PIP QI.
- 201 general practices (around 95%) are registered/in process to participate in My Health Record.
- 134 community pharmacies (around 94%) now registered/ in process to participate in My Health Record.
- The rate of GP attendances in the GCPHN region (761 per 100 people) is above the national rate (627 per 100 people).
- The rate of after-hour GP attendances in the GCPHN region (47 per 100 people) is above the national rate (34 per 100 people).

Access

Utilising health services

Between 2016-2017 and 2019-2020, residents in the GCPHN region utilised various types of health services, including primary health, emergency, and acute health services. Of all 31 Primary Health Network (PHN) regions in Australia, the GCPHN region recorded the fourth lowest proportion of adults who saw a general practitioner (GP) in 2019-2020. In this same time, the proportion of adults in the GCPHN region who went to the Emergency Department (ED) was below the national average and the third lowest among the 31 PHNs (Table 1).

Table 1. Proportion of adults utilising health services by type, Gold Coast and national, 2019-20

Percentage of adults	Region	2016-17	2017-18	2018-19	2019-20
Who saw a GP in the past 12 months	Gold Coast	77.6%	80.6%	79.5%	80.5%
	National	82.5%	84.3%	82.6%	83.5%
Who were admitted to any hospital in the past 12 months	Gold Coast	14.4%	12.0%	12.3%	13.0%
	National	12.6%	12.5%	13.0%	12.3%
Who went to any ED for their own health in the last 12 months	Gold Coast	16.0%	11.5%	12.9%	13.2%
	National	13.8%	14.3%	13.9%	14.3%
Who saw a GP after hours in the past 12 months	Gold Coast	8.4%	8.8%	10.4%	8.4%
	Naional	8.4%	8.5%	7.2%	7.2%

Source: My Healthy Communities (2018), Patient experiences in Australia in 2019-2020

In 2020-21, the rate of GP attendances in the GCPHN region was above the national rate (713 vs 627 per 100 people). Both the GCPHN region and national rate of services has increased over the last five years. Gold Coast-North had the highest rate GP attendances (856 per 100 people) while Mudgeeraba – Tallebudgera (685) had the lowest (685 per 100 people).

Table 2: GP attendances per 100 people, Gold Coast SA3 regions, 2015-16 to 2020-21

Region	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
National	607	613	627	631	612	627
Gold Coast SA4	668	677	699	713	697	761
Broadbeach–Burleigh	712	714	723	738	769	791
Coolangatta	674	668	682	692	712	742
Gold Coast–North	747	753	781	797	812	856
Gold Coast Hinterland	642	647	677	694	727	755
Mudgeeraba–Tallebudgera	620	628	640	657	673	685
Nerang	652	677	694	707	725	736
Ormeau–Oxenford	639	654	692	711	738	748
Robina	634	647	675	689	710	738
Southport	693	703	723	735	761	804
Surfers Paradise	631	630	642	649	670	711

Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2013-14 to 2020-2021, AIHW. Note: GP attendances include Enhanced Primary Care, After-hours GP attendances, Practice Incentive Program (PIP) services, and 'Other' GP services. These services are Medicare-subsidised patient/doctor encounters, such as visits and consultations, for which the patient has not been referred by another doctor.

Similarly, the rate of after-hour GP attendances in the GCPHN region (47 per 100 people) in 2020-2021 was above the national rate (34 per 100 people). While the rate of after-hours attendances has increased nationally over the last three years, the rate has decreased in the GCPHN region (Table 3). The SA3 region with the highest rate of after-hour GP attendances was Ormeau-Oxenford (56.3 per 100).

Table 3: After-hour GP attendances per 100 people, national, Gold Coast SA3 regions, 2015-16 to 2020-21

Region	2015-16	2016-17	2018-19	2019-20	2020-21	2020-21
National	48	49	49	43	34	627
Gold Coast SA4	69	66	62	55	47	761
Broadbeach – Burleigh	63	57	52	48	38	791
Coolangatta	56	55	48	43	36	742
Gold Coast – North	78	75	67	61	52	856
Gold Coast Hinterland	41	44	46	44	41	755
Mudgeeraba – Tallebudgera	56	54	49	43	35	685
Nerang	80	77	69	59	47	736
Ormeau – Oxenford	69	66	71	67	56	748
Robina	59	58	54	48	38	738
Southport	88	85	68	63	54	804
Surfers Paradise	67	64	58	52	43	711

Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2015-16 to 2020-21, Australian Institute of Health and Welfare. This data set is a component of the minimum data set.

13 Health

Besides general practice, residents in the GCPHN region can also access after hours care through telephone services including the Queensland Government's 13 HEALTH, a confidential phone service providing health advice from a registered nurse 24 hours a day, seven days a week at the cost of a local call.

Between July 2021 and June 2022, there was a total of 35,892 calls made to 13 Health by residents of the GCPHN region (accounting for 11.3% of all calls made in Queensland). Of those, 59.3% (n=21,284) of calls were by females, 34.0% (n=12,205) were by males, 6.1% and 0.1% (n=20) of calls were by intersex persons or persons of indeterminate sex. For 6.6% (n=2,383), no information was recorded for sex.

Among callers to 13 Health in the GCPHN region, 3.5% (n=1,260) identified as being of Aboriginal and/or Torres Strait Islander background. Aboriginal and/or Torres Strait Islander people are accessing the service at a higher rate (9 calls per 100 people) compared to calls made by non-indigenous patients (5 calls per 100 people).

Table 4 shows that almost a third of all calls to 13 Health were made by/for children aged 0 to 9.

Table 4. Age groups of people using 13 Health, Gold Coast region, July 2021 to June 2022

Age group	Number	Percent
0-9 years	11,069	30.8%
10-19 years	2,716	7.6%
20-29 years	6,789	18.9%
30-39 years	6,121	17.1%
40-49 years	3,129	8.7%
50-59 years	2,372	6.6%
60-69 years	1,715	4.8%
70-79 years	1,218	3.4%
80+ years	762	2.1%

Source. 13 Health

Ormeau – Oxenford SA3 had the highest rate of people using 13 Health, accounting for 30.5% of all calls (n=10,937), followed by Broadbeach at 13.5% (n=4,848). Pandemic COVID-19, abdominal pain, and chest pain were the leading reasons for calls made to 13 Health by residents of the GCPHN region from July 2021 to June 2022.

The peak time of calls to 13 Health by residents of the GCPHN region were between 4pm to 8pm, with 37% (8,249) of the total calls made during the after hours period (before 8am or after 8pm).

The three leading recommendations made by nurses at 13 Health to Gold Coast residents were to "Seek Emergency Care as Soon as Possible" (n=4,679; 13.2%), "Schedule an appointment to be seen by the doctor within the next 12 hours (same day)" (n=4,124; 11.6%) and "Seek face to face care within 1-4 hours" (n=2,976; 8.4%).

Emergency Department

Emergency care can be accessed in two public hospitals located in the GCPHN region: Gold Coast University Hospital and Robina Hospital. Table 5 shows the numbers of patients presenting to ED in these hospitals from 2016-2017 to 2019-2020. During this time, there has been an increase in the number of presentations in triage categories 2, 4 and 5.

Table 5. Number of patients presenting to public hospital EDs in Gold Coast according to triage category

Triage Category	2016-17	2017-18	2018-19	2019-20	Annual change (%)
Resuscitation (Category 1)	2,835	2,480	2,180	2,094	-26%
Emergency (Category 2)	28,211	29,321	31,093	33,112	17%
Urgent (Category 3)	86,473	87,705	91,146	84,090	-3%
Semi-urgent (Category 4)	43,102	47,655	48,264	59,459	38%
Non-urgent (Category 5)	3,414	3,999	3,911	3,868	13%

Source: AIHW National Non-Admitted Patient Emergency Department Care Database. This data set is a component of the minimum data set.

ED presentations with triage categories 4 and 5, which comprised 35% of all ED patients in 2019-2020, are often used as an indicator of presentations that can be managed by general practice or primary health (i.e., non-urgent care). These presentations therefore provide an indication of the effectiveness of the region's primary healthcare system in preventing unnecessary hospital presentations. The number of ED presentations for these two categories have continued to increase between 2016-2017 to 2019-2020, which suggests that residents of the GCPHN region could potentially better utilise their GP for non-urgent care. The GCPHN region's residents' use of EDs for lower urgency care per 1,000 people is significantly below the national rate per 1,000 people. This highlights that although the rate of lower urgency care ED presentations is increasing among residents of the GCPHN region the rate is significantly below the national rate.

In 2018-19, the total rate of ED presentations for triage category 4 and 5 (68.0 per 1,000 people) was below the national rate (117.4 per 1,000 people). Similar difference can be seen for rates of ED attendance during in-hours and after-hours (Table 6).

Table 6. Use of emergency departments for lower urgency care per 1,000 people, Gold Coast SA3 regions, 2018-19

Region	All-hours	In-hours	After-hours
National	117.4	61.6	55.8
Gold Coast SA4	68.0	37.1	31.0
Broadbeach-Burleigh	64.1	34.4	29.7
Coolangatta	105.2	60.4	44.9
Gold Coast-North	62.1	33.5	28.6
Gold Coast Hinterland	49.0	27.8	21.2
Mudgeeraba-Tallebudgera	84.4	46.6	37.7
Nerang	68.6	37.3	31.3
Ormeau-Oxenford	62.9	33.4	29.4
Robina	75.9	41.2	34.6
Southport	64.8	34.7	30.2

Source: AIHW, use of emergency departments for lower urgency care, 2018-19. This data set is a component of the minimum data set.

General practitioner access

Table 7 shows that there are no significant issues for access to GPs in the GCPHN region. The GCPHN region had a higher rate of GP attendances per 100 people compared to the national rate while also having a lower median out of pocket cost per GP attendances and a higher rate of bulk-billing GPs.

Table 7. Number of general practice and general practitioners, non-hospital Medicare-subsidised services per 100 people (2018-2019), median out-of-pocket cost per GP attendance/ GP bulkbilling (2016/17), Gold Coast SA3 regions

	Number of General Practices	Number of GPs	GP attendances (total)	GP attendances after-hours	GP enhanced primary care services	GP Mental Health Services
National			632	57	57	15
Gold Coast SA4	212	855	714	70	70	19
Broadbeach - Burleigh	29	149	738	52	67	19
Coolangatta	19	86	692	48	72	20
Gold Coast - North	22	84	797	67	89	20
Gold Coast Hinterland	7	33	694	46	76	22
Mudgeeraba-Tallebudgera	7	22	657	49	62	18
Nerang	16	74	707	69	63	18
Ormeau - Oxenford	41	181	711	71	68	19
Robina	21	92	689	54	65	18
Southport	28	131	735	68	74	21
Surfers Paradise	20	67	649	58	61	16

Source. Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data, 2018–19, Patients out-of-pocket spending on Medicare Services 2016-17, Number of general practices and general practitioners was sourced from GCPHN CRM tool as of 25/06/2022, GPs may work at multiple practices which is why the number of general practitioners will not be the total number of general practitioners. GP attendances include Enhanced Primary Care, After-hours GP attendances, Practice Incentive Program (PIP) services, and Other GP services. After-hours GP attendances include urgent and non-urgent after-hours GP care. GP Enhanced Primary Care refers to a range of services such as health assessments, medication management reviews, the creation and review of treatment plans, and coordination of care for people living with complex health conditions who require multidisciplinary, team-based care from a GP and at least two other providers.GP mental health includes early intervention, assessment, and management of patients with mental disorders by GPs or other medical practitioners (who are not specialists or consultant physicians). These services include assessments, planning patient care and treatments, referring to other mental health professionals, ongoing management, and review of the patient's progress. This data set is a component of the minimum data set.

Quality of Care

PIP QI Incentive

Under the Australian Government's Practice Incentive Program Quality Improvement (PIP QI) Incentive, general practices work with their local PHN to undertake continuous quality improvement activities through the collection and review of general practice data on specified improvement measures.

A general practice is required to meet two components to qualify for a PIP QI Incentive payment:

- participation in continuous quality improvement activities, and
- submission of PIP eligible data set to local PHN.

The improvement measures support a regional and national understanding of chronic disease management in areas of high need, and future iterations will respond to emerging evidence on areas of high need. The improvement measures are:

1. proportion of patients with diabetes with a current HbA1c result
2. proportion of patients with a smoking status
3. proportion of patients with a weight classification
4. proportion of patients aged 65 and over who were immunised against influenza
5. proportion of patients with diabetes who were immunised against influenza
6. proportion of patients with COPD who were immunised against influenza
7. proportion of patients with an alcohol consumption status
8. proportion of patients with the necessary risk factors assessed to enable CVD assessment
9. proportion of female patients with an up-to-date cervical screening
10. proportion of patients with diabetes with a blood pressure result

As of March 2022, 91% of general practices in the GCPHN region that were accredited or in the process of accreditation were enrolled in the PIP QI Incentive. These general practices are participating in continuous quality improvement activities in their general practice and submitting PIP eligible data sets at least once every quarter to GCPHN.

In July 2022, the GCPHN region was below the national rate in seven of the ten PIP QI measures.

Table 8. Quality Improvement measures, July 2022

Quality Improvement Measure		Gold Coast	National
QIM 1	Number of patients who have Type 1 diabetes and who have had an HbA1c measurement result recorded	52.0%	56.9%
	Number of patients who have Type 2 diabetes and who have had an HbA1c measurement result	68.2%	71.0%
	Number of patients who have unspecified, generic, or general diabetes diagnosis and who have had an HbA1c measurement result	58.8%	63.2%
QIM 2	Proportion of patients with a smoking status	67.3%	64.2%
QIM 3	Proportion of patients with a weight classification	25.7%	21.1%
QIM 4	Proportion of patients aged 65 and over who were immunised against influenza	52.0%	59.9%
QIM 5	Proportion of patients with diabetes who were immunised against influenza	48.9%	54.0%
QIM 6	Proportion of patients with COPD who were immunised against influenza	59.9%	63.8%
QIM 7	Proportion of patients with an alcohol consumption status	65.3%	57.1%
QIM 8	Proportion of patients with the necessary risk factors assessed to enable CVD assessment	39.8%	49.8%
QIM 9	Proportion of female patients with an up-to-date cervical screening	36.1%	38.2%
QIM 10	Proportion of patients with diabetes with a blood pressure result	51.3%	54.7%

Source: Practice Incentives Program Quality Improvement Measures: Data update 2021-22.

Patient experiences

The Patient Experience Survey provides an indication of people's experiences of the health system at a local level. Good experiences can be associated with quality healthcare, clinical effectiveness, and patient safety. Health experiences have also been measured using the 2016 Coordination of Healthcare Study, which had a specific focus on understanding the experiences with coordination and continuity of care by people aged 45 years and over who had at least one GP visit in the 12 months prior. Tables 9 and 10 highlight the results for the GCPHN region in comparison to the national average for these two surveys.

Table 9. Findings from selected items of Patient Experience Survey, 2019 - 2020

Indicator – 2019-2020	Gold Coast	National
Adults who reported excellent, very good or good health	88.1%	87.5%
Adults who reported having a long–term health condition	49.8%	51.6%
Adults who saw a GP in the preceding 12 months	80.5%	83.5%
Adults who saw a GP 12 or more times in the preceding 12 months	14.0%	10.5%
Adults who saw a GP for urgent medical care in the preceding 12 months	9.4%	10.0%
Adults who saw a dentist, hygienist, or dental specialist in the preceding 12 months	48.9%	48.9%
Adults who saw a medical specialist in the preceding 12 months	35.6%	36.5%
Adults who were admitted to any hospital in the preceding 12 months	13.0%	12.6%
Adults who went to any hospital emergency department for their own health in the preceding 12 month	13.2%	14.3%
Adults who had a preferred GP in the preceding 12 months	78.9%	76.6%
Adults who could not access their preferred GP in the preceding 12 months	20.6%	28.0%
Adults who felt they waited longer than acceptable to get an appointment with a GP	12.9%	18.6%
Adults who felt their GP always or often listened carefully in the preceding 12 months	90.6%	92.3%
Adults who felt their GP always or often showed respect for what they had to say in the preceding 12 months	93.1%	94.6%
Adults who felt their GP always or often spent enough time in the preceding 12 months	89.2%	90.9%
Adults who did not see or delayed seeing a GP due to cost in the preceding 12 months	2.3%	3.8%
Adults who delayed or avoided filling a prescription due to cost in the preceding 12 months	9.3%	6.6%
Adults who did not see or delayed seeing a dentist, hygienist or dental specialist due to cost in the preceding 12 months	19.8%	19.1%
Adults who saw three or more health professionals for the same condition in the preceding 12 months,	17.4%	16.8%
Adults who needed to see a GP but did not in the preceding 12 months	13.2%	13.2%
Adults who saw a GP after hours in the preceding 12 months	8.4%	7.2%
Adults who reported they were covered by private health insurance in the preceding 12 months	48.4%	56.5%
Adults referred to a medical specialist who waited longer than they felt acceptable to get an appointment in the preceding 12 months	26.9%	23.2%

Source: Patient experiences in Australia by small geographic areas in 2017-18, Australian Institute of Health and Welfare, 2019-20

The findings suggest that residents in the GCPHN region have an overall similar experience with the local primary healthcare system, compared to national results, with some notable differences:

- residents of the GCPHN region were more likely to rate their own health and the care provided to them as good, very good or excellent,
- GCPHN had the highest percentage of adults who felt they waited longer than acceptable to get an appointment with a GP 'among al 31 PHNs.

People aged 45 and over

The Coordination of Healthcare Study was developed by the Australian Institute of Health and Welfare (AIHW) and Australian Bureau of Statistics (ABS) to fill a national data gap and provide information on patients' experiences of coordination of care across Australia. The study included the 2016 Survey of Healthcare, which sampled people aged 45 and over who saw a GP between November 2014 to November 2015.

Overall, results in Table 10 show comparable indicators of coordination of healthcare between Gold Coast and nationally. The GCPHN region did have a higher rate of people aged 45 and over who were admitted to a hospital or have been to a hospital ED in the last 12 months.

Table 10. Coordination of healthcare for patients aged 45 and over, GCPHN and national, 2014-15

	Gold Coast	National
Saw GP for own health in the last 12 months	95.6%	96.8%
Has a usual GP	97.5%	97.5%
Had any tests, x-rays, or scans in the last 12 months	73.6%	71.7%
Was admitted to hospital in last 12 months	23.5%	21.9%
Has been to a hospital emergency department in the last 12 months	21.7%	18.4%
Has a long-term health condition	78.4%	75.9%
Saw a specialist doctor (excluding those seen during overnight stays in a hospital) for own health in the last 12 months	52.5%	54.7%
One to four different medications currently taking on a regular and ongoing basis	53%	51.8%
Received care from a health professional for physical health in the last 12 months	45.9%	44.7%
Received care from a health professional for emotional or psychological health in the last 12 months	9.8%	9.4%
Received enough information about care or treatment in the last 12 months	76.9%	76.5%

Source. AIHW (Australian Institute of Health and Welfare) analysis of ABS 2016. Survey of Healthcare, 2016, detailed Microdata, DataLab. Canberra: ABS.

Care Coordination

Care coordination is a term used to describe working with patients to develop a comprehensive plan that helps patients take more control of their health and achieve their goals. Care coordination is for patients with a chronic condition or multiple conditions, at risk of admission to hospital, or may have complex needs (which includes the social determinants of health). It is a patient centered approach that involves the timely coordination of health, community, and social services to meet a patient's needs. It is a partnership between the patient, carers, and providers.

A survey found that patients in five developed countries, including Australia, were "at risk for deficiencies in care coordination, communication failures and medical errors"[1]. Although most patients get their chronic disease care from a single general practice, the lack of a formal relationship leaves GPs uncertain

[1] Blendon R, Schoen C, DesRoches C, et al. Common concerns amid diverse systems: healthcare experiences in five countries. Health Aff 2003; 22: 106-121.

about the extent of their responsibility for ongoing care and care coordination, particularly in psychosocial care[2].

Care coordination is further hindered by gaps between general practice, hospital, community health and non-government organisations in different sectors of the healthcare system, often with conflicting boundaries and without shared lines of accountability.

Wound management

Wound care is a significant issue in Australia, with chronic wounds presenting a large health and economic burden to Australians, the healthcare system, and providers of health services. The Australian Government established a taskforce to review all 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. In 2018, a wound management working group was established to make recommendations to the taskforce on the review of MBS items within its concern, based on rapid evidence review and clinical expertise on wound management.

The taskforce noted that stakeholders strongly supported the work of the Wound Management Working Group to improve the management of wounds in Australia, including the suggested chronic wound cycle of care and the development of a national wound consumables scheme.

Wounds can be broadly classified as acute or chronic based on the duration of the wound and the cause underpinning its development. Most chronic wounds in Australian hospitals and residential aged care facilities (RACF) consist of pressure injuries (84%), venous leg ulcers (12%), diabetic foot ulcers (3%) and arterial insufficiency ulcers (1%)[3,4].

Approximately 450,000 Australians currently live with a chronic wound, directly costing the Australian healthcare system around AUD $3 billion per year[5]. In hospital and residential aged care settings in Australia in 2010-2011, the direct healthcare costs of pressure ulcer, diabetic ulcer, venous ulcer, and artery insufficiency ulcer was found to be approximately USD $2.85 billion[6].

According to the Bettering the Evaluation and Care of Health (BEACH) program, in 2010-11, the application of wound dressings was the second most frequently recorded procedure in general practice and the second most common procedure performed by general practice nurses[7].

Wound management in RACF

Chronic wounds also represent a major health burden in RACFs, with residents often entering RACF with one or more chronic conditions and complex wounds[8]. The elderly in general are at increased risk

[2] Oldroyd J, Proudfoot J, Infante FA, et al. Providing healthcare for people with chronic illness: the views of Australian GPs. Med J Aust 2003; 179: 30-33.

[3] Graves, N and Zheng, H. The prevalence and incidence of chronic wounds: a literature review. Wound practice & research: Journal of the Wound Management Association. 2014. Vol. 22, 1. 4.

[4] Graves, N and Zheng, H. Modelling the direct healthcare costs of chronic wounds in Australia. Wound Practice & Research: Journal of the Australian Wound Management Association. 2014. Vol. 22, 1. 20-4, 6-33.

[5] Pacella R, and the AusHSI chronic wounds team. Issues Paper: Chronic Wounds in Australia. Brisbane: Australian Centre for Health Service Innovation (Aus HSI), 2017. Available from: https://www.aushsi.org.au/news/chronic-wounds-solutions-forum/ [Accessed 30 August 2019]

[6] Graves, N and Zheng, H. Modelling the direct healthcare costs of chronic wounds in Australia. Wound Practice & Research: Journal of the Australian Wound Management Association. 2014. Vol. 22, 1. 20-4, 6-33.

[7] Britt, H, et al. General practice activity in Australia 2010-2011. General practice series no. 29. Sydney: Sydney University Press, 2011.

[8] Jaul, E, et al. An overview of co-morbidities and the development of pressure ulcers among older adults. BMC Geriatrics. 2018. Vol. 18, 305. https://doi.org/10.1186/s12877- 018-0997-7.

of impaired skin integrity due to age related changes to the skin, frailty, malnutrition, incontinence, immobility, and impaired cognition[9].

Discharge summaries

Timely, concise, and accurate communication to a GP and other healthcare providers fundamentally supports the continued safe care of patients upon discharge from hospital. A discharge summary is a collection of information about events during care of a patient by a provider or organisation. The document is produced during a patient's stay in hospital as either an admitted or non-admitted patient and issued when or after the patient leaves the care of the hospital.

When a healthcare provider creates a discharge summary, it will be sent directly to the intended recipient, as per current practices. When a hospital is connected to the My Health Record system, a copy of the discharge summary can also be sent to the patient's My Health Record.

In 2020-2021 there was 98,528 total discharge summaries uploaded to My Health Record from hospitals in the GCPHN region; 49,822 (50.6%) from public hospitals and 48,706 (49.4%) from private hospitals.

COVID-19 response

Access to COVID-19 vaccine

Everyone in Australia aged five years and over is eligible for a free COVID-19 vaccination. Gold Coast residents can receive a COVID-19 vaccination at:

- Selected general practices (n=172)
- Selected community pharmacies
- Aboriginal Controlled Community Health Services
- Aged care in-reach

Access to care if COVID-19 positive

Most people will not get very sick and can manage their symptoms at home, similarly to many other mild viruses. If individuals do need help with their symptoms or looking after themselves, they may contact the national Coronavirus helpline who will assist by connecting the individual to a health professional or hospital care if required.

Medicines for COVID-19 (including antiviral medicines) are available for people at high risk of developing severe illness. If an individual tests positive, they should contact their doctor for advice about eligibility. If the doctor recommends oral antiviral treatments, the individual will need a prescription from their doctor for collection of the medications at a local pharmacy.

PHNs continue to assist in the coordination, planning and delivery of the vaccine rollout, including playing a key liaison and support role with general practices. This includes:

- Providing direct support when requested, particularly relating to COVID-19 vaccine supplies.
- Distribution of COVID-19 updates continued to support access to critical information relating to both the COVID-19 vaccine program and COVID-19 pandemic response.

[9] Pagan, M, et al. Wound programs in residential aged care: a systematic review. Wound Practice and Research. 2015. Vol. 23, 2. pg. 52-60.

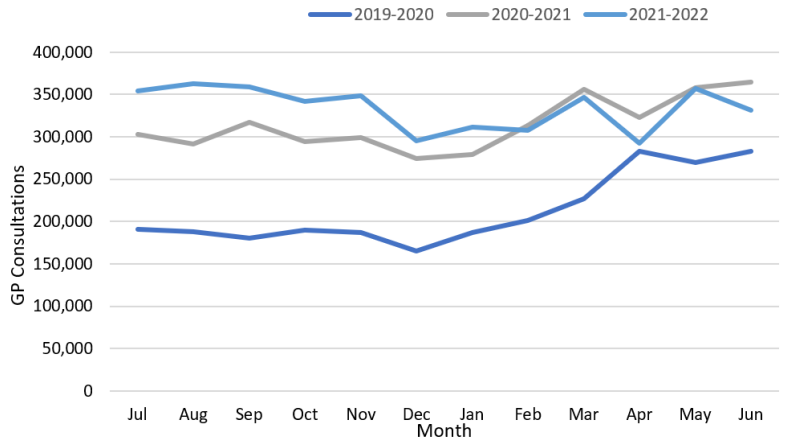
- Coordinating respirator fit testing for P2/N95 mask for Gold Coast general practice staff.
- Personal protective equipment distribution for general practice staff.

Services in general practices during COVID-19

The lockdown period prompted an unexpected and rapid implementation of telehealth services in general practice. In 2021, there was a 25.6% increase in total consultations (face-to-face and telehealth) compared to 2020 amongst a sample of 159 general practices submitting data through Primary Sense (Figure 1).

It remains challenging to engage with general practices who are feeling the strain of responding to COVID-19 since early 2020. The figure below reflects the anecdotal experience of the increasing utilisation of general practices contributing to fatigue, burnout and reduced capacity to participate in a range of other activities.

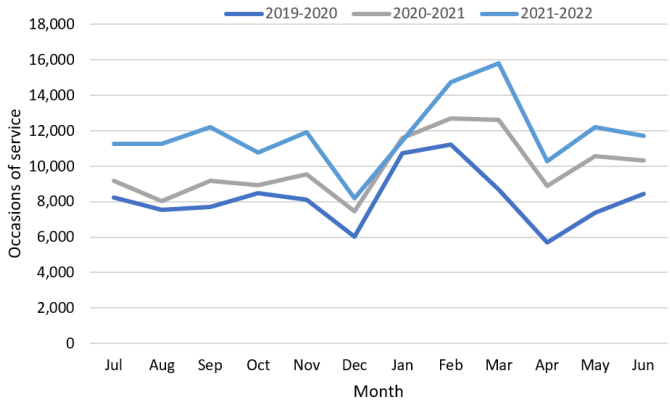
Figure 1.GP Consultations including face to face and telehealth, 159 Gold Coast general practices, 2019-20 to 2021-22



Source. Primary Sense

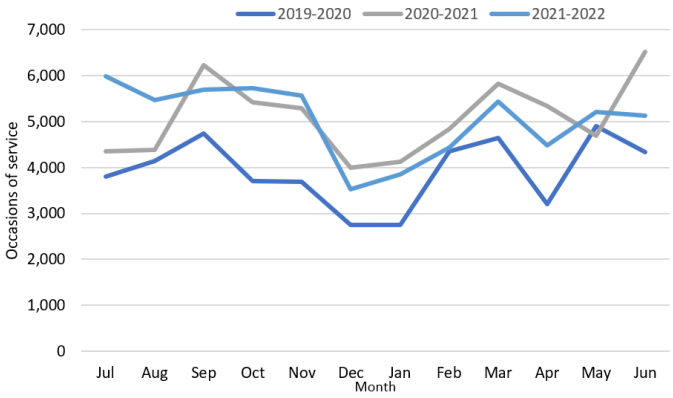
The data extracted from Primary Sense show there was some reduction in routine care for chronic disease management and attendance for cancer screening visits to general practice in 2019-2020 due to COVID-19. Care planning did not reduce to the same extent as cancer screening items as these services were more readily available by telehealth, whereas cancer screening requires a visit or referral letter/ pathology request and appears to have been impacted to a greater extent. Cancer screening includes bowel, breast, cervical and skin. Despite reduced services due to COVID-19, since this time, there have been catch-up periods where general practices have seen increased attendances for these interventions, as seen in Figures 2 and 3. Overall, there are more visits to general practice in 2021-2022 than pre-pandemic in 2019, reinforcing and supporting the anecdotal higher utilisation of general practice. Early in the pandemic there were concerns of reduced visits for ongoing chronic disease issues. Overall, the data does not suggest that there are emerging concerns of longer-term health issues due to people avoiding routine and preventative care in general practices.

Figure 2. Care planning, 159 Gold Coast general practices, 2019-20 to 2021-22



Source. Primary Sense

Figure 3. Cancer screening, 159 Gold Coast general practices, 2019-20 to 2021-22



Source. Primary Sense

Bulk Billing

An increasing number of GPs across Australia are opting to charge a fee instead of bulk billing their patients which may deter patients due to increasing cost. In 2021-22, the national bulk billing rate was 82.2% while the Queensland rate was 80.7% . HealthEd, a private education company for doctors, surveyed 477 GPs in August 2022 and found that 22% had recently changed their billing model. Of those that changed their billing, 33% moved from bulk billing to mixed billing, and 67% changed from mixed billing to private billing. Rising costs was the reason for the switch given by 77% of GPs, while 17% cited Medicare cuts and 6% attributed the change to COVID-related costs .

Gold Coast data show in September 2022, 44% (n=92) of general practices' billing system is bulk billing, while 47% use (n=99) mixed billing and 9% (n=19) private billing.

[10] Medical Benefits Schedule (MBS) quarterly statistics – year to date dashboard (health.gov.au)
[11] Healthed webcast survey, 2 August 2022

Digital health

Several new systems are being integrated in general practice software and workflows, including telehealth, Q scripts, My Health Record, smart referrals, health pathways and electronic prescribing.

Clinical Information Systems

The future of safe and efficient patient care depends to a large degree on clinical information systems. Modern healthcare delivery models require the transfer of information between care teams, across disciplines and between care sites. Clinical information systems are vital tools in the delivery of safe and high-quality healthcare and good practice management. Locally in the GCPHN region, 66% (n=139 of 212) of general practices have Best Practice clinical information system installed, and 26% (n=56 of 207) have Medical Director installed. The remaining general practices have other clinical information systems installed.

Telehealth services

Since the first case of COVID-19 in Australia was reported, there has been a significant impact on the way healthcare has been delivered throughout general practice. While the volume of visits has remained largely unchanged, what has changed is the way these services are delivered.

Telehealth accounted for roughly 30% of all consultations in 2020 in Australia, with 97% of those occurring over the telephone. Previous research indicated that GPs have been more inclined to use familiar technology to meet their telehealth needs. The proportion of telehealth consultations for females was higher than the proportion of in-person consultations for females. Equally, the proportion of telehealth consultations for males was lower than the proportion of in-person consultations for males.

Potential barriers for GPs to undertake video consultations include:

- negative attitudes and unfamiliarity with video technology,
- view that the time taken to set up a video consultation will interfere of the time available to attend the patient,
- interruption and/or disruption to workflows in the general practice,
- low confidence with the technology, equipment, and software,
- patient preference for teleconference versus video conference, and
- limited access to technology to support video conferencing.

Potential barriers to patients' use of video consultations include:

- negative attitudes and unfamiliarity with video technology,
- GP does not provide and/or advocate for the use of video for consultations,
- lack of familiarity, competence, and/or confidence with technology (e.g., elderly persons, culturally and linguistically diverse persons, vision, or hearing-impaired persons), and
- availability/cost of equipment (phone, computer, webcam, microphone, headset, internet access etc.).

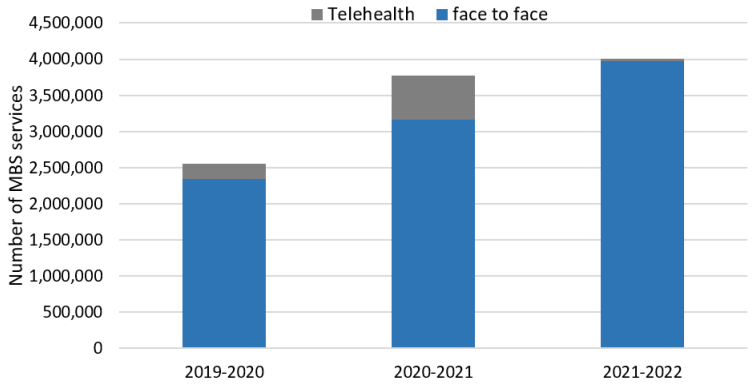
Avant Medical conducted a survey which had over 1,300 responses from health practitioners (just over half of respondents were GPs, and the remainder were physicians, surgeons, and other doctors). Interestingly, for 61% of respondents, the technical ability of patients was a barrier to using video telehealth. For 25% of respondents, their personal preference prevented them from using or more frequently using video telehealth with their patients.

Younger people are much more likely to use telehealth compared to people aged 45 years and over[12]. This was further supported by headspace report which identified that of 1,348 clients who received a headspace service during 6 to 20 May 2020, 94 % agreed that they had a positive experience with headspace while 78 % agreed that the telehealth was suitable for their needs[13].

Locally, analysing data from 159 general practices that submit data to GCPHN through Primary Sense- population health management and clinical audit tool[14]. Telehealth made up 16% (n=613,098) GP consultations between July 2020 – June 2021. Telehealth has since decreased to 1% (n=37,062) of GP consultations for the July 2021- June 2022 period.

Of the telehealth items being claimed in the GCPHN region, 98% were through telephone items while the remaining 2% were through video conference which is consistent with national trends. As can be seen in Figure 4 telehealth consultations increased significantly in 2020-2021.

Figure 4. GP consultations (face to face and telehealth), 159 Gold Coast general practices, 2019-20 to 2021-22



Source. Primary Sense

[12] HOTDOC Telehealth Patient Survey 2020

[13] Young people's experience of telehealth during COVID-19, headspace

[14] Primary Sense is a clinical decision support, population health management and data extraction tool. Primary Sense analyses and manages general practice data in a confidential and safe way. Primary Sense is installed onto the practice's server and de-identified data is exacted and securely transferred to the Primary Sense database in Azure for analysis. Patient information is provided back via the Primary Sense desktop app on practices desktop based on practices selections. Primary Sense enhances the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling, and tracking outcomes over time. Currently, 159 Gold Coast General Practices submit data to the Primary Sense tool and this data is coded by the Clinician at the point of information input.

In June 2021, the GCPHN Community Advisory Council consisting of 16 members, completed a survey on their use of telehealth services. it was established that 93.8% of households had at least one individual that utilised a telehealth service within the last 3-4 months. Of these participants, 60% strongly agreed that their health needs were met through using this service while the remaining 40% agreed their health needs were met. Of the participants, 100% stated they would utilise the service again. One participant stated it was a "terrific experience and an efficient use of my time".

Feedback from the GCPHN Primary Healthcare Improvement Committee (PHCIC) and Clinical Council regarding the use of telehealth identified that it has been a positive experience. Both groups noted it has reduced previous patient transport barriers to access services and resulted in less patient cancellations. One limiting factor that the PHCIC noted was the ability to provide telehealth for younger patients who may not be regular attendees and not meet the 12-month period criteria. Both groups agreed that telehealth compliments face-to-face GP visits, however there will always be a need for face-to-face visits with a GP.

Secure Messaging

In the GCPHN region, 92% of general practices are connected to use secure messaging. The need for a connected healthcare system has never been greater with the impact of COVID-19 highlighting the need for healthcare providers to connect with each other in a safe and secure digital environment.

- Secure messaging is an efficient and timely method for sending and receiving information, which minimises the burden of paper and manual process.
- An increased uptake of secure messaging improves continuity of care for patients, saves time and protects vital health information[15].

Secure messaging system allow healthcare professionals to send health information securely to other healthcare professionals involved in their patients' care. The exchange of health information is typically conducted via the healthcare professional's clinical system. Secure messaging is regarded as a 'point to point' exchange, which is distinct to the 'point to many' exchange used by electronic health records such as the My Health Record.

A review completed by Australian Digital Health Agency 'Secure Messaging National Scaling Final Report' Care on the safety and quality benefits of secure messaging found that the 'point to point' information sharing via secure messaging can enable enhanced models of care. In addition, this review examined the risk of securing messaging use, including when in operation with parallel adjunct information exchange processes, across a range of clinical environments. Of particular focus were environments that had a greater dependence on manual processes, such as fax, telephone, or hand-written information exchange methods.

The overarching themes around the barriers to the expansion of secure messaging can be divided into three main categories:

- Policy and governance
    - inadequate governance over the secure messaging ecosystem,
    - inconsistent uptake of industry offers leading to misalignment on standardisation requirements.

[15]National E-Health Transition Authority 2015. My eHealth record to national eHealth record transition impact evaluation: phase 1 evaluation report. Sydney: National E-Health Transition Authority Ltd.

- Functional and technical
    - challenges in messaging acknowledgements and accurate addressing to end points,
    - negative impacts on clinical workflows and patient care delivery,
    - lack of standardisation in adherence to technical standards for payloads.
- Adoption and usability
    - misalignment in secure messaging value proposition across the healthcare industry,
    - challenges in the usability of secure messaging and inconsistent support mechanisms[16].

Electronic Prescribing

Electronic prescribing allows prescribers and their patients to use an electronic Pharmaceutical Benefits Scheme (PBS) prescription. Electronic prescriptions are part of the broader digital health and medicines safety framework. They enable the prescribing, dispensing, and claiming of medicines, without the need for a paper prescription.

Under the National Health Plan for COVID-19, the Australian Government accelerated electronic prescribing and interim arrangements were established to enable GPs to dispense electronic prescription.

Emerging service concerns have been identified and potential new workflows will be introduced in both general practices and pharmacies to support electronic prescribing including:

- Pharmacies and general practices to have the technological infrastructure established to receive and send electronic prescriptions.
- Ensuring both general practice and pharmacy have the correct patient contact details (mobile number and/or email address) to deliver the prescription.
- Pharmacies will need to change their script in workflow with electronic prescriptions and perhaps the use of software that can create virtual queue system, so the electronic prescription does not get lost in the queue among the paper scripts.

Currently in the GCPHN region, 80% (n=166 of 207) of eligible general practices are enabled for electronic prescribing.

GCPHN have received feedback that general practices are reluctant to introduce electronic scripts unless they have a close relationship with a local pharmacy and know they have software enabled to receive electronic scripts. Additionally, there is no central system for general practice staff to check what pharmacies are enabled to receive electronic scripts.

Conformant clinical software products

The last two decades have seen widespread adoption of clinical information systems in general practice. The future of safe and efficient patient care depends on these systems. Modern healthcare delivery models require the transfer of information between care teams, across disciplines and between care sites. General practice clinical information systems improve accessibility and legibility of data.

[16] Australian Digital health Agency, Deloitte. Secure Messaging National Scaling Report. Sydney: ADHA;2019

However, as the volume of information generated and held within clinical information systems grows, it is becoming increasingly difficult for systems to respond to the needs of GPs and patients as part of the normal clinical workflows and for these clinical information systems to be conformant with other clinical information systems. Anecdotal feedback shows some concern about general practice clinical software incompatibility with other service provider's software.

My Health Record

Healthcare providers authorised by their healthcare organisation can access the My Health Record system to view and add patient health information. Through the My Health Record system healthcare professionals can access timely information about patients such as shared health summaries, discharge summaries, prescription and dispense records, pathology reports and diagnostic reports.

An individual's 'My Health Record' stores their health information which can be viewed securely online, from anywhere, at any time- even if the individual moves or travels interstate. An individual can access their health information from any computer or device that is connected to the internet.

In September 2022, 100% of general practices, specialists and pharmacies in the GCPHN region were informed about my Health Record.

In 2021-22, 22.5% of GCPHN region's primary healthcare providers (n=192 of 855) were regularly uploading rate of regular upload to My Health Record (defined as at least one document was uploaded in a quarter), including:

- 59.6% (n=127 of 213 general practices)
- 41.4% (n=65 of 157 pharmacies)
- 0 of 476 allied health services

Translating and Interpreting service

The Translating and Interpreting service (TIS) is an interpreting service provided by the Department of Home Affairs for people who do not speak English, and for agencies and business that need to communicate with their non-English speaking clients. The interpreting service aims to provide equitable access to key services for people with limited or no English language proficiency.

Medical Practitioners (GPs, nurse practitioners and approved medical specialist) are eligible for the free interpreting service and access to the Medical Practitioner line when providing services that are:

- Medicare-rebatable,
- delivered in private practice, and
- provided to non-English speakers who are eligible for Medicare.

Pharmacies dispense medications that can be dangerous if taken incorrectly and information about medications can be complex. Therefore, it is essential that people can communicate effectively with staff in pharmacies about the medications they are taking, how to take them correctly and any risk or side effects that may be associated. Using interpreters can also protect pharmacists from professional risk.

Analysis of 2019-2020 data from TIS indicates there were a total of 1,007 translation services completed by GPs, specialist, pharmacy, and nurse practitioners in the GCPHN region. Of the 1,007 translation services delivered by TIS, 85% (n=858) were completed by phone while 15% (149) were completed on site.

GPs had the largest usage by phone with 86% (n=742), followed by specialist 12% (n=104). For onsite services, specialist 54% (n=80) had the largest usage followed by GPs 46% (n=69).

Data from the 2016 census identified that there were 9,319 people living in the GCPHN region who did not speak English at home well or not at all[17]. Of the 1,007 TIS translation services that were delivered in the GCPHN region in 2019-20, 10.8% of people who did not speak English at home well or not at all received translation services offered by TIS (noting one patient may use TIS services multiple times).

Areas within the GCPHN region with high usage of TIS translation services included postcodes 4215 (suburbs Southport and Labrador) and 4207 (suburbs such as Beenleigh, Yatala, Logan…). On the other hand, some areas with a high number of people who did not speak English at home well or not at all had low uptake of TIS services – such as postcode 4217 (suburbs Surfers Paradise, Benowa, Bundall, Main Beach) and 4226 (suburbs Robina, Merrimac, Clear Island Water). These areas have high numbers of international students living in them.

[17] ABS, Census of Population and Housing, 2016, General Community Profile - G13

Service system

Service Type	Number in GCPHN region	Distribution	Capacity
General practice	212	Clinics are generally distributed across the GCPHN region, with the majority located in coastal and central areas. Two general practices are available open 24 hours located at Broadbeach and Pimpama	• 855 GPs in the GCPHN region • 28 general practices deliver speciality services such as skin checks • Average number of GPs per general practice: 4.0 • 91% of general practices are accredited or currently working towards accreditation.
Medical deputising services	4	In-home and after-hour visits from a doctor Available across most of the GCPHN region with hinterland areas less well serviced	• All consultations are bulk billed for Medicare and DVA card holders. • Depending on the provider, appointments requested by phone or online.
Pharmacy	143	Well-distributed across the region	• Medication dispensing • Medication reviews • Medication management • Some screening and health checks • Some vaccination
Emergency departments	6	Southport and Robina (public) Southport, Benowa, Robina and Tugun (private)	• Private health insurance is required to access EDs, a gap payment may also be incurred. • Limited integration with general practice data. • Residents near borders may also use nearby hospitals such as Tweed, Logan, and Beaudesert.
Online and phone support	4	Phone or online	• Healthdirect • 13 HEALTH – health information and advice • Lifeline crisis support service • PalAssist – 24-hour palliative care support and advice line
Allied health services	423 services with 1,247 workers	Services are generally well spread across the region; majority in coastal and central areas	Many different allied health groups contribute to the care of people in the GCPHN region both individually and as part of multidisciplinary care teams. Allied health can be provided in a community or hospital setting and range from dieticians, physiotherapists, occupational therapists, pharmacists, podiatrists, psychologists, and social workers.

Specialist practices	233 services with 689 workers	Services are generally well spread across the GCPHN region; majority in coastal and central areas	• Many different specialists contribute to the care of people in the region. • Specialist can range from cardiology, psychiatry, and oncology etc.

Consultations (2021-22)

General practice support

- General practice staff report a lack of capacity to focus on CQI activities.
- General practices report that supporting patients with their COVID-19 vaccination requirements can be time consuming and overwhelming.
- There is a need for development of consistent and appropriate general practice orientation training packages which will support a national standard of training across the sector.
- Access to information about services available in the region, including a "navigation component" is needed because it is difficult for general practices to know what is there and it changes so frequently.
- Financial sustainability of general practices is threatened.
- Case conferencing is underutilised, while case conferencing meetings occur in tertiary settings, GPs are rarely involved.
- Training and staffing needs are accepted as part of doing business in the rapidly changing health environment, and consistent access to quality training for general practice staff is important.

Digital health

- Further information on electronic prescriptions and support for general practices are needed.
- There are concerns about readiness of pharmacy software to support electronic prescribing.
- My Health Record meaningful use in general practice and use of shared health summaries.
- Continued promotion of privacy and security information for all staff still required in telehealth.
- Support for pharmacies is needed with the implementation of electronic prescribing.
- PCPC members raised questions about carers managing Electronic Prescriptions and the ongoing continuity of care.
- Change in policies and procedures for community support organisation who may help patients access pharmacies and or pick up medications.
- Internal and external feedback about Electronic Prescription education for consumers is needed to generate change in behaviour in primary health.
- Active Script List model will see a large responsibility on pharmacies regarding consumer awareness as well as numerous changes occurring in workflow for this stakeholder group could highlight a need for further support.
- Meaningful use and continued education support for My Health Record for Private Specialist practices is challenging with many general practices registered for My Health Record incorrectly set up or not using.
- Support for local pharmacies transitioning to use digital health platforms such as AIR and PRODA is needed. This is highlighted through incoming phone calls requesting of support and stakeholder engagement.
- A heavy promotion to utilise My health Record from every health facility is required, this

would need to be supported by private and public bodies working together and driven by patient demand as well.

- PRODA continues to be highlighted as an area of need for education for Private Specialist staff, in particular registering an organisation in PRODA
- More information and clarification to healthcare providers is needed about how each digital health system interacts such as My Health Record, secure messaging, and The Queensland Viewer.
- Electronic dispensing of tokens appears to have not been adopted in all pharmacies, with feedback that some pharmacists are requesting interim prescribing methods of faxing or emails and are stating they cannot dispense tokens. Other issues are regarding how to provide patients with a token for a repeat script.

Specialists

- Private Specialist Managers are interested and require more training and support for everyday use of PRODA to reduce administration work that can be completed online.
- This may be the same in other Primary Health sectors and could be packaged with digital health information to enhance scope and ability to support sector.

After hours

Local health needs and service issues

- There is decreasing availability of face-to-face primary care options in after hours, which impacts older people, palliative patients and vulnerable people who find it difficult to travel.
- Highest demand for services is 6pm to 8pm.
- Potential areas of higher geographic need for after hours primary care services are the southern (Coolangatta SA3) and less populated western areas (Mudgeeraba-Tallebudgera SA3), as well as the northern corridor (Ormeau- Oxenford SA3) due to sheer demand.
- Among the top reasons for non-urgent presentations (category 4 and 5) to Emergency Department (ED) in the after hours, most relate to injuries (ankle sprains, wounds, and injuries).
- There are difficulties in recruitment and retention of doctors to deliver primary care services in the after hours.
- Access to support in the after hours for people with mental health concerns is particularly high in the northern corridor (Ormeau- Oxenford SA3).
- RACFs have experienced increasing wait times for after hours doctors and operational issues due to staffing issues.
- Flexible delivery of AODs services outside of usual business hours is a factor in successful completion of treatment.

Key findings

- The Gold Coast maintains a high level of accessibility to after hours primary care services (43.3 GP after hours attendance per 100 people) compared to the national rate (32.5 GP after hours attendance per 100 people) in 2020-21.
- The Gold Coast rate for after hours attendances to primary care services has decreased in recent years (from 68.8 per 100 people in 2015-16 to 46.3 per 100 people in 2020-21).
- ED and 13 Health data show that early evening, 6pm up to 8pm, has the highest demand.
- Non-urgent ED presentations (category 4 and 5) have increased in recent years. This aligns with the insights from stakeholder consultations that there are growing wait times for GP attendances at home and that some areas cannot be serviced due to the current level of demand.
- Only one general practice in the GCPHN region is open between the overnight hours of 12am to 6am.
- Service providers report that it is difficult to recruit and retain doctors willing to work in the after hours for the remuneration available and this is impacting on the ability to deliver services to meet demand levels.
- The community values having a face-to-face primary care option, particularly older people who had the highest rate of GP attendances in the after hours period.
    - In contrast, 13 Health services are used more frequently by younger families with children 0 –9 and children.
    - Individuals aged under 15 had the highest rate of presentation to ED after hours.
- People living in areas close to a major hospital are more likely to present to an ED. People living in the higher density areas access after hours GPs services at a higher rate than less densely populated areas. This may be because it is easier from a business perspective for medical deputising services to

deliver services in these areas. As a result, the areas of the Gold Coast to the south and less populated western areas may have reduced access to after hours GP services. The high population growth in the northern corridor and lack of after hours GP clinics in that area highlight this region to be an area of prioritised need.

- Analysis of ED presentations and consultation data indicate that demand for access to mental health support in the after hours has been high for many years in the region. Patients with high levels of distress can attend EDs to seek support, including the Gold Coast Health Crisis Stabilisation Unit. In addition, Gold Coast Health have partnered with Gold Coast Primary Health Network to expand and existing after hours mental health support to a second site. This service is in two location (Mermaid and Southport) and offers support for adults experiencing distress after hours, a time when their usual supports and clinicians may not be available. This service is provided in a friendly place, with easy access to help in an informal, café style environment. Lived experience workers and clinical teams are available so people can feel supported and safe, while they manage their mental health during challenging time and build on their skills for their wellbeing and without having to go to hospital. The northern area of the GCPHN region is now emerging as an area of growing need in terms of mental health support, particularly in the after hours.
- AOD presentations to ED are a regular and resource intensive issue. Local AODs Services that provide flexible hours of delivery are finding good success especially for people with work, carer or other family commitments or where parents and carers are supporting a young person.
- RACFs frequently use after hours home visiting service providers. There are barriers that complicate efficient and effective service delivery, such as:
    - Wait times have grown, which is a problem particularly for palliative patients who may suddenly deteriorate and require additional medication,
    - Limited staffing overnight due to workforce capacity issues, and
    - Operational issues such as entry to facility and access to clinical information.
- New models of care, including private services that directly bill patients for after hours services, are being added to the local service system.

Overview

After hours primary care is offered as an accessible and effective primary healthcare option for people whose health condition cannot wait for treatment until regular primary healthcare services are next available. It should, however, not be a substitute for healthcare that could otherwise occur in-hours.

Within general practice, after hours services are defined for MBS purposes as those provided during:

- Sociable after hours (6pm-11pm on weeknights), and
- Unsociable after hours (11pm-8am on weekdays, hours outside of 8am and 12pm Saturdays, and all day Sunday and public holidays).

Primary Health Networks (PHNs) work with key local stakeholders to plan, coordinate and support after hours health services. PHNs provide an opportunity to improve access to after hours services that are designed to meet the specific needs of different communities.

After hours GP attendances

In 2020/2021, the rate of after-hours GP attendances in the GCPHN region was above the national rate (46.5 vs 33.5 per 100 people). The rate of after-hours attendances decreased between 2015 and 2021 in the GCPHN region and nationally.

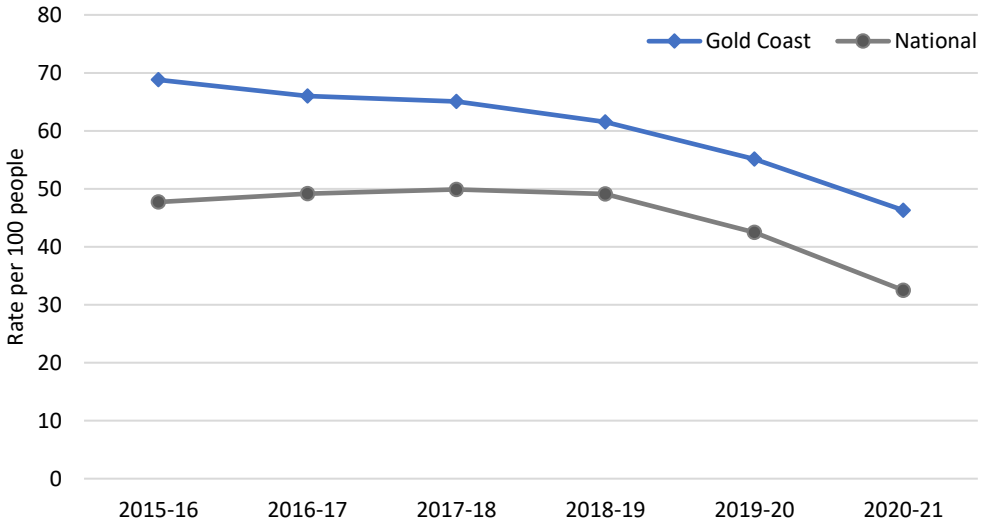
Table 1. Rate of GP after hours attendances per 100 people, Gold Coast SA3 regions, 2015-16 to 2020-21

Region (SA3)	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
National	47.7	49.2	49.9	49.1	42.5	33.5
Gold Coast (SA4)	68.8	66.0	65.1	61.5	55.1	46.5
Broadbeach – Burleigh	62.6	56.5	53.1	51.7	48.2	38.1
Coolangatta	56.4	54.7	53.2	48.1	42.8	35.6
Gold Coast – North	78.1	75.4	73.5	66.7	60.8	52.4
Gold Coast Hinterland	41.4	43.5	45.0	46.2	44.3	41.4
Mudgeeraba – Tallebudgera	55.8	53.7	51.7	49.3	43.4	35.3
Nerang	80.5	77.4	74.0	68.5	59.4	47.4
Ormeau – Oxenford	68.8	66.0	70.4	71.1	67.4	55.6
Robina	59.5	58.0	57.9	54.2	48.4	37.9
Southport	87.6	84.9	78.5	68.4	62.7	54.0
Surfers Paradise	67.3	63.9	63.6	58.3	51.9	42.6

Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2013-14 to 2018-19. This data set is a component of the minimum data set. Note: all results are based on the patient's Medicare enrolment postcode, and not where they received the healthcare service. Note times vary depending on type of after-hours care, whether urgent or non-urgent, and for services provided at a place other than a consulting room.

Figure 1 demonstrates the decrease in GP after hours attendances from 2015-16 to 2020-21, nationally and on the Gold Coast. In contrast, a slight increase in non-urgent after hours ED presentations was seen during this time (please refer to after hours ED use section below).

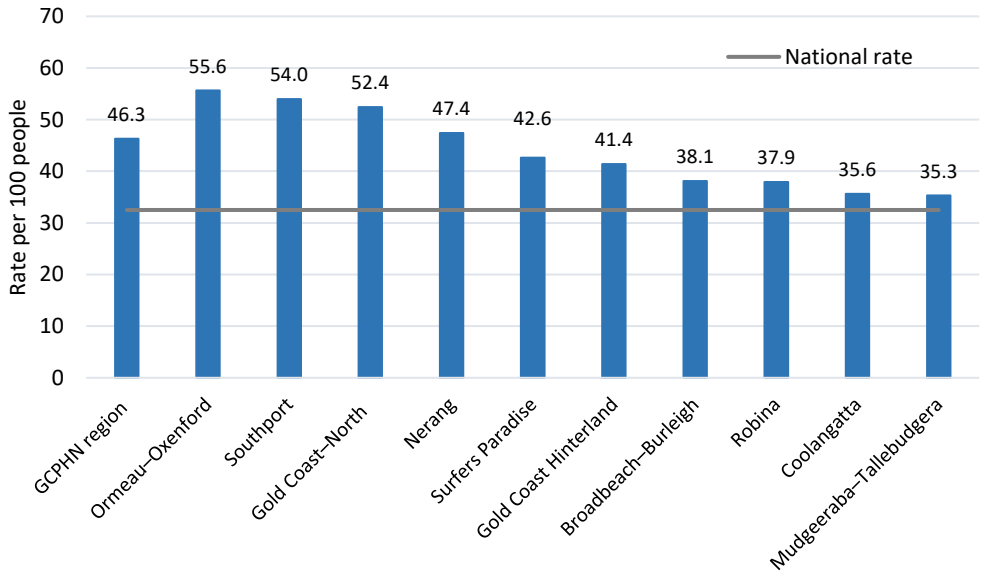
Figure 1. GP after hours attendances per 100 people, 2015-16 to 2020-21



Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2013-14 to 2018-19. This data set is a component of the minimum data set. Note: all results are based on the patient's Medicare enrolment postcode, and not where they received the healthcare service. Note times vary depending on type of after-hours care, whether urgent or non-urgent, and for services provided at a place other than a consulting room. See After-hours GP (urgent) and After-hours GP (non-urgent) for more information.

All Gold Coast SA3 regions had higher rate of GP attendances in the after hours than the national average rate. Ormeau-Oxenford had the highest rate (56.5 per 100 people), while Mudgeeraba – Tallebudgera had the lowest rate (35.3 per 100 people) (Figure 2).

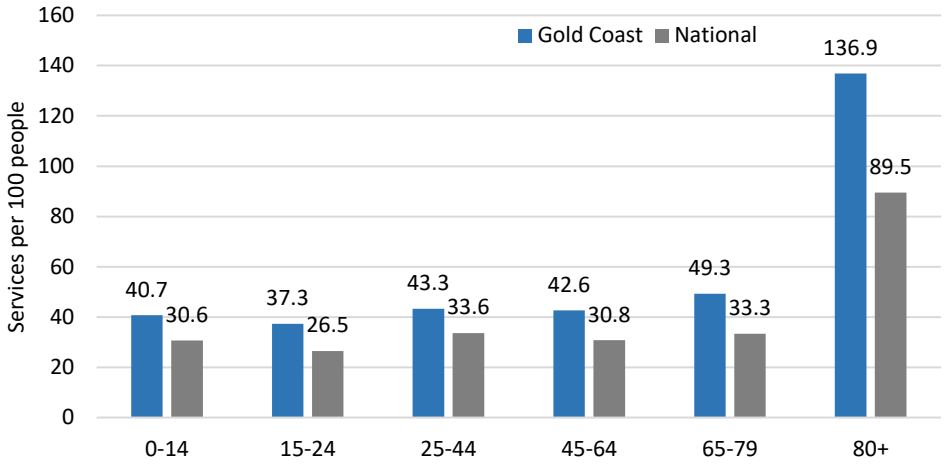
Figure 2. GP after hours attendances per 100 people, Gold Coast SA3 regions, 2020-2021



Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2013-14 to 2020-2021. Note: all results are based on the patient's Medicare enrolment postcode, and not where they received the healthcare service. Note times vary depending on type of after-hours care, whether urgent or non-urgent, and for services provided at a place other than a consulting room.

Among age cohorts that access after hours GP services, rates of service were highest among people aged 80+ years for the GCPHN region (136.9 per 100 people) and nationally (89.5 per 100 people) (Figure 3). The lowest rates were recorded for age group 15-24 (37.3 per 100 people).

Figure 3. Rate of GP after hours attendances per 100 people by age cohorts, Gold Coast and national, 2020-2021



Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2013-14 to 2020-21. Note: all results are based on the patient's Medicare enrolment postcode, and not where they received the healthcare service.

Urgent after hours GP attendance

An urgent after hours GP attendance is where the patient's medical condition requires urgent assessment to prevent decline or potential decline in health and the assessment cannot be delayed until the next in-hours period.

Urgent after-hours are described as follows:

- Social after-hours include, Monday to Friday 7 am–8am and 6 pm–11 pm, Saturday 7 am–8 am and 12 noon–11 pm, and Sunday/and or public holidays 7 am–11 pm,
- Unsociable hours include, Monday to Friday 11 pm–7 am, Saturday 11 pm–7 am, Sunday/and or public holidays 11 pm-7 am[1].

In 2020-21, the rate of urgent after hours services per 100 people in the GCPHN region was over 80% higher than the national rate (5.7 vs 2.3 per 100 people). Among Gold Coast SA3 regions, Ormeau-Oxenford had the highest rate of urgent after hours GP attendances (7.3 per 100 people) while Gold Coast Hinterland had the lowest rate (3.0 per 100 people). A decline in urgent after hours attendances in recent years can be seen in Table 2, both nationally and in the GCPHN region.

[1] Australian Institute of Health and Welfare (AIHW) 2021, *Medicare-subsidised GP, allied health and specialist health care across local areas: 2019–20 to 2020–21,* https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2020-21

Table 2. Rate of urgent GP after hours attendances per 100 people, Gold Coast SA3 regions, 2015-2016 to 2020-2021

Region	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
National	7.7	7.2	6.3	4.8	3.3	2.3
Gold Coast (SA4)	22.4	19.9	17.0	12.2	8.4	5.7
Broadbeach - Burleigh	20.8	17.7	14.9	11.0	6.7	4.6
Coolangatta	18.7	18.3	16.0	10.9	5.9	3.4
Gold Coast - North	24.9	21.6	18.6	13.7	10.1	6.4
Gold Coast Hinterland	9.3	9.2	7.8	5.5	4.2	3.0
Mudgeeraba - Tallebudgera	18.4	16.4	14.3	10.5	6.7	4.5
Nerang	25.6	22.1	18.6	13.4	9.4	6.5
Ormeau - Oxenford	28.6	25.2	21.2	14.5	10.3	7.3
Robina	19.1	17.3	15.3	11.2	7.3	5.0
Southport	23.6	20.8	17.4	13.4	10.1	6.6
Surfers Paradise	14.4	13.3	10.4	7.7	5.0	3.6

Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2013-14 to 2020-2021.Note: all results are based on the patient's Medicare enrolment postcode, and not where they received the healthcare service.

Non urgent after hours GP attendance

Non-urgent after-hours are described as follows:

- At consulting rooms: Monday to Friday before 8 am or after 8 pm, Saturday before 8 am or after 1 pm, and all-day Sunday/and or public holiday,
- At a place other than consulting rooms: Monday to Friday before 8 am or after 6 pm, Saturday before 8 am or after 12 pm, and all day Sunday/and or public holiday.[2]

Non-urgent after hours GP attendances vary in time and complexity and include home visits and visits to Residential Aged Care Facilities (RACF).

As shown in Table 3, in 2020-21, the rate of non-urgent after hours services in the GCPHN region was higher than the national rate (40.8 vs 31.3 per 100 people). Among SA3 regions, Ormeau-Oxenford (48.38) had the highest rate of non-urgent GP after hours attendances (48.4 per 100 people) while Mudgeeraba - Tallebudgera had the lowest rate (30.8 per 100 people).

[2] Australian Institute of Health and Welfare (AIHW) 2021, *Medicare-subsidised GP, allied health and specialist health care across local areas: 2019–20 to 2020–21,* https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2020-21

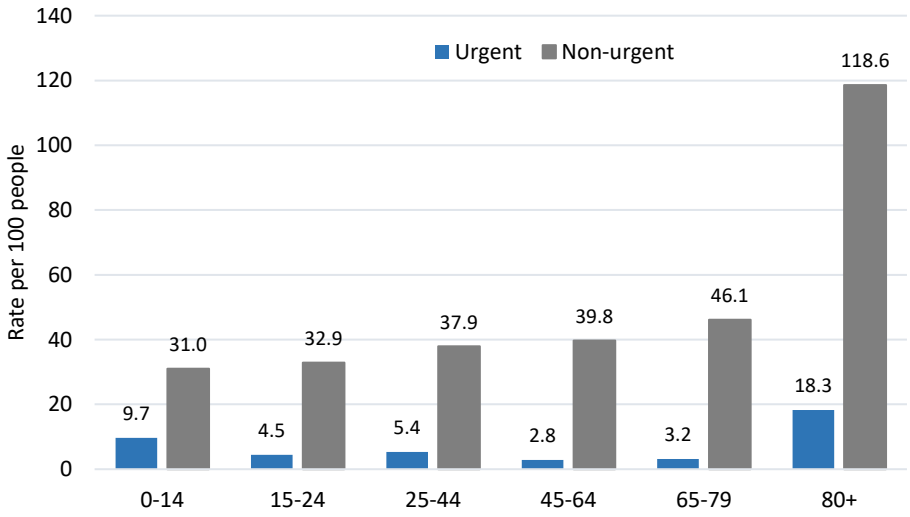
Table 3. Rate of non-urgent GP after hours attendances per 100 people, Gold Coast SA3 regions, 2015-2016 to 2020-2021

Region	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
National	40.0	41.9	43.6	44.2	39.8	31.3
Gold Coast (SA4)	46.4	46.1	48.1	49.3	47.9	40.9
Broadbeach-Burleigh	41.8	38.9	38.2	40.7	41.5	33.5
Coolangatta	37.7	36.4	37.2	37.2	37.0	32.2
Gold Coast-North	53.2	53.8	54.9	53.0	50.7	46.0
Gold Coast Hinterland	32.1	34.3	37.2	40.7	40.1	38.4
Mudgeeraba-Tallebudgera	37.4	37.3	37.4	38.9	36.6	30.8
Nerang	54.9	55.3	55.4	55.1	50.0	40.9
Ormeau-Oxenford	40.2	40.8	49.2	56.6	57.0	48.4
Robina	40.4	40.7	42.6	43.0	41.2	32.9
Southport	64.0	64.1	61.1	55.1	52.6	47.3
Surfers Paradise	52.9	50.6	53.2	50.6	46.9	38.9

Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2013-2014 to 2020-2021. Note: all results are based on the patient's Medicare enrolment postcode, and not where they received the healthcare service.

Figure 4 shows that the rate of non-urgent GP after hours services was highest for people aged 80 years and over (118.5 per 100 people) and lowest for children aged under 14 (31.0 per 100 people).

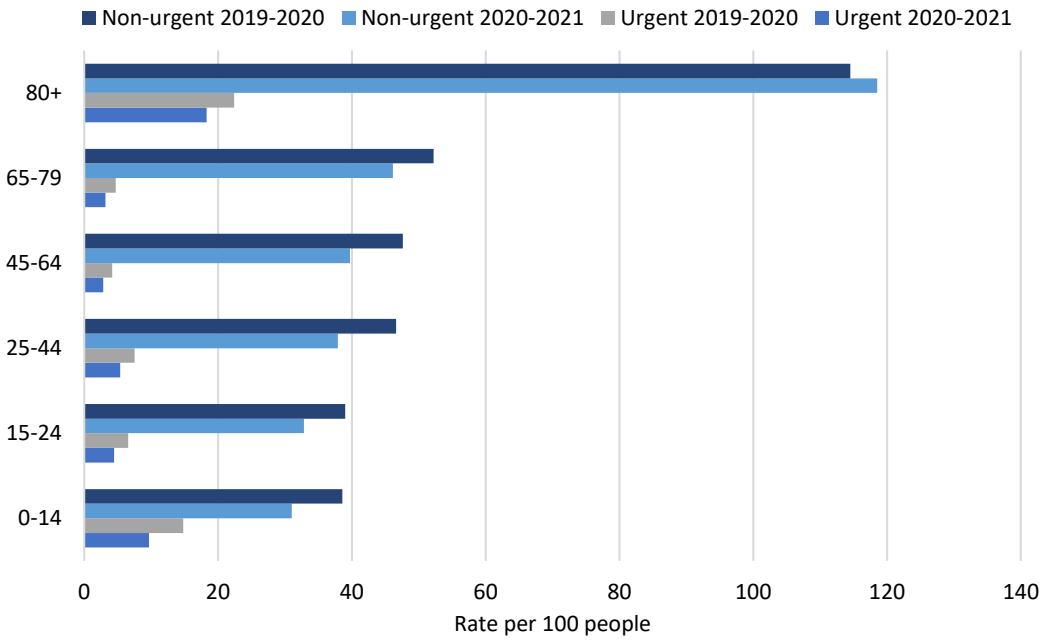
Figure 4. Urgent and non-urgent after hours GP attendances by age cohort, Gold Coast, 2020-2021



Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2013-14 to 2020-2021. Note times vary depending on type of after-hours care, whether urgent or non-urgent, and for services provided at a place other than a consulting room.

Across most age groups there has been a decrease in non-urgent and urgent after hours services between 2019-2020 and 2020-2021, apart from the 80+ cohort has seen an increase in non-urgent services and a decrease in urgent care over the same time period (Figure 5).

Figure 5. Urgent and non-urgent after hours GP attendances by age cohort on the Gold Coast, 2019-2020, and 2020-2021



Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2013-14 to 2020-2021. Note times vary depending on type of after-hours care, whether urgent or non-urgent, and for services provided at a place other than a consulting room.

13 Health

Besides through attending general practice, residents in the GCPHN region can also access after hours care through telephone services, including the Queensland Government's 13 HEALTH, a confidential phone service providing health advice from a registered nurse 24 hours a day, seven days a week at the cost of a local call.

Between July 2021 and June 2022, there was a total of 35,892 calls made to 13 Health by residents of the GCPHN region (accounting for 11.3% of all calls made in Queensland). Of those, 59.3% (n=21,284) of calls were made by females, 34.0% (n=12,205) were by males, 6.1% and 0.1% (n=20) of calls were by intersex persons or persons of indeterminate sex, and for 6.6% (n=2,383), no information was recorded for sex.

Among callers to 13 Health, 92.5% (n=33,192) of patients were neither Aboriginal nor Torres Strait Islander, 3.5% (n=1,260) of callers identified as Aboriginal and/or Torres Strait Islander. Though there is a low number of calls made to 13 Health from people who identify Aboriginal and/or Torres Strait Islander, they are accessing the service at a higher rate of the population (9 calls per 100 people), compared to calls made by non-Indigenous patients (5 calls per 100 people).

Table 4 shows that almost a third of all calls to 13 Health were made by/for children aged 0 to 9.

Table 4. Age groups of people using 13 Health, Gold Coast region, 2021-22

Age group	Number	Percent
0-9	11,069	30.8%
10-19	2,716	7.6%
20-29	6,789	18.9%
30-39	6,121	17.1%
40-49	3,129	8.7%
50-59	2,372	6.6%
60-69	1,715	4.8%
70-79	1,218	3.4%
80+	762	2.1%

Source. 13 Health

In 2021-22, Ormeau – Oxenford SA3 region had the highest rate of people using 13 Health, accounting for 30.5 % of all calls (n=10,937), followed by Broadbeach SA3 at 13.5 % (n=4,848). COVID-19 pandemic, abdominal pain, and chest pain were the leading reasons for calls made to 13 Health.

37% (n=8,249) of the total calls to 13 Health by residents of the GCPHN region made were made during the after hours period (before 8am or after 8pm), and the peak time of calls were between 4pm to 8pm.

The three leading recommendations made by nurses at 13 Health to Gold Coast residents were to Seek emergency care as soon as possible (n=4,679; 13.2%), Schedule an appointment to be seen by the doctor within the next 12 hours (same day) (n=4,124; 11.6%) and Seek face to face care within 1-4 hours (n=2,976; 8.4%).

After hours Emergency Department use

Understanding who uses emergency care services can inform future healthcare planning, coordination, and delivery to ensure that people receive the right care, in the right place, and at the right time. Some lower urgency Emergency Department (ED) presentations may be avoidable through delivery of other appropriate services in the community.

Lower urgency care are ED presentations where the patient:

- had a type of visit to the ED of Emergency presentation,
- was assessed as needing semi-urgent (triage category four: should be seen within one hour) or non-urgent care (category five: should be seen within 2 hours),
- did not arrive by ambulance, or police or correctional vehicle, and
- was not admitted to the hospital, was not referred to another hospital, and did not die.

Emergency care can be accessed in two public hospitals located in Gold Coast: Southport and Robina and three private hospitals, located at Tugun, Benowa and Southport. There is also a public hospital located at the Tweed area, New South Wales, that many GCPHN residents report accessing.

Table 5 highlights that in 2019-2020, the rate of lower urgency care in the after hours period for GCPHN residents attending emergency departments was over 50% lower compared to the national rate (32.9 vs 52.0 per 1,000 people).

The rate of people presenting for lower urgency care in the after hours period has slightly increased in the GCPHN region from 2015-2016 (30.5 per 1,000 people) to 2019-2020 (31.9 per 1,000 people). During the same time, the national rate has decreased from 59.8 to 52.0 per 1,000.

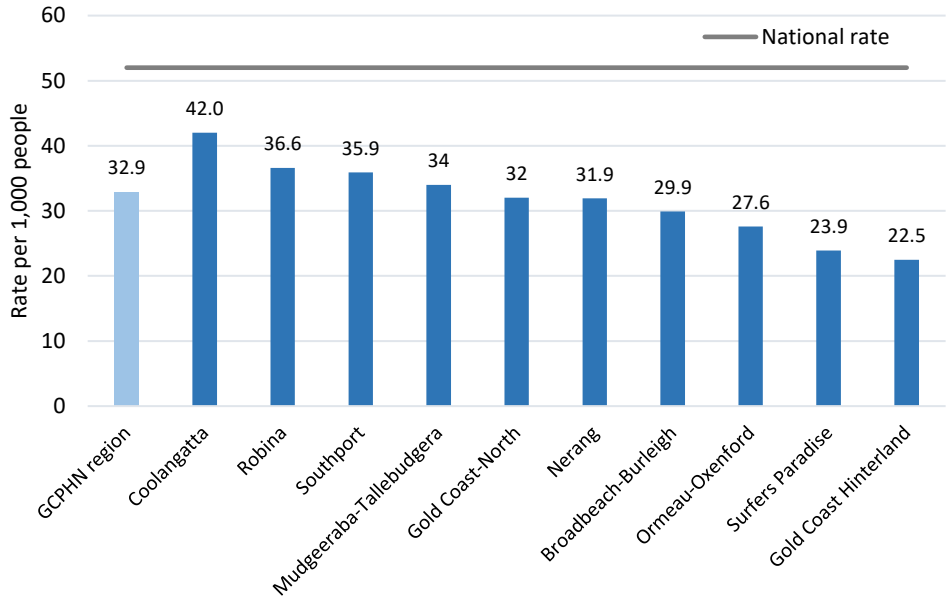
Table 5. Rate of after hours lower urgency emergency department presentations to public hospitals per 1,000 people, Gold Coast SA3 regions, 2015-2016 to 2019-2020

Region	2015-16	2016-17	2017-18	2018-19	2019-20
National	59.8	57.9	56.9	56.9	52.0
Gold Coast (SA4)	30.5	30.5	32.2	31.9	32.9
Broadbeach-Burleigh	27.7	27.4	28.4	29.6	29.9
Coolangatta	45.3	45.1	46.2	44.5	42.0
Gold Coast-North	26.0	27.4	28.3	28.4	32.0
Gold Coast Hinterland	18.1	19.4	20.7	21.0	22.5
Mudgeeraba-Tallebudgera	37.5	37.6	36.7	37.4	34.0
Nerang	31.3	30.6	31.4	31.2	31.9
Ormeau-Oxenford	26.4	26.5	29.4	28.6	27.6
Robina	33.6	32.7	34.4	34.4	36.6
Southport	27.3	26.7	29.9	30.1	35.9
Surfers Paradise	19.8	20.4	21.0	18.9	23.9

Source: Use of emergency departments for lower urgency care, 2015-16 to 2019-2020. This data set is a component of the minimum data set. Note: all results are based on where the person accessing service lived, and not where they received the healthcare service.

In 2019-20, Coolangatta had the highest rate of lower urgency ED presentations (42.0 per 1,000 people) while Gold Coast Hinterland had the lowest rate (22.5 per 1,000 people) (Figure 6).

Figure 6. Rate of lower urgency emergency departments presentations (after hours) per 1,000 people, Gold Coast SA3 regions, 2019-2020



Source: Use of emergency departments for lower urgency care, 2019-2020. Note: all results are based on where the person accessing service lived, not where they received the healthcare service).

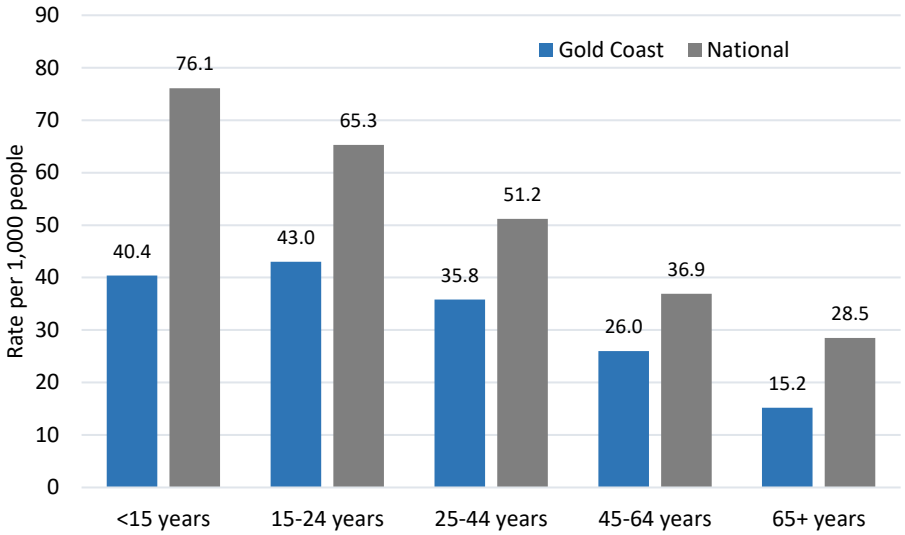
Table 6 shows rates of EDs presentations during after hours for different age groups. Children and young people (15-24 years) attended lower urgency ED care at a higher rate than older age cohorts (Table 6 and Figure 7); this trend was seen in GCPHN and nationally. In contrast, people aged 65+ were more likely to present to general practice in the after hours compared to younger cohorts (Figure 4).

Table 6. Rate of lower urgency emergency departments presentations (after hours) per 1,000 people by age groups, Gold Coast SA3 regions, 2019-2020

	<15 years	15-24 years	25-44 years	45-64 years	65+ years
National	76.1	65.3	51.2	36.9	28.5
Gold Coast (SA4)	40.4	43.0	35.8	26.0	15.2
Broadbeach-Burleigh	35.2	46.5	37.2	24.8	12.6
Coolangatta	43.4	68.5	53.1	37.5	17.8
Gold Coast-North	47.2	47.7	38.3	28	13.9
Gold Coast Hinterland	34.3	26.3	34.7	16.1	7.6
Mudgeeraba Tallebudgera	35.9	43.5	37.7	30.9	21.8
Nerang	41.3	42.3	36.2	25.4	15.5
Ormeau-Oxenford	38.9	36.3	27.1	18.8	11.2
Robina	41.5	42.9	42.2	32.6	22.5
Southport	48.2	44.9	39.6	30.2	19.1
Surfers Paradise	34.0	33.1	26.8	20.5	12.2

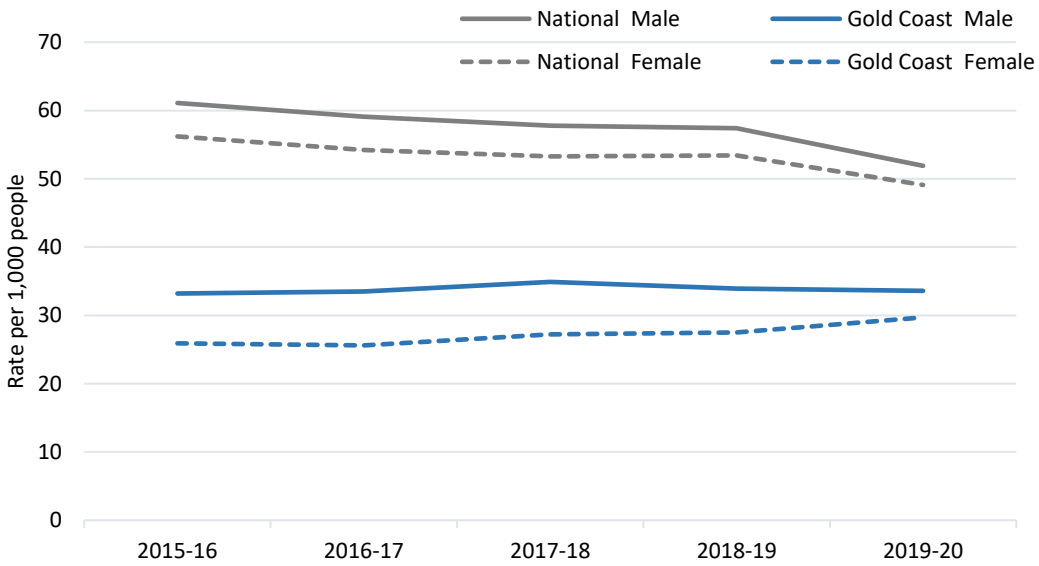
Source: Use of emergency departments for lower urgency care by Statistical Area Level 3 (SA3), 2015–16 to 2019-2020. Note: all results are based on where the person accessing service lived, and not where they received the healthcare service.

Figure 7. Rate of after hours lower urgency emergency departments presentations, by age groups, Gold Coast and national, 2019-2020



Source: Use of emergency departments for lower urgency care by Statistical Area Level 3 (SA3), 2015–16 to 2019-2020. Note: all results are based on where the person accessing service lived, and not where they received the healthcare service.

Figure 8. ED presentations after hours lower urgency care per 1000 people by gender from 2015-2016 to 2019-2020 (AIHW)



Source: Use of emergency departments for lower urgency care by Statistical Area Level 3 (SA3), 2015–16 to 2019-2020. Note: all results are based on where the person accessing service lived, and not where they received the healthcare service.

The top ten reasons/diagnoses for presentations to ED after hours for lower urgency care (triage category 4 and 5) to Gold Coast public hospitals are shown in Table 7.

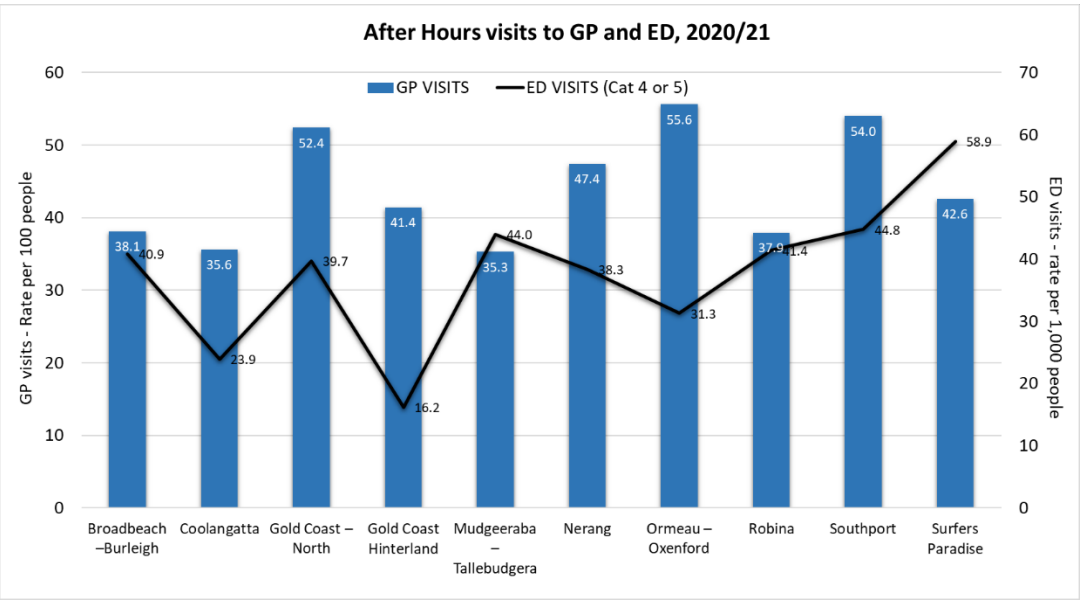
Table 7. Top 10 reasons / diagnosis for lower urgency care presentations in afterhours to Gold Coast Emergency Department, 2021/22

Reasons / diagnosis for presentations after hours	Number	Percent
Sprain and strain of ankle, part unspecified	616	3.1%
Other and unspecified abdominal pain	425	2.1%
Open wound of unspecified body region	412	2.0%
Open wound of finger(s) without damage to nail	341	1.7%
Unspecified injury of head	299	1.5%
Injury, unspecified	295	1.5%
Emergency use of U07.1	283	1.4%
Unspecified dorsalgia, site unspecified	239	1.2%
Pain in limb, ankle and foot	231	1.1%
Open wound of other parts of head	228	1.1%

Source. Gold Coast Hospital and Health Service, 2022

Figure 9 compares the rates of GP visits and lower urgency ED visits in the after hours period across Gold Coast SA3 regions. Ormeau-Oxenford, Gold Coast Hinterland and Nerang had high rates of visits to the GP and low rates of ED visits, suggesting the potential for the greater accessibility of primary health care providers in the after hours leading to reduced presentations to ED for lower urgency health concerns. However, this association is not seen across all regions, and thus warrants further investigation to better understand the relationship between the availability and accessibility of health care providers and patterns of engagement at a regional level.

Figure 9. After hours visits to Gold Coast General Practices and Emergency Department presentation, 2020/21



Source: GP data – AIHW Medicare MBS data (filtered by "Service – GP subtotal – After hours"); ED data – Gold Coast Health (excluding diagnosis B34.9 as it has the majority of Fever clinic presentations).

Mental health

Hospital EDs play a large role in treating mental illness. People seek mental health-related services in EDs for multiple reasons, often as an initial point of contact for after hours care[3]. Mental health-related ED presentations below are defined as presentations to public hospital EDs that have a principal diagnosis of 'Mental and behaviour disorders' as outlined in the ICD-10-AM[4].

In 2019-2020, males had a higher number of mental-health related ED presentations than females in 2019-2020 (53% and 47% of all presentations, respectively) but were more equally represented in all ED presentations (49.9% and 50.1%, respectively). The rate of mental health-related ED presentations for males was higher than the rate for females (127.9 and 115.4 per 10,000 population, respectively)[5].

Data on mental health-related presentations by principal diagnosis is based on the broad categories within the 'Mental and behaviour disorders' chapter of the ICD-10-AM. More than 76% of mental-health related ED presentations in Australian EDs were classified by four principal diagnoses grouping in 2019-2020:

- mental and behavioural disorders due to psychoactive substance use (F10–F19) (28.1%),
- neurotic, stress-related and somatoform disorders (F40–F49) (27%),
- Schizophrenia, schizotypal and delusional disorders (F20–F29) (11.9%), and
- mood (affective) disorders (F30–F39) (9.7%).

The arrival mode records the transport mode of arrival to the emergency department. Just over half of mental health-related ED presentations in 2019-2020 arrived via ambulance (50.5%). This was almost double the proportion of all ED presentations that arrived by ambulance (26.9%).

In the GCPHN region, there was a total of 6,586 mental health-related ED presentations in 2019-2020. Of those, just under 40% were during the after hours period. Ormeau-Oxenford SA3 region had the highest number of mental health-related ED presentations (n=1,222), followed by Southport (n=988).

Table 8 shows the rate per 10,000 of mental health-related ED presentations. Southport and Gold Coast-North SA3 regions had the highest rate of mental health-related ED presentations in the past four years.

[3] Morphet J, Innes K, Munro I, O'Brien A, Gaskin CJ, Reed F et al. 2012. Managing people with mental health presentations in emergency departments—A service exploration of the issues surrounding responsiveness from a mental healthcare consumer and carer perspective. Australasian Emergency Nursing Journal 15:148-55

[4] International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australia Modification 10th Edition

[5] National Non-admitted Patient Emergency Department Care Database.

Table 8. Rate of emergency department mental health-related presentations in public hospitals per 10,000 people, Gold Coast SA3 regions, 2014-2015 to 2019-2020

Region	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20
National	107.8	115.8	113.6	115.8	120.5	121.6
Queensland	115.7	118.6	115.0	114.9	118.0	128.3
Broadbeach-Burleigh	104.5	107.1	109.2	113.1	114.0	100.6
Coolangatta	124.2	117.7	115.9	130.0	130.1	115.0
Gold Coast-North	126.1	135.7	142.7	147.1	150.9	128.2
Gold Coast Hinterland	73.3	73.0	79.6	72.0	75.1	94.7
Mudgeeraba-Tallebudgera	69.9	79.4	85.4	89.0	84.7	68.0
Nerang	99.3	101.6	97.4	97.5	108.9	80.0
Ormeau-Oxenford	76.4	81.8	87.4	86.4	86.3	81.6
Robina	94.7	100.0	112.1	116.1	106.6	98.4
Southport	150.5	166.9	160.0	154.7	166.1	156.2
Surfers Paradise	119.7	130.8	114.7	101.4	111.8	129.0

Source: Mental health services provided in emergency departments 2019-2020 by National, state, and SA3 regions. Data are mapped to patient's residential postcode. This data set is a component of the minimum data set.

In 2019 to 2020, the highest proportion of mental health-related ED presentations was among patients aged 18–64 (79.4%), followed by patients aged 65+ (12.0%) in the GCPHN region. Aboriginal and Torres Strait Islander people, who represent about 1.8% of the Gold Coast population, accounted for 4.4% of mental health-related ED presentations. Nationally, the rate of mental health-related ED presentations for Indigenous Australians was more than 4-times higher than for other Australians (480.9 and 107.9 per 10,000 population, respectively).

Table 9: Distribution ofhealth-related emergency department presentation in public hospitals, by age group, Gold Coast, 2014-2015 to 2019-2020

Age group	2014–15	2015–16	2016–17	2017–18	2018-19	2019-20
0-4	0.2%	0.3%	0.3%	0.4%	0.3%	0.2%
5 to 11	1.4%	1.5%	1.6%	1.5%	1.5%	1.3%
12 to 17	8.6%	8.8%	9.1%	9.0%	9.5%	7.1%
18-64	80.8%	80.4%	78.0%	77.3%	77.9%	79.4%
65+	8.9%	9.0%	11.0%	11.8%	10.9%	12.0%

Source: State and territory health authorities (2004–05 to 2013–14); National Non-admitted Patient Emergency Department Care Database (2014–15 onwards). Data are mapped to patient's postcode.

After hours mental health (Safe Space)

The After-Hours Safe Space service is a low to moderate intensity community-based service, with sites situated in both Mermaid Beach and Southport. The service provides a place for mental health consumers to go to when they need support outside of business hours, or when access to their usual support may not be available. The service provides a warm and welcoming café style environment where consumers can walk in and access face-to-face supports form lived experience workers, with further support available from a specialised mental health clinician if needed.

The Mermaid Beach site has successfully been operational since 2018. This initial service funded by the Gold Coast Primary Health Network (GCPHN) saw the successful commissioning of a non-government provider who has since also been commissioned to operate the second site, being a codesign between GCPHN and the Gold Coast Health (GCH). Queensland Health provided funding across the state to implement After Hours Safe spaces, and Gold Coast Health secured funding for a community based safe space (as opposed to a hospital-based service) for the Gold Coast catchment. This provided the opportunity for a working co-design between the GCPHN and GCH for a regional model based on the existing Mermaid Beach non-government model, with the new service being situated in Southport and refined with operating hours, procedures etc. The Mermaid Beach service remains operational with some changes to align with the Southport site. Both are operational 7 days a week (6pm to 9pm Monday - Friday, 12pm to 8pm Saturday - Sunday).

In 2021-22, across the two sites there was a total of 2,099 service contacts (1,523 at Mermaid Beach location and 576 at Southport):

- Most popular times both services are accessed is between 6pm-8pm Monday – Friday, and between 12pm-5pm on the weekend;
- A small percentage of people accessing the service are consumers with access to NDIS supports (Mermaid Beach 2.5%, Southport 3.5%);
- Around a third of people attending the service reported an improvement in mood after attending the service for supports;
- Around 45% of clients reported that attending the afterhours service provided an alternative to seeking supports through the Emergency Department.

The service has improved linkages with other external support services which has now seen many homeless clients no longer attending the service as they linked into suitable alternative services.

Many of the attendees of the service are from surrounding suburbs with limited attendees from Ormeau-Oxenford SA3 region which has been highlighted above as a GCPHN region with the highest number of mental health-related ED presentations. The uptake of this service reflects the need for additional after-hours services across the wider GCPHN region.

Alcohol and other drugs

ED presentations relating to mental and behavioral disorders due to alcohol and other drugs accounted for over 2,000 presentations to ED in the 2021-22 financial year. The majority, almost 1,400 of these occur in the after hours period. Presentations relating to the use of alcohol accounted for almost 70% of the AOD presentations in the after hours. Please note that people who present primarily for an injury incurred while intoxicated may not be reflected in these numbers[6].

Data sourced from 153 general practices in the GCPHN region via Primary Sense™ indicated that in 2021, around 5,500 presentations were due to alcohol or other drug issues. Alcohol was identified as a health concern more frequently compared to other drugs.

GCPHN currently funds two providers to deliver services to support people to cease/reduce use of alcohol and other drugs. In reviews undertaken both have identified the need for after hours service provision in order to optimize patient engagement and successful completion of treatment. This is particularly important to allow parents and carers who are supporting young people, or for people with work, care or other family responsibilities.

[6] Gold Coast Hospital and Health 2021/22 ED presentations

Service system

Services	Number in the GCPHN region	Distribution	Capacity discussion
General Practice	212	Clinics are generally distributed across the GCPHN region, with the majority located in coastal and central areas. Numbers of general practices open during extended hours: • Extended hours Monday-Friday 11pm to 8am: 10 • Extended hours Monday-Friday to 10PM: 14 • Extended hours Saturdays after 12 noon: 64 • Extended hours Sundays: 54 • Extended hours public holidays: 50 There is **one** practice open between the hours of 11pm and 6am.	• 855 GPs in the GCPHN region. • 32 practices deliver speciality services such as skin checks. • Average number of GPs per general practice is 4.0. • 87% of general practices are accredited or currently working towards accreditation.
Medical Deputising Services	4	In home and after-hour visits from doctor. Available across most of GCPHN region with hinterland areas less well serviced.	• All consultations are bulk billed for Medicare and DVA card holders. • Depending on the provider, appointments can be requested by phone or online.
Pharmacy	131	Pharmacies with extended hours are well distributed across the GCPHN region: • Extended hours Monday-Friday 11pm to 8am: 1 • Extended hours Monday-Friday to 10PM: 6 • Extended hours Saturdays after 12 noon: 21 • Extended hours Sundays: 18 • Extended hours public holidays: 15	• Medication dispensing • Medication reviews • Medication management • Some screening and health checks
Emergency Departments	6	Southport and Robina (public)	• Private health insurance is required to access private EDs. A gap payment may also be incurred.

		Southport, Robina, Benowa and Tugun (private)	• Limited integration with general practice data. • Residents near borders may also use nearby hospitals such as Tweed, Logan, and Beaudesert.
Crisis stabilisation unit	1	Robina	For people who are experiencing a current mental health crisis. Referral from ED or 1300MHcall.
Online and phone support	4	Phone or online	• Healthdirect • 13 HEALTH – health information and advice • Lifeline crisis support service • PalAssist – 24-hour palliative care support and advice line • Medinet
After hours safe space (community based mental health service)	2	• Mermaid Beach and Southport sites: • 6pm – 9pm Monday to Friday • 12pm – 8pm Saturday and Sunday	• Walk-in: no referral or appointment required. • Capacity of approx. 15 people at any one time. • Operates under a COVID-safe plan as required, which limits how many people can attend at one time.
AODs withdrawal services with after hours delivery		• 2	Accessibility enhanced by availability of outside of hours appointments.
WiSE	1	• Robina	Private fee for service walk-in emergency clinic opened in September 2022.
Urgent Care Clinics	TBA	• TBA	Both the State and Federal Governments have made announcements regarding establishment of urgent care clinics and/or satellite hospital facilities. However, we await more details.

Consultation

Community facing survey (June 2022)

An online community survey received 44 responses from community members residing in the GCPHN region.

Survey findings

- The majority of respondents had awareness of multiple after hours services available.
- Method of awareness either an online search or through word of mouth.
- 33%of respondents accessed after hours services multiple times in the previous 12 months.
- The majority of people opted for face-to-face services in the after hours period, with 38% of people seeing an after hours GP at a clinic and 34% seeing a home visiting doctor.
- 56% of people accessing the services were accessing on behalf of someone else.
- Predominant reasons for using after hours services:
    - did not perceive their health issue as an emergency
    - to avoid long wait times in ED
    - their GP was not available
    - inability to travel
    - to get a prescription
    - potentially having COVID 19
- The majority of respondents had a positive experience engaging with after hours services.
- Some comments on what would make the services improve: a need for more staff to meet the demands of the GCPHN region; not enough services that take walk-ins after hours; long wait times for house home call doctors; and a need for more after hours pharmacies.
- There is a great need for more face-to-face clinics, and an increased workforce.

Consultation with medical deputising services (July 2022)

GCPHN consulted with three medical deputising services that service the GCPHN region. Medical deputising services provide urgent and non-urgent primary health care to patients either at home or at RACFs and are often referred to as house call doctors.

Most common reasons for call outs

- Mothers calling for their young children often needing reassurance
- Rash, abdominal pain, cough, injuries, and medical certificates
- Lack of access to regular GP including during hours

Major challenges that deputising services are currently facing

- Work force issues, particularly the inability to retain or attract workers was cited by some providers.
- Previous changes to MBS items that impacted the financial incentive to work in the after hours space.
- Limited capability to service hinterland areas, and the region south of Burleigh.

- There is not enough after hours GP clinics in the GCPHN region to service the population. Many clinics are open 'after hours' but are closing at 8pm leaving a gap with those open in the later hours of the night or early hours in the morning.

RACF specific challenges for deputising services

- Impacts of COVID 19 on accessibility to servicing RACFs creating barriers with inconsistent requirements of entry (PPE, RAT tests) therefore increasing time before treating patient and getting to the next appointment.
- Logistical issues such as gaining access to the facility, this is a time consuming process which impacts on the financial viability of these visits.
- Further barriers for RACFs are lack of availability of staff to show the Doctor where to go or provide a handover to ensure the patient is assessed properly. This can often lead to unnecessary hospitalisations.

Consultation with general practices in the Hinterland area (July 2022)

Current arrangements in place for servicing their patients after hours

- Practices in the Gold Coast Hinterland have arrangements with alternative providers (deputising/telehealth). However, face-to-face services are limited which may lead to hospitalisations.
- Though these practices do have capacity to see the patient the following morning if needed.
- Most residents requiring face to face attendance are presenting to ED.

Challenges for Hinterland practices

- After hours telehealth is not a replacement for house call doctors or clinic open after hours.
- Older residents in the Hinterland cannot easily access pharmacies or their medication.
- The lack of workforce is hindering the practices' ability to provide longer opening hours.

Consultation with RACFs (September 2022)

- Most common times for call bells and falls in facilities is between 5pm-9pm.
- Both the Regional Assessment Service (RAS) and the Specialitst Palliative Care in Aged Care (SPACE) team help the RACFs to prevent hopitalisations and provide a "great advisory service". Having their input reduces need for after hours interventions.
- At times there can be a long wait for an after hours provider to attend. This is particularly a problem if a person is palliative and deteriorates quickly, necessitating additional medication.
- Due to decreasing availability of bulk billing GPs, residents may not seek services in a timely way from usual GP. This makes the facility more reliant on after hours services.
- Common reasons for hospitalisation are infections, pneumonia, minor falls for a check-up and monitor.
- Barriers to after hours care for residents are often internal operational issues such as, rostering staff over the peak period of 5pm-9pm, and lack of staff availability to ensure that deputising services have access to the building and provide appropriate clinician information once they arrive.

GCPHN Community Advisory Council (CAC) (1 July 2022)

- There are longer wait times for home visiting medical deputising services than there have been in the past.
- After hours medical deputising services not servicing Hinterland areas.
- Some concerns were raised about the variability of the quality of clinicians, wait times and areas such as Surfers Paradise not well serviced.
- CAC members want to see a balance between convenience and appropriate use of government resources.
- There is a limited understanding by public of costs associated with different after-hours options as most are experienced by patients as “free”, limited health literacy of access to service options.
- People feel more confident about going to ER, knowing that “the problem” will be sorted out.

Unplanned Hospital Care

Local health needs and service issues

- Rate of potentially preventable hospitalisations (PPH) in the GCPHN region is above the national rate. Top conditions included:
    - urinary tract infections
    - iron deficiency anaemia
    - dental conditions
    - cellulitis
    - ear, nose and throat infections
- Lower urgency care (triage category 4 and 5) ED presentations have been increasing annually above the Gold Coast population growth rate.
- Chronic obstructive pulmonary disease had the most potentially preventable hospitalisation bed days in 2019-2020 in the GCPHN region.

Key findings

- The GCPHN region had the second lowest rate per 1,000 people amongst all PHNs for lower-urgency (triage category four and five) ED presentations in 2018-2019.
- Leading potentially preventable hospitalisations (PPH) among residents of the GCPHN region in 2019-2020:
    - urinary tract infections, including pyelonephritis (359 PPH per 100,000 people)
    - iron deficiency anaemia (309 PPH per 100,000 people)
    - dental conditions (300 PPH per 100,000 people)
    - cellulitis (243 PPH per 100,000 people)
- Gold Coast Hospital and Health Service (HHS) had the lowest PPH (as a proportion of total episodes) of all Queensland HHSs from 2018-2019 to 2020-2021.
    - In 2018-2019, 7.7% of episodes were potentially preventable (Queensland: 8.8%)
    - In 2019-2020, 7.5% were potentially preventable (Queensland: 8.7%)
    - In 2020-2021, 6.9% were potentially preventable (Queensland: 8.0%)
- Younger residents of the GCPHN region are using 13 Health at a higher rate compared to older residents; the leading recommendation made by nurses was to 'Seek emergency care as soon as possible'.

Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPH) are used as a measure of access to timely, effective and appropriate primary and community healthcare. PPH are specific hospital admissions that could potentially have been avoided through preventative health interventions (such as vaccination), or appropriate individualised disease management (such as treatment of infections or management of chronic conditions) in the community.

Classifying a hospitalisation as "potentially preventable" does not mean that the hospitalisation itself was unnecessary, it means the optimal management at an earlier stage might have prevented the patient's condition from worsening to the point where they needed hospitalisation.

PPHs are grouped into three broad categories:

- vaccine preventable
- acute conditions
- chronic conditions

Prevention of hospitalisations

Primary healthcare interventions that help people avoid hospitalisations for some conditions include:

- reducing and managing risk factors for disease,
- vaccination,
- oral health checks,
- sexual health checks,
- antenatal care,
- diagnosis and prescribing to manage infections,
- lifestyle interventions to reduce the development of chronic conditions, and
- management of chronic conditions to slow progression and risk of complications, including support for self-management.

This care is usually delivered by general practitioners (GPs), medical specialist, dentists, nurses, and allied health professionals and may be accessed through a variety of community settings, including Aboriginal and Community Controlled Health Services.

Factors that affect PPH other than primary care

PPH are a useful tool to identifying and investigating variation in health outcomes between different populations. It is important not to assume that higher rates of PPH always indicate a less effective primary care system. There are other reasons why an area or group of people may have higher rates of PPH – including higher rates of disease, lifestyle factors and other risk, as well as genuine need for hospital services.

Some PPH may not be avoidable, such as those by chronically ill or elderly patients who have received optimum primary care, or procedures such as tonsillectomies that are an appropriate follow-up to primary care.

Changes in hospital coding standards, admission policies and clinical policies can artificially affect PPH rates – conditions knowns to be impacted include:

- hepatitis B
- iron deficiency anaemia

- angina and some conditions requiring rehabilitation care

Most common type of PPH on the Gold Coast

In 2019-20, 20,359 residents of the GCPHN region were admitted to hospital for a PPH, which accounted for approximately 6.6% of all hospital admissions[1]. Overall, the most common reason for hospitalisation was urinary tract infections, including pyelonephritis. Urinary tract (acute PPH) and chronic obstructive pulmonary disorder (COPD) accounted for the most days of hospital care, reflecting their tendency to affect elderly people who often require more complex or longer-term hospital care.

Age groups affected by PPH

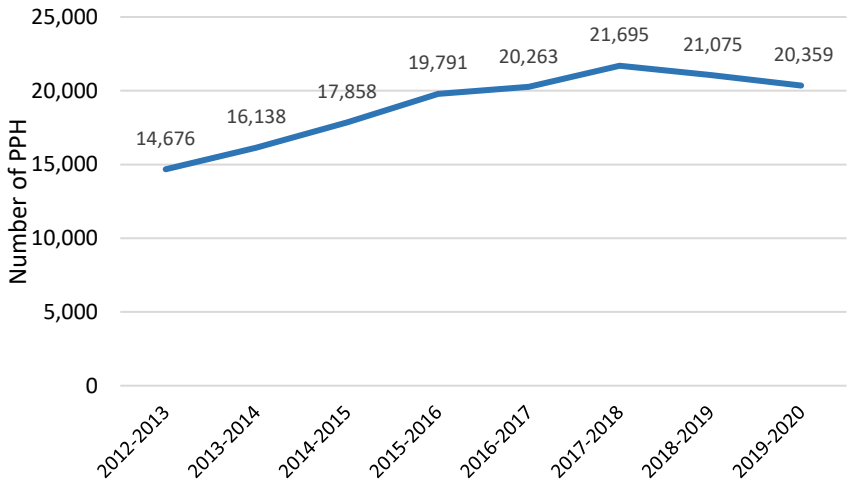
Of the 20,359 admissions of residents in the GCPHN region, 10,324 (50.0%) were under 65 years of age and 10,034 (49%) were 65 years and over[2]. A wider disparity was observed in bed days (from admission to separation) among the two age cohorts.

Of the total 67,351 bed days from PPH among residents of the GCPHN region in 2019-2020, people aged 65 years and under accounted for 35%, and people aged 65 years and over accounted for 65%. Across major public hospitals, the average cost to treat acute admitted patients was $4,680 in 2014-2015[3]. There is continuing debate about the 'preventability' of hospital admissions in older people, due to complexity of disease that is often seen in these age groups.

Total PPH

Total PPH is a grouping of total acute, total chronic and total vaccine preventable. The GCPHN region's rate of PPH have increased by 39% from 2012-13 to 2019-20, while the growth rate of the Gold Coast population was 20% in the same period[4,5]. Figure 1 highlights the increase of PPH in the GCPHN region from 2012-13 to 2017-18 with a slight decrease from 2017-18 to 2019-20.

Figure 1. Potentially preventable hospitalisations, Gold Coast, 2012-2013 to 2019-2020



[1] Disparities in potentially preventable hospitalisations across Australia, Australian Institute of Health and Welfare, 2012-2013 to 2017-2018
[2] AIHW (Australian Institute of Health and Welfare) 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20. Cat. No. HPF XX. Canberra: AIHW.
[3] Hospital Performance: Cost of acute admitted patients in public hospitals from 2012-2013 to 2014-2015
[4] Disparities in potentially preventable hospitalisations across Australia, Australian Institute of Health and Welfare, 2012-2013 to 2017-2018
[5] Australian Bureau of Statistics. Regional Population Growth, Australia, ABS 3218.0, various editions

Source: Australian Institute of Health and Welfare. Disparities in potentially preventable hospitalisations across Australia, 2012-2013 to 2017-2018. This data set is a component of the minimum data set.

As seen in Table 1, from 2012-2013 to 2019-2020 the total number of PPH increased by 39%, acute PPH increased by 26%, chronic PPH increased by 39% and vaccine preventable PPH increased by 246%. In the same period, the population growth in the GCPHN region was 20%[6].

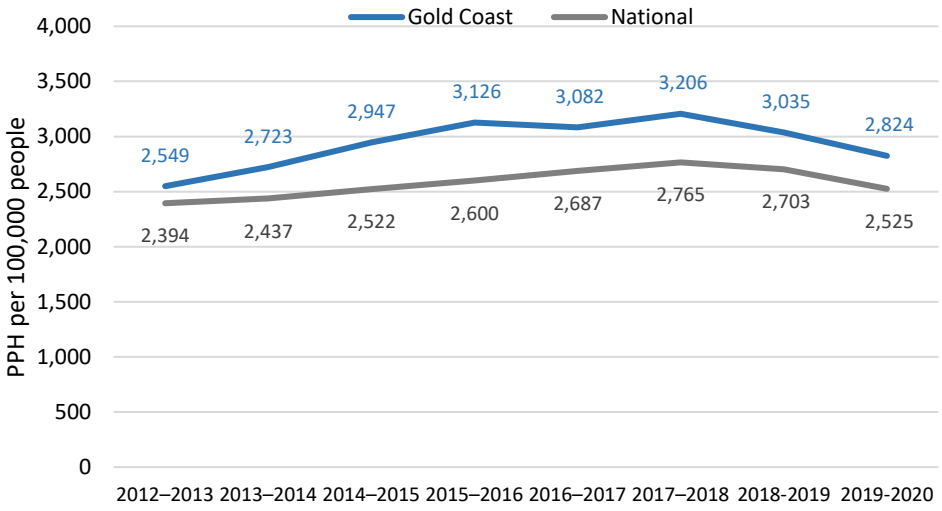
Table 1. Number of PPH and total PPH bed days, Gold Coast, 2012-2013 to 2019-2020

	Number of PPH		Change %	Total PPH bed days		Change %
	2012–13	2019-20		2012–13	2019-20	
Total PPH	14,676	20,359	39%	52,493	67,351	28%
Acute PPH	7,561	9,535	26%	22,291	27,171	22%
Chronic PPH	6,717	9,307	39%	27,855	32,614	17%
Vaccine preventable PPH	485	1,676	246%	2,893	8,788	204%

Source: Disparities in potentially preventable hospitalisations across Australia, Australian Institute of Health and Welfare, 2012-13 to 2019-20

From 2017-18 to 2019-20, both nationally and the Gold Coast has seen a decrease in potentially preventable hospitalisations (Figure 2).

Figure 2. Total PPH per 100,000 people, national and Gold Coast, 2012-13 to 2019-20



Source: Australian Institute of Health and Welfare 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20. Cat. No. HPF XX. Canberra: AIHW.

Vaccine-preventable conditions

Diseases that can be prevented by vaccination are categories into pneumonia and influenza (vaccine-preventable) and other vaccine preventable conditions. Other vaccine-preventable conditions include:

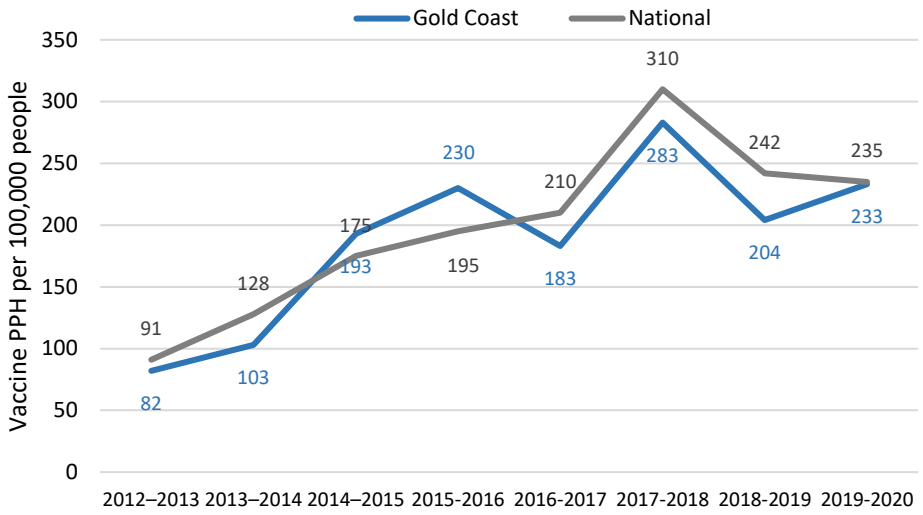
- chicken pox (varicella)
- diphtheria
- haemophilus meningitis
- hepatitis B
- German measles (rubella)
- measles

[6] ABS 3218.0, Regional Population Growth, Australia, various editions

- mumps
- polio
- rotavirus
- tetanus
- whopping cough (pertussis)

Vaccine preventable PPH in the GCPHN region have increased from 82 per 100,000 people (n=465) in 2012-13 to 233 per 100,000 (n=1,676) in 2019-2020, an increase of 260%. There was a peak in 2017-18 which dropped in 2018-20; this could be explained by COVID-19 restrictions reducing exposure to vaccine preventable conditions.

Figure 3. Vaccine PPH per 100,000 people, national and Gold Coast, 2012-13 to 2019-20



Source: AIHW (Australian Institute of Health and Welfare) 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20. Cat. No. HPF XX. Canberra: AIHW

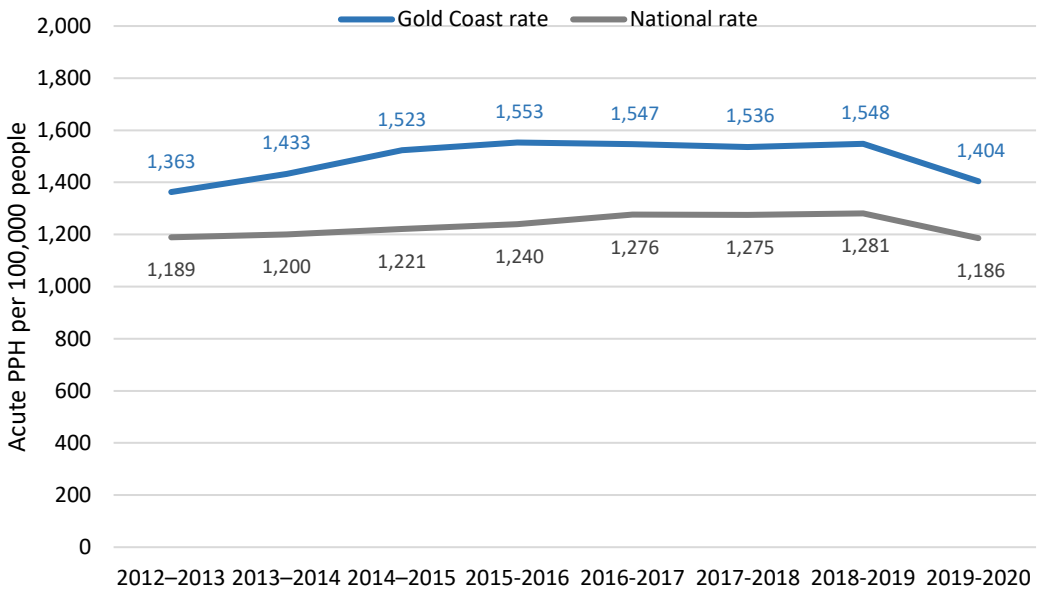
Acute conditions

These are conditions that theoretically would not result in hospitalisation if adequate and timely care (usually non-hospital) was received. They include:

- cellulitis
- convulsions and epilepsy
- dental conditions
- ear, nose, and throat infections
- eclampsia
- gangrene
- pelvic inflammatory disease
- performed/bleeding ulcer
- pneumonia (not vaccine-preventable)
- urinary tract infections (including kidney infections)

The number of acute PPH have increased 26% from 2012-13 to 2019-20. In 2019-20, a total of 9,535 residents (1,404 per 100,000 people) in the GCPHN region were hospitalised for potentially preventable acute conditions, which accounted for 27,171 bed days. Figure 4 shows the steady incline between 2012 and 2019, followed by a decline in acute PPHs for the 2019-20 period which could be attributed to the start of COVID-19 with less people exposed to communicable acute conditions paired with reluctance to present to hospital during the pandemic.

Figure 4. Total acute PPH per 100,000 people, national and Gold Coast, 2012-13 to 2019-20



Source: AIHW (Australian Institute of Health and Welfare) 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20. Cat. No. HPF XX. Canberra: AIHW

Urinary tract infections

Up to half of all women will get a UTI in their lifetime[7] while women are about 50 times more likely to get a UTI than men[8]. One in four women is likely to have a repeat UTI[9]. Prevalence increases with age in men and women[10].

In 2019-2020, urinary tract infections (UTI), including pyelonephritis, was the leading PPH in the GCPHN region, with a rate of 359 per 100,000 people. This is 33% higher compared to the national rate of 270 per 100,000 people.

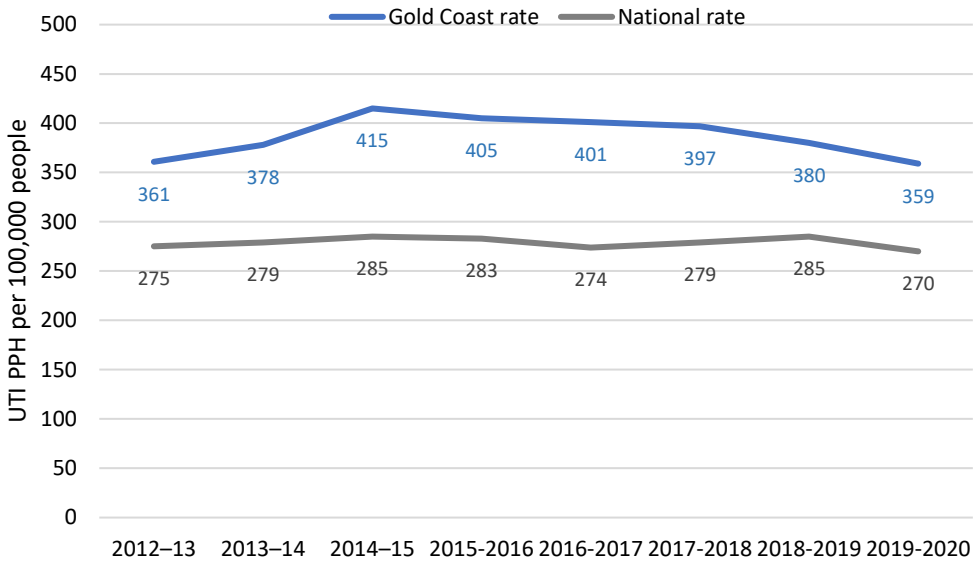
[7] Foxman B 2002. Epidemiology of urinary tract infections: incidence, morbidity, and economic costs. The American Journal of Medicine 113(1):5-13

[8] Zalmanovici Trestioreanu A, Green H, Paul M, Yaphe J & Leibovici L 2010. Antimicrobial agents for treating uncomplicated urinary tract infection in women. Cochrane Database of Systematic Reviews 10.

[9] Franco AV 2005. Recurrent urinary tract infections. Best Practice & Research: Clinical Obstetrics & Gynaecology 19(6):861-73.

[10] RACGP (The Royal Australian College of General Practitioners) 'Silver Book' National Taskforce 2006. Medical care of older persons in residential aged care facilities (4th edition). Melbourne: The Royal Australian College of General Practitioners.

Figure 5. Urinary tract infections PPH per 100,000 people, national and Gold Coast, 2012-13 to 2019-20



Source: AIHW (Australian Institute of Health and Welfare) 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20. Cat. No. HPF XX. Canberra: AIHW

Chronic conditions

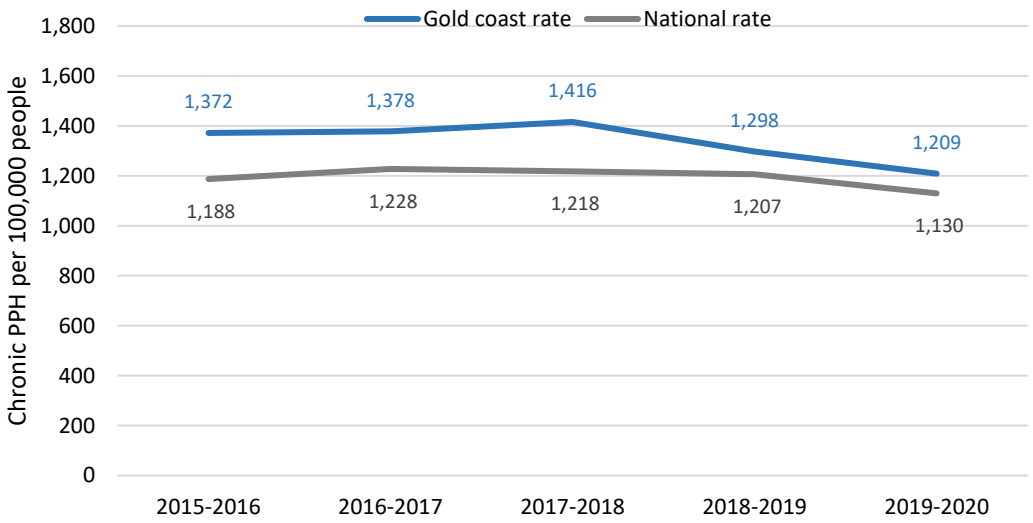
These are conditions that may be preventable through behaviour modification and lifestyle change but can also be managed effectively through timely care (usually non-hospital) to prevent deterioration and hospitalisation. They include:

- angina
- asthma
- bronchiectasis
- chronic obstructive pulmonary disease (COPD)
- congestive cardiac failure
- diabetes complications
- hypertension
- iron deficiency anaemia
- nutritional deficiencies
- rheumatic heart disease

The number of chronic PPH have increased by 39% from 2012-2013 to 2019-2020. In 2019-2020, the total chronic PPH rate was 1,209 per 100,000 (n=9,307) in the GCPHN region compared to the national rate of 1,130 per 100,000 people (Figure 6).

In the GCPHN region hospitalisations for potentially preventable chronic conditions accounted for 32,614 bed days.

Figure 6. Total chronic PPH per 100,000 people, national and Gold Coast, 2015-16 to 2019-20

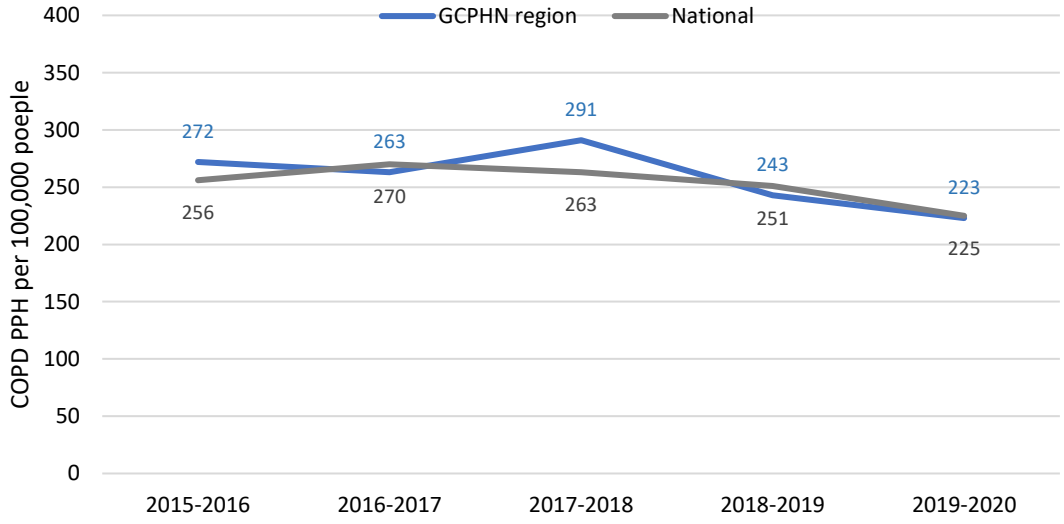


Source: AIHW (Australian Institute of Health and Welfare) 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20. Cat. No. HPF XX. Canberra: AIHW

COPD

In 2017-2018, COPD was the third leading PPH with a rate of 296 per 100,000 people, which is 11% higher compared to the national rate of 267 per 100,000 people. In 2019-2020, CPOD dropped to the sixth leading PPH in the GCPHN region (223 per 100,000), dropping below the national rate (225 per 100,000).

Figure 7. Chronic obstructive pulmonary disease PPH per 100,000 people, national and Gold Coast, 2015-16 to 2019-20



Source: AIHW (Australian Institute of Health and Welfare) 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20. Cat. No. HPF XX. Canberra: AIHW

Smoking is the most common risk factor for COPD - although it is worth noting that in 2017-2018, one quarter (26%) of people aged 45 and over with COPD had never smoked cigarettes[11].

Data from GCPHN's PATCAT system[12] shows that as of March 2022, of the 587,244 active patients (having had three visits in the past two years) 2% (n=13,401) had a coded COPD diagnosis. Table 2 highlights risk factors and management recorded for COPD from 174 general practices in the GCPHN region.

Table 2. Active patients with coded COPD diagnosis, risk factors and management recorded, March 2022

	Number	Rate
Total Population	587,244	
Active patients with coded chronic obstructive pulmonary disease diagnosis	13,401	2%
Active patients with COPD and smoking status recorded	13,095	98%
Active patients with COPD and blood pressure recorded	12,049	90%
Active patients with COPD and a GPMP in the last year	8,482	63%
Active patients with COPD and TCA in the last year	8,024	60%

Source. PATCAT

Emergency departments for lower urgency care

Many people present to an Emergency Department (ED) for health conditions that may be managed more appropriately and effectively in a different healthcare setting, such as through their GP. Understanding who uses emergency care services can inform healthcare planning, coordination, and delivery to ensure that people receive the right care, in the right place, at the right time.

Lower urgency care is defined as presentations at formal public hospital EDs where the person:

- was assessed as needing semi-urgent (triage category 4) or non-urgent (triage category 5)
- did not arrive by ambulance, or police or correctional vehicle.
- was not admitted to the hospital, was not referred to another hospital and did not die.

The Australian Bureau of Statistics Patient Experience Survey found that 14.7% of respondents aged 15 and over who visited ED for any reason though their care could have been managed by a GP[13].

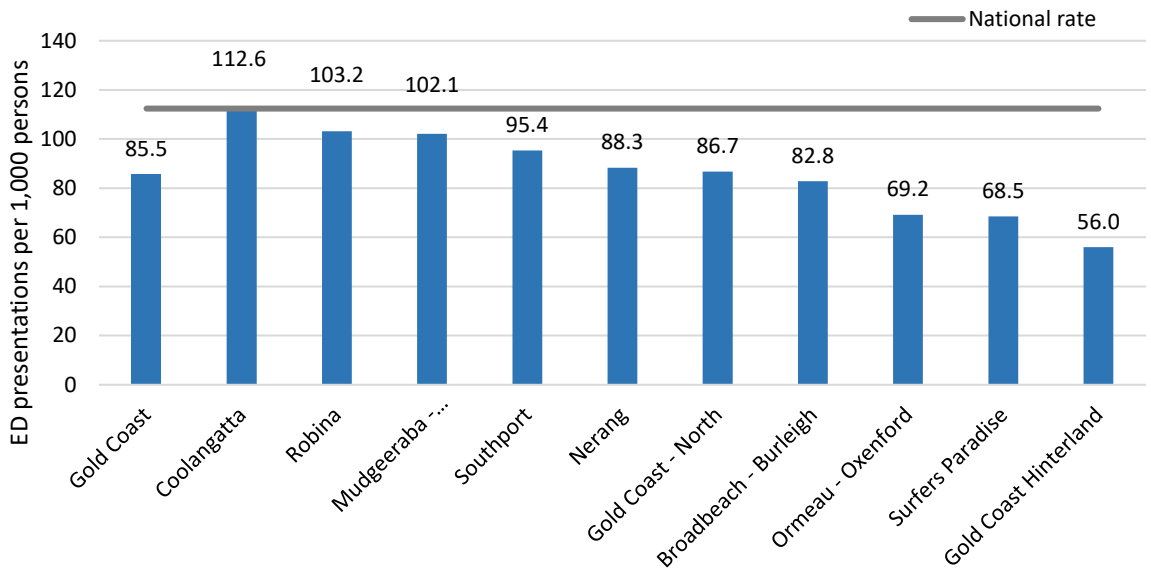
Analysing local data, all SA3s in the GCPHN region were below the national rate of 112.4 per 1,000 people for all hours lower urgency ED presentations, except for Coolangatta (112.6 per 1,000 people). A reason for this may be the limited after-hours services available in this region. The data in the report is mapped to the patients address meaning a patient living in Coolangatta SA3 region who visited Tweed Heads ED would be included.

[11] AIHW 2019d. Chronic obstructive pulmonary disease (COPD), associated comorbidities and risk factors. Cat. no. ACM 40. Canberra: AIHW

[12] PAT CAT is a web-based interface that aggregates de-identified General Practice data for population health management and research programs

[13] Patient Experiences in Australia: Summary of Findings, Australian Bureau of Statistics, 2020-21

Figure 8. Lower urgency ED presentations per 1,000 persons, Gold Coast SA3 regions, 2019-20



Source: Australian Institute of Health and Welfare (AIHW) analysis of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), 2015–16, 2016–17, 2017–18, 2018–19 and 2019-20

In 2019-20, Coolangatta had the highest rate of lower urgency ED presentations (112.6 per 1,000 people), and Ormeau-Oxenford region had the highest total number of lower urgency ED presentations. This mirrors the Ormeau-Oxenford SA3 having the largest population in the GCPHN region (n=6,383). Table 3 shows the total number of lower urgency ED presentations for in and after hours in 2019-2020.

Table 3. Total number of in hours and after hour's lower urgency ED presentations, Gold Coast SA3 regions, 2019-2020

Region	In-hours lower urgency ED presentations	After-hours lower urgency ED presentations	Lower urgency ED presentations – total
Gold Coast SA4	55,016	20,358	34,657
Broadbeach - Burleigh	3,518	1,990	5,508
Coolangatta	4,117	2,445	6,562
Gold Coast - North	3,922	2,298	6,220
Gold Coast Hinterland	677	455	1,132
Mudgeeraba - Tallebudgera	2,482	1,238	3,720
Nerang	4,062	2,295	6,357
Ormeau - Oxenford	6,383	4,242	10,625
Robina	3,650	2,009	5,659
Southport	3,786	2,282	6,068
Surfers Paradise	2,064	1,107	3,171

Source: Australian Institute of Health and Welfare (AIHW) analysis of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), 2015–16, 2016–17, 2017–18, 2018–19 and 2019-20

The rate of lower urgency ED presentations from residents in the GCPHN region increased by 46% from 37,738 in 2015-16 to 55,016 in 2019-20, which is above the population growth rate.

Table 4. Total number of lower urgency ED presentations, Gold Coast, 2015-16 to 2019-20

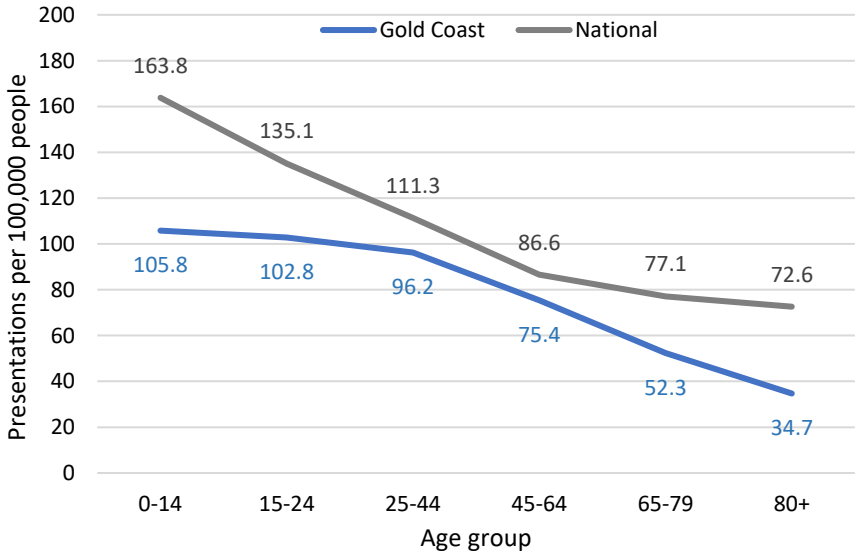
	2015–16	2016–17	2017–18	2018–19	2019-20	Increase from 2015-16 to 2019-20
0-14	8,846	9,443	11,466	11,629	12,345	40%
15-24	7,495	7,387	7,721	7,585	8,434	13%
25-44	11,416	11,258	11,670	11,709	16,994	49%
45-64	7,057	7,011	7,399	7,789	12,046	71%
65-79	2,406	2,597	2,917	2,925	4,286	78%
80+	519	640	661	684	911	76%
All persons	37,738	38,336	41,834	42,321	55,016	46%
Females	16,923	17,207	18,985	19,381	27,396	62%
Males	20,813	21,127	22,842	22,938	27,617	33%

Source: Australian Institute of Health and Welfare (AIHW) analysis of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), 2015–16, 2016–17, 2017–18, 2018–19 and 2019-20

Higher rates among children and young people

Under half of all lower urgency ED presentations (n=20,779; 38%) were for people aged under 25, which is comparable to national figures. Children aged 14 and under accounted for 22% of all lower urgency ED presentations and had the highest presentation rate (105 per 1,000 people) in the region, while people aged 65+ accounted for 9% of lower urgency ED presentations (at a rate of 48 per 1,000 people).

Figure 9. Lower urgency ED presentations per 1,000 people, by age group, national and Gold Coast, 2019-2020



Source: Australian Institute of Health and Welfare (AIHW) analysis of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), 2015–16, 2016–17, 2017–18, 2018–19 and 2019-20

Lower urgency ED presentations after-hours

The rate of people presenting for lower urgency care in after hours period has slightly increased in the GCPHN region from 2015-2016 (30.5 per 1,000 people) to 2019-2020 (31.9 per 1,000 people). During the same time, the national rate has slightly decreased from 59.8 to 52.0 per 1,000.

37% of all lower urgency ED presentations occurred during a period when general practices and other alternative health services are usually closed. People aged under 65 were more likely to present to ED after hours (37% of presentations in this age group) than people aged 65 and over (31% of presentations for this age group).

Reason for lower urgency ED presentations

The most common presentations to ED for lower urgency care amongst GCPHN residents was sprain and strain of ankle, open wound, unspecified injury of head and fracture of lower end of radius. Of all lower urgency ED presentations in the GCPHN region, the arrival mode for 90% of presentations was walked in/public or private transport, with 9% arriving by ambulance.

13 Health

Besides general practice, residents in the GCPHN region can also access care through telephone services including the Queensland Government's 13 HEALTH, a confidential phone service providing health advice from a registered nurse 24 hours a day, seven days a week at the cost of a local call.

Between July 2021 and June 2022, there was a total of 35,892 calls made to 13 Health by residents of the GCPHN region (accounting for 11.3% of all calls made in Queensland). Of those, 59.3% (n=21,284) of calls were made by females, 34.0% (n=12,205) were by males, 6.1% (n=20) of calls were by intersex persons or persons of indeterminate sex, and the remained had no information about sex.

3.5% (n=1,260) of callers to 13 Health identified as Aboriginal and/or Torres Strait Islander. Aboriginal and/or Torres Strait Islander people are accessing the service at a higher rate of the population (9 calls per 100 people) compared to calls made by non-Indigenous patients (5 calls per 100 people).

Table 5 shows that almost a third of all calls to 13 Health were made by/for children aged 0 to 9.

Table 5. Age groups of people using 13 Health, Gold Coast region, July 2021 to June 2022

Age group	Number	Rate
0-9	11,069	30.8%
10 to 19	2,716	7.6%
20-29	6,789	18.9%
30-39	6,121	17.1%
40-49	3,129	8.7%
50-59	2,372	6.6%
60-69	1,715	4.8%
70-79	1,218	3.4%
80+	762	2.1%

Source: 13Health

Ormeau – Oxenford SA3 had the highest rate of people using 13 Health, accounting for 30.5 % of all calls

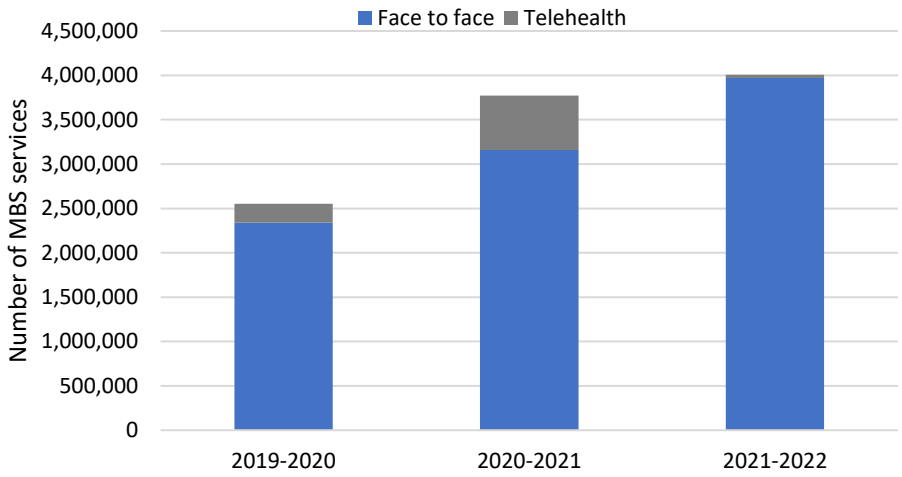
(n=10,937), followed by Broadbeach at 13.5 % (n=4,848). Pandemic COVID-19, abdominal pain, and chest pain were the leading reasons for calls made to 13 Health by residents of the GCPHN region from July 2021 to June 2022.
The peak time of calls to 13 Health by residents of the GCPHN region were between 4pm to 8pm, with 37% (8,249) of the total calls made during the after hours period (before 8am or after 8pm).

The three leading recommendations made by nurses at 13 Health to Gold Coast residents were 13.2% (n=4,679) were informed to "*Seek emergency care as soon as possible",* 11.6% (n=4,124) "*Schedule an appointment to be seen by the doctor within the next 12 hours (same day*)" and 8.4% (n=2,976) "*Seek face to face care within 1-4 hours*".

COVID-19 and general practice attendance

Even during the disruptive lockdown period that prompted an unexpected and rapid implementation of telehealth services in general practices, there was a 94.1% increase in total consultations (face to face and telehealth) in 2021 compared to 2019 (Figure 10).

Figure 10. Consultations (telehealth and face to face) in 159 practices in GCPHN region, 2019-20 to 2021-22



Source: Primary Sense

Service system

Services	Number in the GCPHN region	Distribution	Capacity discussion
General practice	212	Clinics are generally distributed across the GCPHN region with the majority located in coastal and central areas.	• 855 GPs in the GCPHN region. • 28 practices deliver speciality services such as skin checks. • Average number of GPs per general practice: 4.0. • 85% of general practices are accredited or currently working towards accreditation.
Medical deputising services	4	In-home and after-hour visits from a doctor. Available across most of GCPHN region with hinterland areas less well serviced	• All consultations are bulk billed for Medicare and DVA card holders. • Depending on the provider, appointments requested by phone or online.
Online and phone support	4	Phone or online	• Healthdirect • 13 HEALTH – health information and advice • Lifeline crisis support service • PalAssist – 24-hour palliative care support and advice line
Pharmacy	143	Well distributed across the GCPHN region	• Medication dispensing • Medication reviews • Medication management • Some screening and health checks • Some vaccination

Hospitals	5	Southport and Robina (public) Southport, Benowa, and Tugun (private)	• Private health insurance is required to access EDs, a gap payment may also be incurred. • Limited integration with general practice data. • Residents near borders may also use nearby hospitals such as Tweed, Logan, and Beaudesert.

Consultation

Primary Care Partnership Council

In July 2021, GCPHN utilised the Primary Care Partnership Council as an engagement mechanism to discuss emerging issues relating to unplanned hospital care in the GCPHN region. Key issues and themes raised include:

- Dementia clients being admitted to hospital for review of medication, due to COVID-19 families unable to visit, patients getting really agitated leading to more medication etc.
- Cost is a factor for many people from culturally and linguistically diverse background, bulk billing not always an option with GPs so easy to go to hospital.
- For some, it may be safer to be seen where not known e.g., a doctor starts to bulk bill and was not expected, confronting and embarrassing.
- People do have a preference to wait at home rather than go to hospital especially with COVID-19.

Community Advisory Council

In July 2021, GCPHN utilised the Community Advisory Council as an engagement mechanism to discuss emerging issues relating to unplanned hospital care in the GCPHN region. Key issues and themes raised include:

- Lack of preventative healthcare and early intervention initiatives.
- Cost of healthcare means that people go to the hospital because it's perceived as free and everyone knows where the hospital is, whereas bulk billing doctors' surgeries are not as well-known and even then, a first time visit will cost.
- Factors effecting PPH should focus on rehabilitation, there is limited, or no rehabilitation offered at the early and mid-stages of recovery.
- Together with the cost to low-income families of multiple family members needing medical treatment that can't be handled by GP clinics.
- Consultation time constraints of patients with co-morbidities needing multiple appointments with their GPs leading to higher cost.
- The cost of private health cover and the gap payments that keep escalating due the widening gap between government rebates to doctors and costs of a service provision.

Clinical Council

In August 2021, GCPHN utilised the Clinical Council as an engagement mechanism to discuss emerging issues relating to unplanned hospital care in the GCPHN region. Key issues and themes raised include:

- Lower urgency ED presentations increased slightly in past years, but the general practice services increased a lot more.
- New models of care are required to address potentially preventable hospitalisations.
- Significant increase in managing iron infusions in general practice in recent years may not be reflected in data. Some GPs still hesitant to do iron infusions but it is now widely available in the Gold Coast.
- Pharmacies are seeing less after-hours doctor scripts particularly home visiting services.
- Increased ED attendances could relate to drops in private health insurance, and even with private cover, out of pocket costs are high so many go to public system.
- Consumers get lost in primary system – go to a GP, then radiology, then few doctors can do plaster etc., whereas ED is a one stop shop (even if you must wait a while).
- COPD has highest PPH bed rates – look at smoking to address (note Gold Coast has relatively low rates of smoking).
- Lower than average immunisation rate of flu on the Gold Coast – links to high potentially preventable hospitalisations.
- 13 Health – look at younger cohort of kids, why they are going to ED.
- Aging population - increased utilisation of services and drop in private health insurance – leads to more PPHs.

Cancer

Local health needs and service issues

- Participation in BreastScreen, bowel and cervical cancer screening is below national rate.
- Low participation in all cancer screening in Ormeau-Oxenford.
- Rate of new cancers diagnosed annually in the Gold Coast region is above the national rate in 2013-2017.
- Breast cancer and colorectal cancer had the highest number of cases in the Gold Coast region between 2013-2017.
- Higher rates of melanoma across the Gold Coast region compared to national rates.
- Low community awareness of eligibility for cancer screening in the Gold Coast region, for men in particular.
- General practice has limited view of screening data to support proactive steps with patients.
- Limited BreastScreen translated resources available for people from culturally and linguistically diverse backgrounds.

Key findings

- The incidence of new cancer diagnosed in the Gold Coast region for common cancers such as breast, colorectal and lung, is generally in line with national rate, except for melanoma (GCPHN region has a substantially higher rate).
- Utilisation of cancer screening services varies across the GCPHN region. The data identifies opportunities to further improve overall cancer screening participation rates. Some areas with low participation rates across all screening types (e.g., Surfers Paradise) require an overall effort to increase screening consistency. Others require targeted strategies corresponding to screening type, age and specific locations.
- Consultation suggests that low awareness of screening target groups in addition to limited knowledge about eligibility causes confusion with community and health professionals, resulting in fewer people being screened.
- During the COVID-19 pandemic, there was a concern that people may have been staying away from clinics for fear of contracting the virus or not wanting to waste their GP's time. However, the National Bowel Cancer Screening Program continues to mail out faecal occult blood test to eligible people, and elective procedures continue to be offered through most public and private health providers. BreastScreen Queensland services are also back to "business as usual", with additional safety measures in place, following a brief suspension. Eligible patients are strongly encouraged to continue cancer screening as part of their routine healthcare.

Cancer incidence

On the Gold Coast, number of all cancers have increased by 15.4% from 2013 to 2017. In 2017, Ormeau-Oxenford had the highest number of cancers, which has increased by 45.4% from 2013.

Table 1. All cancer Incidence, Gold Coast SA3 regions, 2013 to 2017

	2013	2014	2015	2016	2017	Total	Change 2013-17
Gold Coast SA4	3,390	3,484	3,488	3,738	3,913	18,013	15.4%
Broadbeach – Burleigh	441	501	465	447	458	2,312	3.9%
Coolangatta	383	385	401	422	421	2,012	9.9%
Gold Coast – North	483	540	503	568	576	2,670	19.3%
Gold Coast Hinterland	118	136	122	133	135	644	14.4%
Mudgeeraba – Tallebudgera	168	193	188	199	196	944	16.7%
Nerang	397	326	395	424	438	1,980	10.3%
Ormeau – Oxenford	465	503	532	585	676	2,761	45.4%
Robina	312	280	285	319	302	1,498	-3.2%
Southport	378	377	353	381	424	1,913	12.2%
Surfers Paradise	245	243	244	260	287	1,279	17.1%

Source: Queensland Health. Oncology analysis system (OASys). Cancer Alliance Queensland, Queensland Cancer Control Analysis Team: Brisbane; 2020. https://canceralliancegld.health.qld.gov.au/applications/qool. Accessed 26 May 2021., All the data in OASys is based on the location of residence of the person diagnosed with cancer, and NOT the treating facility/HHS etc.

In 2017, cancer incidence for Gold Coast was slightly above the Queensland rate (546 vs 541 per 100,000). Ormeau-Oxenford SA3 region had the highest rate and Robina had the lowest rate.

Table 2. All cancer incidence per 100,000 people, Gold Coast SA3 regions, 201 to 2017

	2013	2014	2015	2016	2017
Queensland	543	539	535	542	541
Gold Coast SA4	541	537	523	538	546
Broadbeach – Burleigh	555	616	568	529	541
Coolangatta	540	532	555	566	551
Gold Coast – North	531	567	504	551	563
Gold Coast Hinterland	532	581	515	543	564
Mudgeeraba – Tallebudgera	512	580	542	579	537
Nerang	580	460	544	559	559
Ormeau – Oxenford	505	519	528	539	581
Robina	564	491	487	516	491
Southport	583	550	510	524	569

Surfers Paradise	492	488	468	463	489

Source: Queensland Health. Oncology analysis system (OASys). Cancer Alliance Queensland, Queensland Cancer Control Analysis Team: Brisbane; 2020. All the data in OASys is based on the location of residence of the person diagnosed with cancer, and NOT the treating facility/HHS etc

Incidence of various cancer types

Table 3 provides the incidence of selected cancer types across the GCPHN region. The data shows that the GCPHN region has a slightly higher rate of new cancers diagnosed, compared to the Queensland rate for breast, colorectal, lung, melanoma, and prostate cancer.

Over 12,000 cases of melanoma are diagnosed each year in Australia[1], and people who live in Queensland have the highest rates of melanoma in the world. Globally it is the third most common cancer in men (after prostate and colorectal cancer) and women (after breast and colorectal cancer)[2].

Data analysis at a more granular level provides further insight into geographic regions where increased effort may be required to prevent and treat types of cancer:

- Gold Coast rate for breast cancer is above Queensland rate (66), and Gold Coast-North (81) has the highest rate among the SA3 regions in the GCPHN region,
- Gold Coast rate for colorectal cancer (59) is slightly below Queensland rate (60),
- Gold Coast rate for lung cancer (46) is slightly below Queensland rate (47),
- Gold Coast rate for melanoma (82) is above Queensland rate (75), with Broadbeach-Burleigh (165) having the highest rate among the SA3 regions in the GCPHN region.

[1] Whiteman DC, Green AC, Olsen CM. The Growing Burden of Invasive Melanoma: Projections of Incidence Rates and Numbers of New Cases in Six Susceptible Populations through 2031. J Invest Dermatol. 2016; 136: 1161-71.

[2] Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clinic. 2018; 68: 394-424.

Table 3. Incidence and age-standardised rate per 100,000 people of various cancer types, Gold Coast SA3 regions, 2013-2017

Region	Breast cancer		Colorectal cancer		Lung cancer		Melanoma		Prostate cancer	
	Number	ASR	Number	ASR	Number	ASR	Number	ASR	Number	ASR
Queensland	3,435	66	3,161	60	2,523	47	3,885	75	4,081	154
Gold Coast SA4	462	71	397	59	320	46	535	82	512	153
Broadbeach-Burleigh	56	72	46	53	41	46	83	107	67	165
Coolangatta	41	62	38	49	34	43	77	111	52	142
Gold Coast-North	74	81	60	60	57	55	66	73	79	160
Gold Coast Hinterland	17	71	16	70	10	40	18	85	20	151
Mudgeeraba-Tallebudgera	27	76	22	65	14	43	26	75	28	158
Nerang	55	74	45	62	37	50	54	76	52	142
Ormeau-Oxenford	73	67	63	63	41	42	77	73	83	161
Robina	40	72	30	50	24	40	43	76	41	145
Southport	46	70	47	66	39	54	52	77	48	144
Surfers Paradise	33	65	29	54	24	43	39	76	41	145

Source: Queensland Health. Oncology analysis system (OASys). Cancer Alliance Queensland, Queensland Cancer Control Analysis Team: Brisbane; 2020. All the data in OASys is based on the location of residence of the person diagnosed with cancer, and NOT the treating facility/HHS etc.

Cancer mortality

Incidence of cancer has obvious impacts on individual health and the health system more broadly, which makes monitoring the incidence of new cancers important. AIHW mortality data[3] indicates that within the GCPHN region between 2015 and 2019:

- Cancer accounted for eight of the top 20 leading causes of death.
- Lung cancer caused 1,088 deaths at a rate of 29.1 deaths per 100,000 persons, same as the national rate of 29.4. It was the 4th leading cause of death.
- Colorectal cancer caused 663 deaths at a rate of 17.7 deaths per 100,000 persons in the GCPHN region compared to the national rate of 18.0. It was the 6th leading cause of death.
- Prostate cancer caused 479 deaths at a rate of 12.3 deaths per 100,000 persons in the GCPHN region compared to the national rate of 10.8. It was the 7th leading cause of death.
- Pancreatic cancer caused 386 deaths at a rate of 10.3 deaths per 100,000 persons in the GCPHN region compared to the national rate of 10.1. It was the 10th leading cause of death.
- Breast cancer caused 364 deaths at a rate of 10.0 deaths per 100,000 persons in the GCPHN region compared to the national rate of 10.5. It was the 11th leading cause of death for people.

Service utilisation data

Table 4 shows the rates of participation in national cancer screening initiatives for bowel, breast, and cervical cancers in the Gold Coast region in 2019-20 and 2018-20.

[3] AIHW, 2019. MORT (Mortality Over Regions and Time) books: Primary Health Network (PHN), 2015-2019.

Table 4. Participation rates in national cancer screening programs, by SA3 region, 2019-20 and 2018-20

	Bowel cancer screening % of persons aged 50–74 (2019-20)	Breast cancer screening % of women aged 50-74 (2019-20)	Cervical cancer screening % of women aged 25-74 (2018-20)
National	41.6%	49.9%	62.4%
Gold Coast SA4	37.6%	49.9%	55.9%
Broadbeach – Burleigh	39.1%	53.5%	64.0%
Coolangatta	40.0%	52.2%	61.1%
Gold Coast – North	n.p.	49.7%	n.p.
Gold Coast Hinterland	n.p.	50.0%	n.p.
Mudgeeraba – Tallebudgera	n.p.	51.9%	n.p.
Nerang	36.8%	49.1%	57.1%
Ormeau – Oxenford	36.8%	48.9%	52.8%
Robina	38.8%	53.7%	58.1%
Southport	n.p.	47.1%	n.p.
Surfers Paradise	34.1%	43.5%	49.2%

Source: AIHW analysis of National Bowel Cancer Screening Program Register, BreastScreen Australia data and state and territory cervical screening register data. (The majority of screening mammography performed in Australia is through BreastScreen Australia. However, a relatively small amount of screening mammography occurs through services other than BreastScreen Australia, which are not within the scope of the data below), SA3s with a numerator less than 20 or a denominator less than 100 have been suppressed.

In 2019-2020, participation in the National Bowel Cancer Screening Program among residents of the GCPHN region aged 50-74 years (37.6 %) was lower compared to national rate (37.6% vs 41.6 %). Bowel screening participation was lowest in SA3 region of Surfers Paradise.

The rate of women aged 50-74 years participating in BreastScreen Australia screening services in 2019-20 in the GCPHN region (49.9 %) was in line with the national rate (49.9%). Breast cancer screening participation was lowest in SA3 region of Surfers Paradise.

The rate of women aged 25-74 years participating in cervical screening services 2018-2020 in the GCPHN region was below the national rate (55.9% vs 62.4%). There were several SA3 regions with lower rates of participation in the National Cervical Screening Program, particularly Surfers Paradise, and Ormeau-Oxenford.

Prevalence

Data extracted through PATCAT[4] from 174 general practices in the GCPHN region from March 2022 show there were a total of 587,244 active patients[5]. Of those, 27,285 patients (4.6%) had an active cancer condition. Table 5 shows the prevalence of each cancer types.

[4] PAT CAT is a web-based interface that aggregates de-identified General Practice data for population health management and research programs.

[5] Active population represents the portion of the total population that have had at least three visits to the same practice in the last 2 years as per RACGP Accreditation Standards for general practice.

Table 5. Active patients with active cancer condition, March 2022

Cancer type	Number	Rate
Total Population	587,244	
Cancer prevalence	27,285	4.6%
Leukemia	980	3.6%
Lymphoma	1,401	5.1%
Multiple Myeloma	347	1.3%
Breast Cancer	6,530	23.9%
Bowel (Colorectal) Cancer	3,485	12.8%
Pancreatic Cancer	194	0.7%
Cervical Cancer	657	2.4%
Ovarian Cancer	301	1.1%
Prostate Cancer	4,938	18.1%
Uterine Cancer	420	1.5%
Melanoma	7,100	26.0%
Lung Cancer	932	3.4%

Source: Gold Coast Primary Health Network PATCAT tool, data extract from 174 general practices.

Cancer screening and COVID-19

The COVID-19 pandemic affected many areas of people lives, including their access to and use of health services such as cancer screening programs. As part of these restrictions, many healthcare services also suspended or changed the way they delivered their services. Due to this, and the potential for people to change their behaviour whilst under restrictions, there is increased public interest around the effects of COVID-19 on Australia's three national cancer screening programs[6]:

- **BreastScreen Australia** services (screening mammograms) are delivered in specialised facilities which usually involve close contact between clients and health workers. BreastScreen services were suspended from late March to late April/early May 2020 due to COVID-19 restrictions. The BreastScreen Queensland Gold Coast Service suspended screening between 1-30 April 2020.
- **The National Cervical Screening Program** involves a test which is usually carried out by a person's GP. While GP services continued during the pandemic, cervical screening tests require in-person consultations. There was no suspension of the National Cervical Screening Program.
- **The National Bowel Cancer Screening Program** involves home test kits, sent to eligible participants who return them by mail. People do not need to leave their homes to complete the test, or to get their results, but do need to mail their completed test kit to the pathology laboratory. There was no suspension of the National Bowel Cancer Screening Program.

[6] Cancer screening and COVID-19 in Australia, Australian Institute of health and Welfare, 2020.

The long-term effects of delayed screening during the COVID-19 pandemic will not be known for some time. It will be important to continue monitoring the effects of this changing situation on cancer screening and other health services in future years.

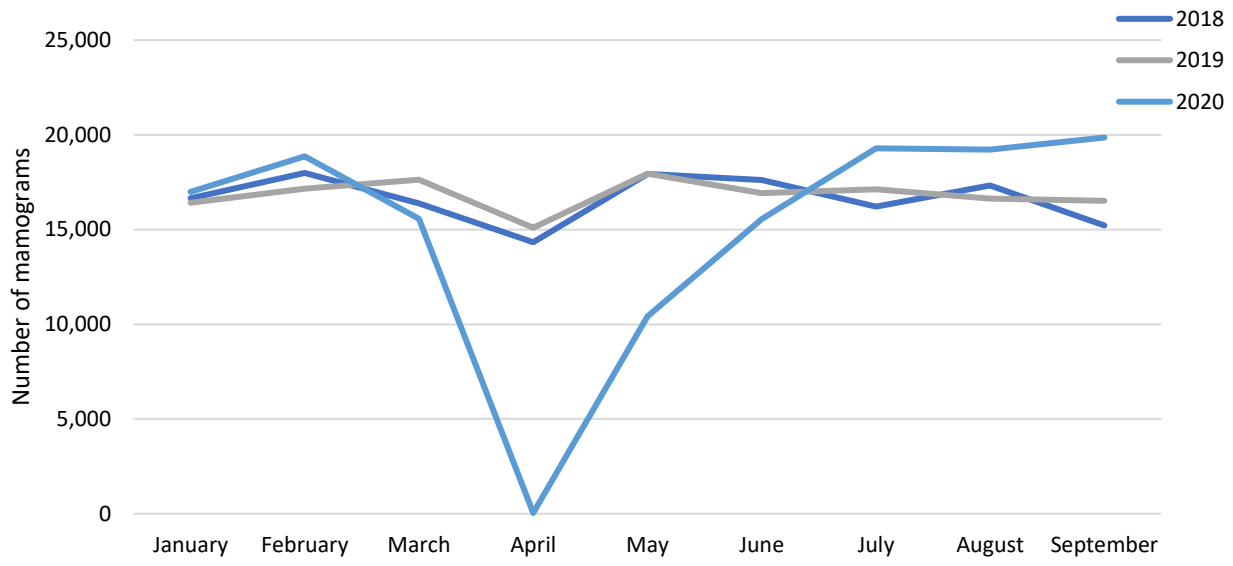
BreastScreen Australia

The number of screening mammograms performed through BreastScreen Australia declined in March in 2020 in Australia and Queensland as the COVID-19 pandemic worsened and tighter restrictions were put in place that included a suspension of all BreastScreen services from 25 March 2020.

In March 2020, 15,578 screening mammograms were conducted in Queensland, this decreased to 38 in April. Following an easing of restrictions that included a lifting of the suspension from late April/May 2020, the number of screening mammograms increased through May and June. In total 15,660 less mammograms were completed in Queensland in 2020 compared to 2019.

Figure 1 shows the number of screening mammograms through BreastScreen Australia in Queensland.

Figure 1.Number of screening mammograms through BreastScreen Australia, 2018-20

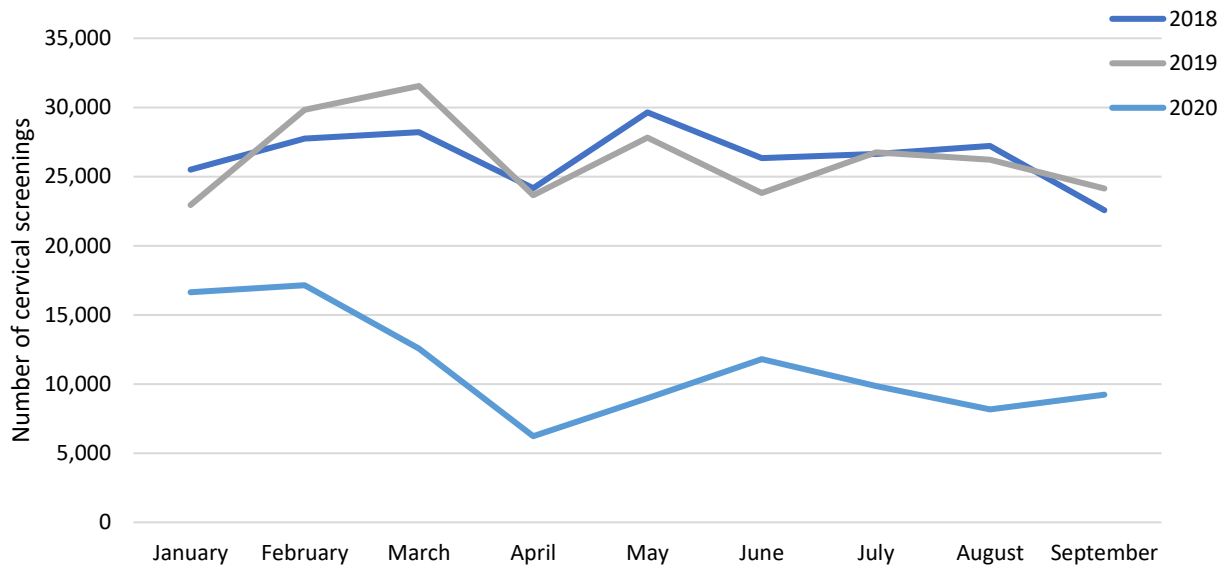


Source: Australian Institute of Health and Welfare analysis of state and territory BreastScreen register data

National Cervical Screening Program

The expected trend of fewer cervical screening test in 2020 compared with 2019 due to the change from 2-yearly to 5-yearly screening is evident. While there was fewer cervical screening test in 2020 compared with 2019 in Queensland, the impact of COVID-19 cannot be measured without further years of data (as 2020 is the first year impacted by the transition to 5-yearly screening. Figure 2 shows the number of screening test through National Cervical Screening program in Queensland.

Figure 2. Number of screening test through the National Cervical Screening program, 2018-20



Source: Australian Institute of Health and Welfare analysis of National Cancer Screening Register data.

National Bowel Cancer Screening program

In 2020, 573,547 bowel cancer screening kits were sent to Queensland residents, which was an increase of 9% compared to 2019. The rate of screening test returned in 2020 in Queensland was 27% compared to 2019 where the rate was 42%.

Table 6 shows the number and rate of bowel cancer screening invites sent and screening test returned in Queensland.

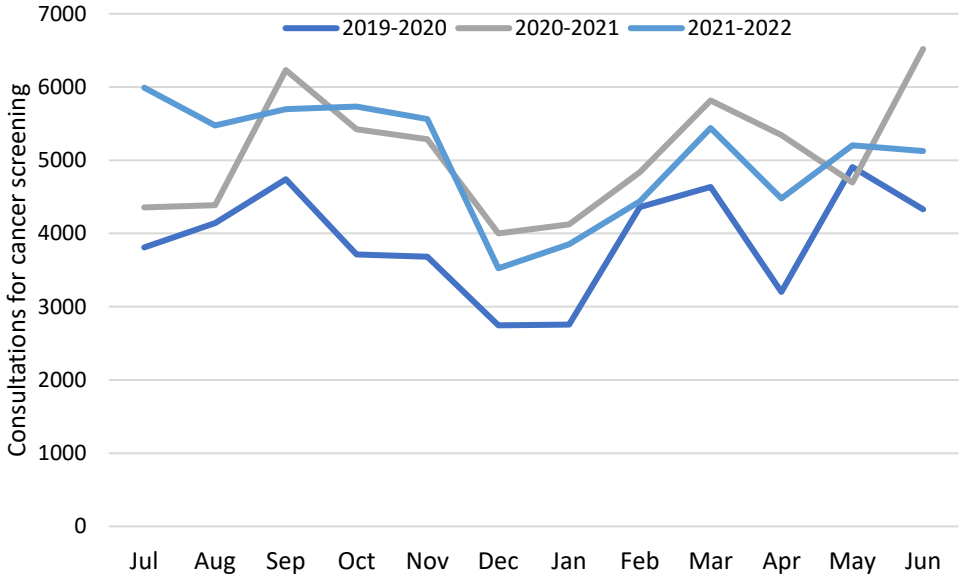
Table 6. Number of invites and number of screening tests through the National Bowel Cancer Screening Program by month, ages 50–74, 2019 and 2020.

	2019			2020		
	Invites	Screening tests	Rate	Invites	Screening tests	Rate
January	40,566	15,713	38.7%	4,069	10,867	267.1%
February	40,115	17,762	44.3%	39,858	7,389	18.5%
March	56,860	20,424	35.9%	72,773	7,310	10.0%
April	57,452	20,104	35.0%	76,227	13,085	17.2%
May	64,224	24,871	38.7%	101,351	17,737	17.5%
June	82,944	29,103	35.1%	67,335	24,086	35.8%
July	57,534	27,978	48.6%	42,401	29,239	69.0%
August	56,114	37,205	66.3%	56,164	18,652	33.2%
September	70,707	25,947	36.7%	113,369	25,481	22.5%
Total	526,516	219,107	42%	573,547	153,846	26.8%

Source: Australian Institute of Health and Welfare analysis of National Cancer Screening Register data.

The data extracted from Primary Sense in Figure 3 shows there was some reduction in attendance for cancer screening visits to general practice due to COVID-19 in the 2019-2020 financial year period. Cancer screening requires a visit or referral letter/pathology request and appears to have been impacted to a greater extent. Cancer screening includes bowel, breast, cervical and skin. Despite reduced services due to COVID-19 in early 2019-2020, since this time, there has been a catch-up period during 2020-2021 where general practices have seen increased attendances for these interventions. Overall, there are more visits to general practice in 2021-2022 (YTD) than pre pandemic in the 2019-2020 period, reinforcing and supporting the anecdotal higher utilisation of general practice. Overall, the data does not suggest that there are emerging concerns of longer-term health issues due to people avoiding routine and preventative care in general practices.

Figure 3. Cancer screening in 159 Gold Coast General Practices, 2019-20 to 2021-22



Source: Primary Sense, data extract from 159 practices

Service system

Services	Number in GCPHN region	Distribution	Capacity discussion
General practice	212	Broad distribution and availability across GCPHN region	• Screening for cervical cancer. • Skin checks for melanoma • Limited integration of utilisation and results data with general practice impacts follow up, availability and accessibility. • National cervical screening program have electronic results going to GP • Cancer screening training and information event well attended in GCPHN region.
BreastScreen	5	4 permanent sites (Helensvale, Robina, Southport, West Burleigh), plus a monthly staff clinic at Gold Coast University Hospital 1 mobile service visiting 6 locations (North Tamborine Mountain, Nerang, Elanora, Beenleigh, Pimpama, and Beaudesert)	• Public breast screening • Fewer permanent sites than comparative HHS regions (e.g. Sunshine Coast area). • Wait times at the Gold Coast Service are currently one week or less. • Follow up occurs at Southport site. • Follow up of abnormal results usually incurs a 2 week wait as service is often at capacity. • BreastScreen has set a screening target of 33,700 for the GCPHN region in 2020-2021.
Private breast screening clinics	5	Majority of providers along eastern strip of Gold Coast.	• Growing market—some private imaging clinics, some women's health-focused. • Eligible for Medicare rebate— out-of-pocket costs still generally apply.
National Bowel Cancer Screening Program (NBCSP)	1	Eligible people aged 50 – 74, identified by Medicare and Department of Veterans' Affairs, are posted a faecal occult blood test	• Current roll-out NBCSP results sent electronically to GP. • Follow up of abnormal results from the program incurs a variable wait time.

		(FOBT) kit and invited to complete the test.	• People with a positive result may choose to follow up with a private referral.
Private bowel cancer screening			• Non-program FOBTs can be sourced privately through some pharmacies, pathology companies and organisations such as Bowel Cancer Australia and Rotary. These are not integrated with the National Cancer Screening Register or factored into local bowel cancer screening participation rates. • Some people who are eligible for the NBCSP screen via private colonoscopy which provides added cost and health risk.
Skin clinics	32	Spread across GCPHN region Mostly located at medical centres.	• An identified shortage of culturally appropriate and culturally safe services inhibit access for CALD and many Aboriginal and Torres Strait Islander consumers.

Consultation

Community and stakeholders identified:

- Many people in the community are not aware of cancer screening target groups.
- There is negative stigma with the screening process itself.
- There are low levels of health literacy in specific pockets of the population which adversely influences screening awareness and uptake.
- Barriers to general practice playing a more prominent role in screening include:
    - Invitations to participate in the National Bowel Cancer Screening Program are sent out to eligible Australians separate to general practice, with GPs initially left out of the loop.
    - While FOBT kits are easily available, those not issued through NBCSP are not being integrated with the National Cancer Screening Register, making it difficult for GPs to receive information and provide follow-up.
    - While results from BreastScreen and the NBCSP are now coming directly into general practice software, GPs are not made aware of NBCSP service decliners, so they cannot be proactively followed up.
- Potential of over-screening – people may receive an invite to screen in the NBCSP despite completing a recent FOBT or colonoscopy if this takes place outside of the national program.
- People attending private breast screening services are not entered into the state reminder system.
- Cultural complexities may inhibit screening for some groups.
- Regularly changing eligibility criteria and national priorities.
- Funding model for screening in general practices influences uptake and cost effectiveness of consultations.
- The change for cervical cancer screening to a 5-year timeframe is causing some anxiety for women so education is needed to support the change.
- Limited resources and information for community on the three programs, difference in cervical screening test.
- Breast cancer is rising in the under 50 age group, need to advocate to lower the age for breast screening to 40 and promote to the community.

In 2017 consultation, GCPHN Community Advisory Council (CAC) noted a limited awareness in Gold Coast community regarding screening and eligibility requirements:

- 66% knew about cervical cancer screening, 75% knew about breast cancer screening, 50% knew about bowel cancer screening
- 50% indicated they were aware of target groups for the different screening services

The CAC also noted:

- The community expects health professionals to notify/remind them to get screened, carry out the screening test if relevant and make referral if required – this ranked as more important than providing them with information on what screening services are available.
- The community has differing attitudes towards public and private screening services.
- The community has difficulty accessing services due to high complexity navigating the system.

- There is a “embarrassment” factor in breast, bowel and cervical screening that inhibits uptake.

Immunisation, communicable diseases, and COVID-19

Local health needs and service issues

- Gold Coast Primary Health Network region's rate of children fully immunised for one, two, and five-year old's is below the national rate.
- High number of children (aged 1, 2, and 5) not fully immunised in Ormeau-Oxenford SA3 region.
- Lower rates of HPV vaccination in the Gold Coast region compared to the national figure.
- Vaccine potentially preventable hospitalisations in the Gold Coast region have increased 322% between 2012-13 to 2017-18 (1,960 hospitalisations in 2017-18).
- Ensuring accurate and timely information to general practices in relation to COVID-19.
- Slow uptake COVID-19 vaccination for Resident Aged Care Facilities residents and staff.

Key findings

- The immunisation rates of children (aged 1, 2, and 5) in the GCPHN region remained stable in recent years, although are still below (but comparable) to national and Queensland rates as of May 2021.
- Immunisation rates for Aboriginal and Torres Strait Islander children are below the national rates in the GCPHN region for 1 year old's, while above the national rate for 2 and 5 year old's as of May 2021.
- Areas that have low immunisation rates include Surfers Paradise and Gold Coast Hinterland. However, these GCPHN regions have some of the lowest absolute numbers of children who are not fully immunised. The region with a highest absolute number of children not immunised is Ormeau-Oxenford.
- In the GCPHN region, rates of HPV vaccination are increasing but remain lower than national rates.

Immunisation coverage

Table 1 shows the percentage of children immunised against a range of infectious diseases by antigen and those considered fully immunised according to Australian Immunisation Register at age one year, two years and five years as of December 2021. These immunisations are based on the National Immunisation Program Schedule, which include:

- diphtheria, tetanus, and pertussis (DTP)
- polio
- haemophilus influenza type b (HIB)
- hepatitis B
- measles, mumps, and rubella (MMR)
- pneumococcal
- meningococcal
- varicella

Table 1. Percentage of children immunised based on National Immunisation Program Schedule, June 2022

	1 year old		2 year olds		5 year olds	
	Gold Coast	National	Gold Coast	National	Gold Coast	National
% DTP	91.0%	94.6%	90.9%	93.5%	90.8%	94.7%
% Polio	91.0%	94.6%	93.8%	96.6%	91.9%	94.7%
% HIB	90.9%	94.6%	91.4%	94.3%	N/A	N/A
% HEP	90.9%	94.6%	93.8%	96.6%	N/A	N/A
% MMR	N/A	N/A	90.8%	93.7%	N/A	N/A
% Pneumo	92.6%	95.9%	92.8%	95.5%	N/A	N/A
% MenC	N/A	N/A	92.9%	95.7%	N/A	N/A
% Varicella	N/A	N/A	91.0%	93.8%	N/A	N/A
% Fully Immunised	91.0%	94.2%	90.1%	92.6%	91.6%	94.5%

Source: https://www.health.gov.au/resources/collections/childhood-immunisation-coverage-data-phn-and-sa3

Data analysis at a more granular level provides further insight into geographic regions where increased effort may be required to improve immunisation coverage. The data displayed in Table 2 highlights SA3 regions with a low immunisation rate at either ages 1, 2, or 5 years old in 2022.

Table 2. Percentage of 1, 2 and 5-year olds fully immunised, by SA3 region, June 2022

Region	1 years	2 years	5 years
National	94.2%	92.6%	94.5%
Gold Coast (SA4)	91.0%	90.1%	91.6%
Broadbeach - Burleigh	88.7%	88.3%	90.9%
Coolangatta	87.1%	88.2%	87.4%
Gold Coast - North	92.3%	90.2%	91.6%
Gold Coast Hinterland	85.6%	85.7%	84.1%
Mudgeeraba - Tallebudgera	90.1%	87.3%	93.5%
Nerang	92.7%	90.8%	92.5%
Ormeau - Oxenford	91.6%	91.0%	93.0%
Robina	91.2%	90.9%	91.5%
Southport	92.4%	91.6%	91.3%
Surfers Paradise	87.2%	89.9%	92.0%

Source: Australian Government, Department of Health, QLD childhood immunisation coverage data by SA3

Gold Coast Hinterland has low immunisation rates across all age groups. However, this region has some of the lowest total number of children who are not fully immunised. Ormeau-Oxenford has the highest number of unvaccinated children in all age groups, but the highest population of children.

GCPHN region had returned slightly lower immunisation rates for children aged 1, 2 and 5 years for the five-year period when compared to the national rate in 2022. Immunisation rates for Aboriginal and Torres Strait Islander children in the GCPHN region are below the national rates for 1 year olds and above the national rate for 2 year old and 5 year old rate as of December 2021. The large changes of rates for Aboriginal and Torres Strait Islander children are due to the relatively small Aboriginal and Torres Strait Islander child population in the region.

Local trends in immunisation rates largely mirror national trends which may reflect the significance of Australia-wide immunisation policy and universal immunisation initiatives.

Tables 3 and 4 below illustrates the childhood immunisation rates for all children, as well as those who identified as Aboriginal and Torres Strait Islander, within the GCPHN region.

Table 3. Immunisation trends over time, all children, 2016-21

All children		2016	2017	2018	2019	2020	2021
1 year old	Gold Coast	93.9%	92.8%	92.9%	94.4%	92.4%	91.5%
	National	93.4%	94.0%	94.0%	94.3%	94.7%	94.6%
2 year old	Gold Coast	91.1%	90.7%	89.8%	90.4%	91.0%	89.6%
	National	91.4%	90.8%	90.8%	91.6%	92.6%	92.6%
5 year old	Gold Coast	91.9%	92.2%	92.7%	92.5%	93.5%	91.7%
	National	93.2%	94.0%	94.7%	94.8%	95.1%	95.0%

Source: AIHW analysis of Department of Human Services, Australian Immunisation Register statistics

Table 4. Immunisation trends over time, Aboriginal and Torres Strait Islander children, 2016-21

Aboriginal and Torres Strait Islander children		2016	2017	2018	2019	2020	2021
1 year old	Gold Coast	95.1%	91.0%	96.9%	92.5%	92.3%	94.2%
	National	91.2%	92.2%	92.6%	92.6%	93.8%	92.0%
2 year old	Gold Coast	91.1%	94.4%	89.2%	92.8%	93.3%	91.1%
	National	89.1%	88.2%	88.2%	90.0%	91.4%	91.0%
5 year old	Gold Coast	97.9%	97.1%	93.6%	96.4%	99.1%	95.7%
	National	95.2%	96.2%	97.0%	97.0%	97.3%	96.8%

Source: AIHW analysis of Department of Human Services, Australian Immunisation Register statistics

Human papillomavirus vaccine

The human papillomavirus vaccine (HPV) is provided free to girls and boys aged 12–13 years as part of the National HPV Vaccination Program. Table 5 shows the percentage of females and males aged 15 years who had received the third dose in 2017. It shows lower levels of vaccination in both males and females in the GCPHN region compared to national levels.

Table 5. Percentage of children aged 15 years on 30th June 2017 who had received Dose 3 of HPV vaccine

	Gold Coast	National
Females	74.4%	80.5%
Males	67.1%	76.1%

Source: Public Health Information Development Unit (PHIDU), Torrens University using data from the National HPV Vaccination Program Register

Health service utilisation

Potentially preventable hospitalisations (PPHs) are an indicator of both adverse health outcomes and financial costs to the health system. Table 6 shows the rate of PPH per 100,000 people for vaccine-preventable conditions between 2015-2016 and 2017-2018.

Table 6. Age-standardised rate of potentially preventable hospitalisations per 100,000 people for vaccine-preventable conditions, 2015-16 to 2017-18

Region	2015-2016	2016-2017	2017-2018
Gold Coast SA4	236	186	287
National	199	213	313

Source: Potentially preventable hospitalisations in Australia by small geographic regions 2020, Australian Institute of Health and Welfare. This data set is a component of the minimum data set.

Table 7 shows the GCPHN region had a higher rate of PPHs for pneumonia and influenza conditions compared to the national figure in 2017-2018. These conditions accounted for approximately 1,500 hospitalisations in the GCPHN region in 2017-2018 and accrued a total of 9,646 hospital bed days. The rate of vaccine

preventable PPHs have increased in line with national trends, pneumonia and influenza are the largest components of vaccine-preventable PPH.

Table 7. Regional breakdown of age-standardised rate of potentially preventable hospitalisations (PPHs) per 100,000 people for pneumonia/ influenza and other vaccine preventable conditions, 2017-18

	Pneumonia and influenza	Other vaccine preventable conditions
National	207	108
Gold Coast SA4	219	70
Broadbeach-Burleigh	169	65
Coolangatta	230	40
Gold Coast- North	238	88
Gold Coast Hinterland	240	n.p
Mudgeeraba-Tallebudgera	218	51
Nerang	224	47
Ormeau-Oxenford	225	78
Robina	254	96
Southport	243	101
Surfers Paradise	153	60

Source: Australian Institute of Health and Welfare. Potentially preventable hospitalisations in Australia by small geographic regions 2020, n.p: not publishable because of small numbers, confidentiality, or other concerns about the quality of the data

In 2017-2018, the rate of PPHs for pneumonia and influenza were higher across all local areas of the GCPHN region compared with the national rate except for Broadbeach-Burleigh and Surfers Paradise. Robina had the highest rate per 100,000 people for pneumonia and influenza while Surfers Paradise had the lowest rate for other vaccine preventable conditions. Avoidable admissions data provided from Gold Coast Health indicates that young children aged 0 to 5and older people aged 65-75 have the highest percentage of people being admitted to hospital for influenza and pneumonia.

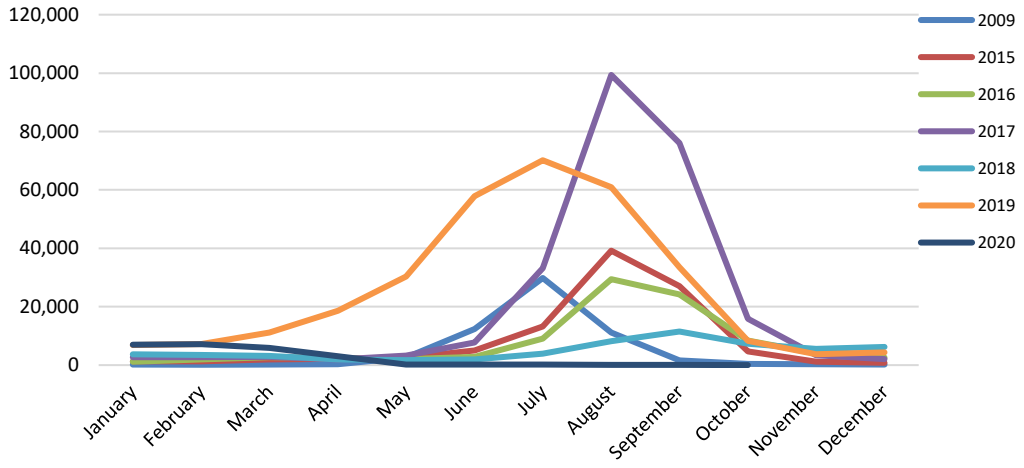
Influenza

In 2014-2018, influenza and pneumonia were the 14th leading cause of death in the GCPHN region with 278 deaths[1]. Due to COVID-19, the closure of Australian borders to international travellers, physical distancing and improving hand hygiene there has been a large decrease in the number of confirmed cases of influenza nationally and in the GCPHN region. The annual total for lab confirmed influenza cases in 2018 was 2,095 which jumped to 7,301 cases in 2019. The GCPHN region saw a significant decline to 30 cases in 2020[2]. These trends are also being seen nationally. Figure 1 highlights the low number of laboratory confirmed influenza cases in Australia in 2020 compared to past years.

[1] Mortality over regions and time (MORT) books, Australian Institute of Health and Welfare, 2020

[2] Notifiable conditions annual reporting, Queensland health, https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/surveillance/reports/notifiable/annual

Figure 1. Annual Australian laboratory confirmed influenza numbers



Source: Australian Government Department of Health, National Notifiable Diseases Surveillance System

Influenza vaccine

Each year, the World Health Organization recommends the strains to be included in influenza vaccines based on the global influenza epidemiology[3]. The Australian Influenza Vaccine Committee uses this recommendation to determine the influenza virus composition of vaccines for use in Australia[4].

GCPHN's PATCAT system captures de-identified patient data submitted by registered general practices throughout the GCPHN region and can be extracted for analysis[5]. Based on this data from March 2022, of the 587,244 active patients (who have had three visits in the past two years), 31.4% (n=184,338) received the influenza vaccination.

The rate of people who received the influenza vaccination varied with different age cohorts; people aged 80 to 89 had the highest rate (72.8%) while people aged 20 to 29 had the lowest rate (15.3%). Table 8 outlines 2022 influenza vaccination rates in the GCPHN region, based on vaccinations that were given in general practices in the GCPHN region and excludes all pharmacies who were also administering the influenza vaccine.

3 World Health Organization (WHO). WHO recommendations on the composition of influenza virus vaccines. (Accessed May 2018).

4 Therapeutic Goods Administration. Australian Influenza Vaccine Committee (AIVC). 2016. (Accessed Apr 2018).

5 Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

Table 8. Influenza vaccination on the Gold Coast PHN, 2022

Age	Number	Active population	Percent
0-9	15,521	58,477	26.5%
10-19	12,375	54,270	22.8%
20-29	11,960	78,145	15.3%
30-39	15,639	84,092	18.6%
40-49	16,293	78,726	20.7%
50-59	20,743	77,565	26.7%
60-69	31,703	69,641	45.5%
70-79	38,676	56,736	68.2%
80-89	23,928	17,421	72.8%
90+	5,632	4,005	71.1%
All ages	184,338	587,244	31.4%

Source: GCPHN PATCAT

Outbreaks for communicable diseases

The notification system in Australia enables Public Health authorities to track communicable diseases and detect outbreaks and increases in disease. Numerous outbreaks occur each year. Outbreaks can include an outbreak of influenza in a specific community or outbreaks of gastroenteritis transmitted through consumption of contaminated food.

Queensland Health provide data on weekly and annual notifications of communicable diseases online, allowing tracking of the incidence of disease over time. Table 9 shows the numbers of notifications of selected diseases from 2015 to 2019 for the GCPHN region.

There has been a rise in the number of chlamydia and gonorrhoea notifications over the period shown, although the number of notifications of chlamydia decreased in 2019. Notifications for chlamydia and gonorrhoea are down in 2020 compared to previous years, likely due to either decreased social interactions or fewer people getting tested.

Table 9. Notifiable conditions annual reporting number of cases, 2016-2022

Disease	2016	2017	2018	2019	2020	2021	2022
Blood borne disease							
Hepatitis B (newly acquired)	7	5	1	6	1	0	3
Hepatitis B (unspecified)	118	97	91	96	82	56	67
Hepatitis C (newly acquired)	11	11	10	14	14	5	8
Hepatitis C (unspecified)	276	209	165	185	185	98	78
HIV	31	33	24	24	18	10	13
Gastrointestinal diseases							
Campylobacter	711	840	901	1083	826	720	646
Cryptosporidiosis	228	122	106	51	58	48	23
Salmonellosis	501	487	433	422	472	268	232
Shigellosis	18	12	51	88	32	4	7
Yersiniosis	102	104	96	76	66	38	52
Hepatitis A	9	3	4	8	2	0	10
Invasive diseases							
Group A Streptococcal	23	37	43	25	16	8	22
Meningococcal	4	7	5	2	2	0	1
Pneumococcal	22	33	48	25	13	13	20
Other vaccine preventable diseases							
Measles	0	3	0	11	1	0	0
Mumps	7	13	12	7	11	1	3
Pertussis	269	146	259	225	59	0	5
Rotavirus	98	292	134	240	41	19	43
Rubella	0	0	1	1	0	0	0
Varicella	975	981	1183	1197	1362	830	777
Sexually transmissible infections							
Chlamydia (STI)	2942	3310	3309	3144	2796	1829	1972
Gonorrhea (STI)	596	638	672	801	770	452	593
Syphilis (infectious)	47	126	124	117	96	90	89
Syphilis (late)	23	27	27	31	31	26	10
Mosquito borne diseases							
Dengue	47	44	23	53	10	0	4
Ross River virus	108	123	98	118	259	36	24
Barmah Forest Virus	12	24	9	8	38	17	6
Zoonotic diseases							
Potential ABLV exposure	16	27	37	53	34	26	21
Potential rabies exposure	47	67	66	61	10	0	3
Other diseases							
Adverse event following immunisation	44	39	61	35	58	25	10

Source: QLD Health, Notifiable conditions weekly totals, https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/surveillance/reports/notifiable/annual. The elevated rate of shigella in 2018 and 2019 may be due to a change in in case definition introduced mid-2018. This data set is a component of the minimum data set.

COVID-19

COVID-19 is a coronavirus and is spread person to person via respiratory secretions. Symptoms include fever, coughing, sore throat, and shortness of breath. On 19 January 2020 the first case of COVID-19 was detected in Australia and on 21 January 2020 the first case was detected in the GCPHN region and Queensland.

Table 10 indicates the total number of confirmed COVID-19 cases and deaths reported in Australia, Queensland, and Gold Coast as of the 16 August 2022.

Table 10. Confirmed cases of COVID-19 and deaths from COVID-19 as of 16th August 2022

	Total confirmed cases	Total deaths
National	9,810,517	12,886
Queensland	1,579,334	1,774
Gold Coast SA4	93,970	260

Source: Queensland health, https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/current-status/statistic

COVID-19 vaccination

The Australian COVID-19 vaccination program commenced on 23 February 2020 in Queensland at the Gold Coast University Hospital. Phase 1a priority populations included:

- aged care and disability care residents,
- residential aged care workers and disability care workers,
- priority frontline healthcare workers,
- priority quarantine and border workers.

Phase 1b of Australia's COVID-19 vaccination rollout commenced on 22 March 2021. Nationally more than 4,500 accredited general practices participated in Phase 1b which was supported by more than 130 respiratory clinics and over 300 Aboriginal Community Controlled Health Services.

Locally in the GCPHN region, 121 accredited general practices participated in Phase 1b, supported by four respiratory clinics and one Aboriginal Community Controlled Health Service.

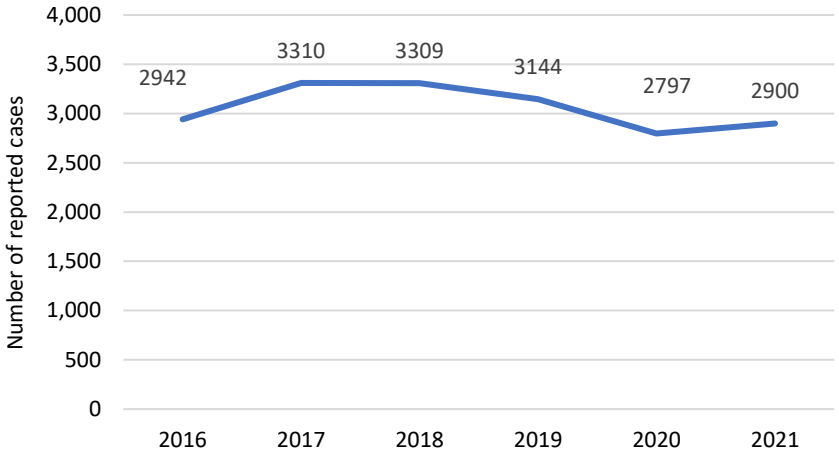
People who are eligible for vaccination under Phase 1b are:

- elderly people aged 70 and over,
- healthcare workers currently employed and not included in Phase 1a,
- household contacts of quarantine and border workers,
- critical and high-risk workers who are currently employed,
- Aboriginal and Torres Strait Islander people aged 55 years and over,
- adults with an underlying medical condition or significant disability.

Sexually Transmissible Infections (STI)

The number of sexually transmitted chlamydia cases increased by 3% in the GCPHN region from 2,797 in 2020 to 2,900 in 2021 (Figure 3), while the number in Queensland increase by 0.5% in the same period. However, both GCPHN region and Queensland numbers have dropped significantly from 2019, which may be due the fear of infection by COVID-19 which may have reduced sexual encounters and led to a genuine decline in STIs. However, patients may have also been postponing testing because of worries about attending the clinic during the pandemic, as has also described for other medical specialities.

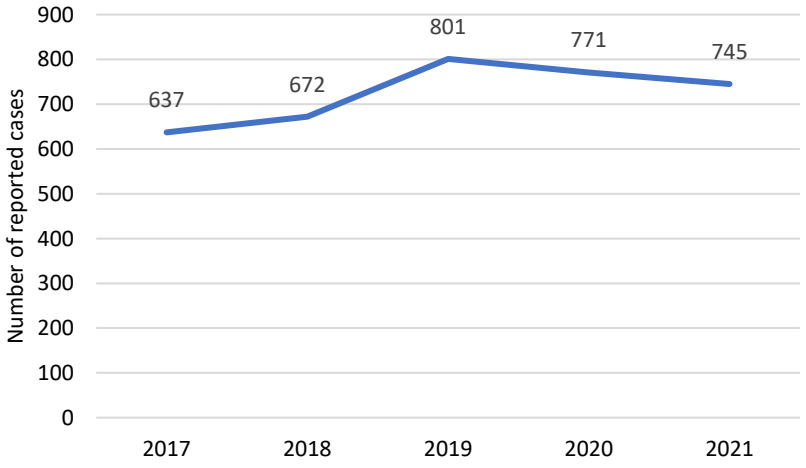
Figure 3. Number of sexually transmitted chlamydia reported cases on the Gold Coast, 2016-2021



Source: QLD Health, Notifiable conditions annual reporting, https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/surveillance/reports/notifiable/annual.

The number of sexually transmitted gonorrhoea reported cases slightly decreased in the GCPHN region from 771 in 2020 to 745 in 2021 (Figure 4), which is comparable to the trends for total Queensland.

Figure 4. Number of sexually transmitted gonorrhoea reported cases on the Gold Coast, 2017 to 2021



Source: QLD Health, Notifiable conditions annual reporting, https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/surveillance/reports/notifiable/annual.

Examining chlamydia and gonorrhoea notification rates by a local level (SA3) in the GCPHN region from 2019 indicated the rates shown below per 100,000 people.

Table 11. Rates of chlamydia and gonorrhoea per 100,000 people, Gold Coast SA3 regions, 2019

	Chlamydia	Gonorrhea
Gold Coast	672.0	157.1
Broadbeach-Burleigh	880.4	200.1
Coolangatta	624.9	121.8
Gold Coast- North	470.6	168.9
Gold Coast Hinterland	321.2	129.5
Mudgeeraba-Tallebudgera	474.8	85.3
Nerang	584.3	125.4
Ormeau-Oxenford	722	157.5
Robina	679.7	126.0
Southport	793.0	183.4
Surfers Paradise	861.7	238.1

Source: Gold Coast Public Health Unit, QLD Health, Notifiable conditions

In 2018-2019, due to the increasing rate of reported cases for STIs in Queensland and the poor awareness about sexual health and unsafe behaviours, particularly among young people aged 15-29 years old, Queensland Government launched the “Stop the rise of STIs” campaign.

The campaign focusses on improving knowledge and awareness around sexual health and encourages young Queenslanders (aged 15-29) who are sexually active to get tested regularly, positioning STI testing as a normal part of their health routine.

13 HEALTH Webtest is a free urine test for chlamydia and gonorrhoea that can be ordered online, and Queenslanders can order the test online and receive the result through 13 HEALTH. This service is confidential and can be ordered without a Medicare Card.

Service system

Services	Number in the GCPHN region	Distribution	Capacity discussion
General practices	212	General practices are well spread across the GCPHN region, including in the northern growth corridor where many children live. 81% of general practices have a general practice nurse many of whom assist in immunisation	• Childhood immunisations are free due to funding by the Government, but the consultation fee may differ between general practices. • Many new general practice nurses require training in immunisation—40% increase in number of general practice nurses between 2015-2016. • Immunisation education events are always well attended and often have a wait list. • General practices require support from GCPHN regarding data recording on Australian Immunisation Register.
General Practices enrolled in COVID-19 vaccination	121	General practices are well spread across the GCPHN region.	• Some general practices can provide COVID-19 vaccines or recommend other options

Aboriginal Controlled Health Organisations COVID-19 vaccination	3	Bilinga, Coomera, and Miami	• All Kalwun health clinics are currently offering the AstraZeneca COVID-19 vaccination for:
			  • Aboriginal and Torres Strait Islander clients aged 50+
			  • Elderly people aged 70+
			  • People aged 50+ who are eligible for the Queensland 1B rollout

Gold Coast Health COVID-19 vaccination clinic	2	Broadbeach Waters and Southport	• Members of the community aged 16 years and over can register to receive the COVID-19 vaccine at the Gold Coast University Hospital COVID-19 Vaccination Centre or at the temporary Albert Waterways COVID-19 Vaccination Centre in Broadbeach Waters
Gold Coast Respiratory Clinics	3	Burleigh Waters, Upper Coomera, and Hope Island	• Providing COVID-19 vaccinations for anyone aged 50+ and for people without a Medicare card, do not have a regular general practitioner (GP) and do not have their regular GP participating in the vaccine rollout

			• Bookings are essential
Kalwun/Nerang respiratory clinics	1	Nerang	• Providing vaccinations to anyone aged 50+ including the Aboriginal and Torres Strait Islander community. • Due to current medical advice, Kalwun is not vaccinating anyone aged under 50 until further notice.
Dedicated GP immunisation clinics	3	Labrador, Mermaid and Canungra	• These clinics provide a separate waiting area and no appointment is required.
Community immunisation clinics, Gold Coast Health	7	Burleigh Heads, Carrara, Coomera, Helensvale, Robina, Southport, Upper Coomera	• Drop-in—no appointments required • Free for people with a Medicare card to attend the clinic. • Vaccines on the National Immunisation Program Schedule Queensland are provided free. • Other vaccines incur a cost.
Online chlamydia and gonorrhoea test request	Online	Online	• 13 HEALTH Webtest is a free urine test for chlamydia and gonorrhoea that can be ordered online. The test is available to Queenslanders 16 years and older. • Queenslanders can order the test online and receive the results through 13 HEALTH. It is confidential and can be ordered without a Medicare Card.
Schools	111	Public and private schools across the GCPHN region	• Free vaccinations including HPV through the school immunisation program coordinated by GCPHU. • Queensland has legislated to require schools to provide student details to immunisation providers to assist with communication and consent processes.
Gold Coast Hospital Maternity and Antenatal Clinic	1	Southport	• Pregnant women can access immunisations including whooping cough and influenza. •
Private obstetricians and midwives	12	9 obstetricians, 3 midwives Spread across GCPHN region	• As above
Pharmacy	143	Various locations	• Pharmacist must undertake additional training to administer

			vaccines and pharmacies must implement additional processes (e.g. cold chain). • Pharmacists cannot vaccinate children or pregnant women.
Mobile services for vaccines	2	Various locations	• Onsite service for efficient administration of flu shots at aged care facilities, workplaces and schools. • Specialist immunisation nurses with vast experience in the industry. • Up to date Quadrivalent flu vaccines recommended by the World Health Organization.
Gold Coast University Hospital	1	Southport	• Pharmacy • Children's Critical Care • Birth Suite
Gold Coast Sexual Health Service	2	Southport and Palm Beach	• The Gold Coast Sexual Health Service provides testing and treatment for STIs and HIV management including PEP (Post Exposure Prophylaxis). • Sexual health counselling, information, education, and advice. • Vaccinations for Hepatitis B. • Free confidential walk-in and appointment-based service.
Griffith University health and Medical Service	1	Southport	• Vaccinations for Griffith University students attending clinical placement. • Travel vaccinations and flu vaccinations are offered.
Bond Medical Clinic	1	Varsity Lakes	• The medical clinic is a facility for currently enrolled students and staff members of Bond University.
Community based testing sites	1	Burleigh Heads	• Operating 3-6pm every Thursday, HIV and Syphilis testing
Information	Multiple	Web, brochures etc.	• While there are credible sources, there is a lot of incorrect information on the internet.

Consultation

GCPHN Community Advisory Council (September 2019)

- CAC members agreed there is not as much "fear" with the newer generations when it comes to sexual health.
- There appears to be a lack of understanding and education when it comes to:
    - contracting diseases orally
    - engaging in sexual activity with people from different age demographics.
    - the risk of cancer/HPV diseases
- Sexual education could be revisited so teenagers are better informed.
- More advertisements around sexual health, with a focus on social media to target youth and programs for incoming tourists were also suggested.
- Homeless people's access to vaccinations may be more difficult

GCPHN Clinical Council (August 2019)

- Lower immunisation numbers on the Gold Coast compared to national rate is a health issue.
- There is a chance to upskill general practice nurses and GP registrars on immunisation.
- Access generally not an issue for immunisation on the Gold Coast.
- Immunisation gets a lot of media coverage.
- Northern Gold Coast is a region that can be targeted for immunisation programs for children, as its overall rates are high but number of children that are not immunised is also high, this may be due to the large population of the region.

General practices and the GCPHN Primary Health Care Improvement Committee

- Consistent and reliable supply of some vaccines to general practice remains an issue. Most but not all general practice clinics have a reminder system in place to follow up overdue immunisations and the inconsistent supply impacts on ability to efficiently manage use of recall and reminder systems, resulting in many immunisations being done opportunistically.
- Travel vaccinations also noted as challenging with a desire for improved access to up-to-date information to support GPs.
- Larger uptake of flu vax for children observed over recent season, noted this is likely due to media coverage.
- Some general practices advertise to the general population that flu vax is free 'for everyone' creating confusion for some patients if they are not in an eligible group and the general practice they visit does not bulk bill.
- Ongoing education for staff in a highly mobile workforce is very important. In addition, there are some concerns there may be health professionals on the Gold Coast who do not actively support or recommend vaccination, further reinforcing the need for ongoing education.
- Complicated changes to schedules and variation between states cause issues, particularly for cross border patients.

GCPHN Community Advisory Council (October 2017)

- As flu vaccines only covers some strains there is scepticism about effectiveness of flu vaccine and having / hearing about reactions to vaccines make many reluctant to have one.
- Growing awareness in community of potential harm of vaccine preventable diseases but still some who are adamant against childhood vaccines in particular. Some concerns that forcing people to vaccinate their children through monetary and other mechanisms is not ethical.
- Where there is a cost for a vaccine it is a significant barrier for many.

Perinatal and early childhood

Local health needs and service issues

- High rates for children who are developmentally vulnerable across two or more domains in the Ormeau-Oxenford and Gold Coast-north SA3 regions.
- Younger mothers (aged under 20) have higher rates of smoking while pregnant, low birthweight babies and are less likely to breastfeed, compared to mothers aged 20 years and more in the GCPHN region.
- Aboriginal and Torres Strait Islander women have higher rates of smoking while pregnant and low birthweight babies compared to non-Aboriginal and Torres Strait Islander women on the Gold Coast.
- Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs.
- Addressing these mental health issues for children in care is hampered by:
    - long wait times for assessment and treatment in the public system,
    - cost of private services,
    - barriers around sharing information and centralised depository from medical history that non-health professionals can contribute to, and
    - limited availability of low-cost assessments for diagnosis and National Disability Insurance Scheme applications,
- Rate of women being diagnosed with perinatal depression are increasing.

Key findings

- The data explored in this needs assessment suggests that mothers in the GCPHN region have high rates of antenatal care through their pregnancy which is linked to positive health outcomes and behaviours for mothers and their newborns.
- Consultation suggests that there is room for preventive care around postnatal depression, with mental health assessed in the pre- and postnatal stages.
- There is a large waitlist for fetal alcohol spectrum disorder (FASD) assessments for 7 to 10 year olds in the GCPHN region.

Prevalence, service usage and other data

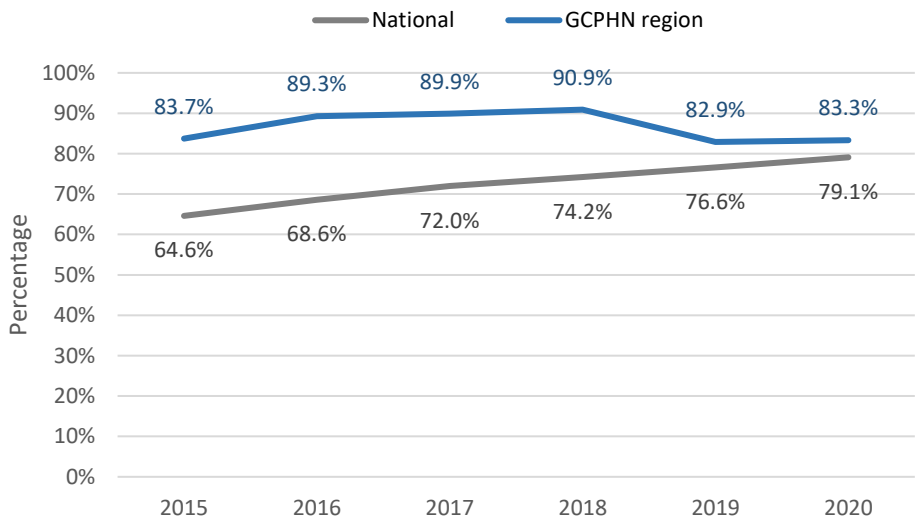
The early years of a child's life provide the foundation for future health, development, and wellbeing. Maternal nutrition and toxic avoidance are the foundation for the child's growth. The first year of life is also important for the newborn's health through appropriate feeding, including breastfeeding and sleep. As the child ages the education that they receive shapes their future health outcomes.

Antenatal care

Antenatal care is a preventive healthcare which includes regular check-ups for the mother that allow health professionals to treat and prevent potential health problems through the duration of pregnancy and to promote healthy lifestyles that benefit both mother and child.

The Gold Coast Primary Health Network (GCPHN) region had a higher rate of antenatal visits compared to the national rate across 2015 to 2020. The national rate increased by 14.5% from 2015 to 2020, while the rate in the GCPHN region first increased from 2015 to 2018, and then declined by 7.6% from 2018 to 2020. The slight decline in the GCPHN region for 2019 and 2020 could be attributed to increased personal safety concerns and the ability for women to attend a face to face service due to COVID-19 pandemic[1].

Figure 1. Percentage of women who gave birth and had at least one antenatal visit in the first trimester, nationally GCPHN region, 2015-2020



Source: Australian Institute of Health and Welfare 2022. National Core Maternity Indicators. Cat no. PER 95. Canberra: AIHW.

Breastfeeding

Breastfeeding promotes healthy growth and development of infants and young children. The National Health and Medical Research Council recommends that infants are exclusively breastfed until around six months of age when solid foods are introduced and that breastfeeding is continued until 12 months of age and beyond, for as long as the mother and child wish. In 2016 in Queensland, 77% of infants were receiving only breast

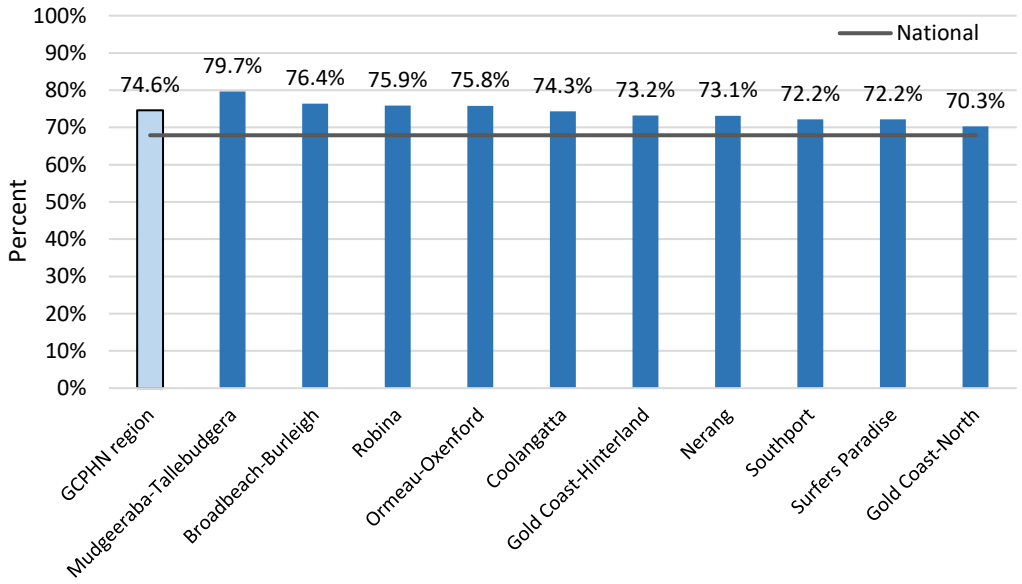
[1] Australian Institute of Health and Welfare (2022) Health of mothers and babies, AIHW, Australian Government

milk at discharge from hospital, 16% received breastmilk and infant formula, and 7% were receiving only infant formula.

The GCPHN region had a higher percentage of fully breastfed babies (no formula) at three months with 75% compared to the national rate of 68% in 2014-2015.

Among GCPHN's SA3 regions, Mudgeeraba-Tallebudgera (80%) and Broadbeach-Burleigh (76%) had the highest percentage of fully breastfed babies at three months, and Gold Coast-North (70%) and Surfers Paradise (72%) had the lowest percentages of fully breastfed babies.

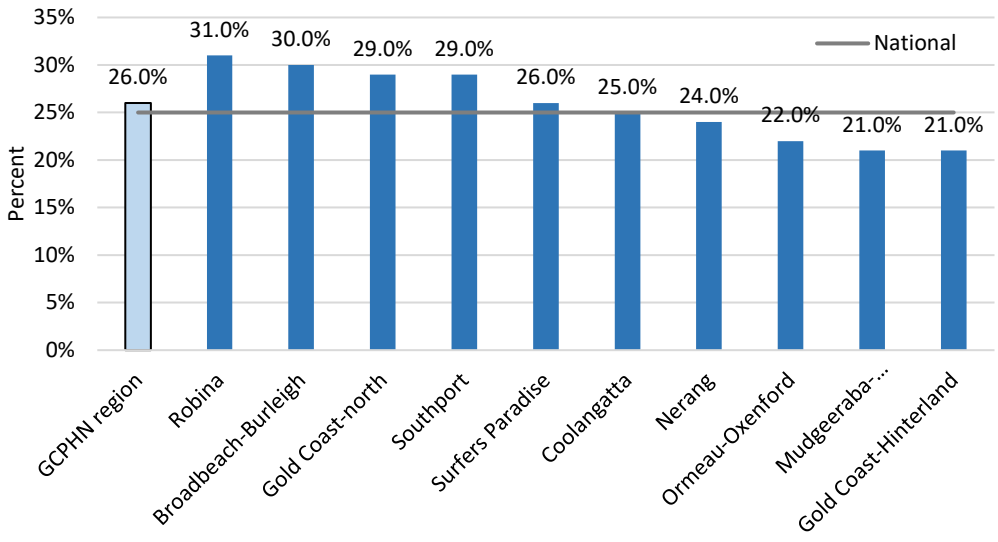
Figure 2. Percentage of fully breastfed babies at 3 months, Gold Coast SA3 regions, 2014-2015



Source: PHIDU, Social Health Atlas, http://phidu.torrens.edu.au/social-health-atlases/data

The GCPHN region had a comparable percentage of fully breastfed babies at six months as the national rate of (26% and 25%, respectively) in 2014-2015. Among SA3s in the GCPHN region, Robina (31%) and Broadbeach-Burleigh (30%) had the highest percentage of fully breastfed babies at six months, and Gold Coast Hinterland (21%) and Mudgeeraba-Tallebudgera (21%) had the lowest rate (Figure 3).

Figure 3. Percentage of fully breastfed babies at 6 months, Gold Coast SA3 regions, 2014-2015.



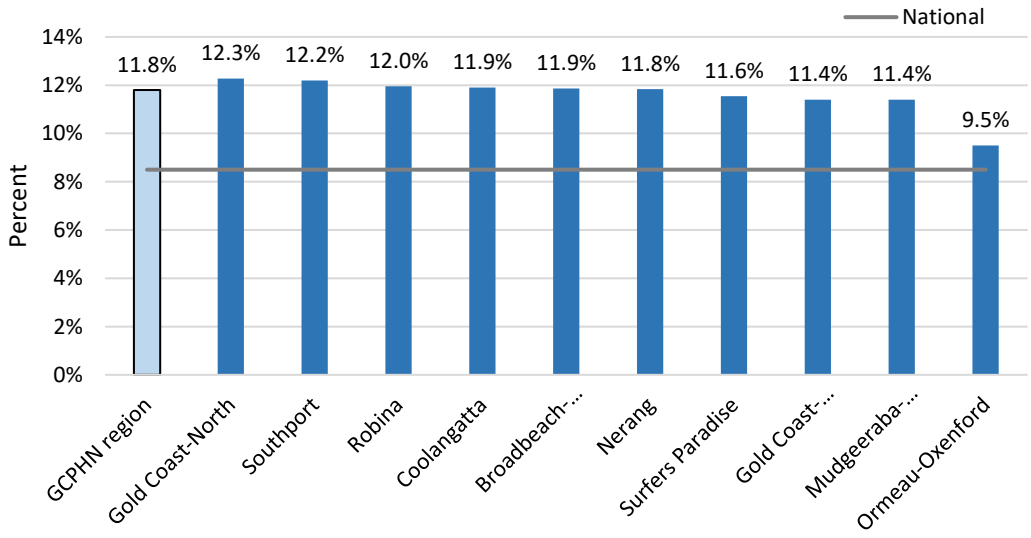
Source: PHIDU, Social Health Atlas, http://phidu.torrens.edu.au/social-health-atlases/data

The Department of Health strongly recommend that solids are not introduced before four months of age, since at this age, the digestive system, immune system, kidneys, and ability to chew and swallow the foods are not fully developed or ready for solids. As solids are introduced, there often is a reduction in breastfeeding.

The GCPHN region had a higher percentage of children aged zero to three years who first ate semi-solid or solid food before four months with 11.8% compared to the national rate of 8.5%.

Gold Coast-North (12.3%) had the highest percentage of children who ate semi- solid or solid food before four months while Ormeau-Oxenford had the lowest percentage in the GCPHN region (9.5%) (Figure 4).

Figure 4. Children aged 0-3 years who ate semi-solid or solid food before 4 months of age, Gold Coast SA3 regions, 2014-15



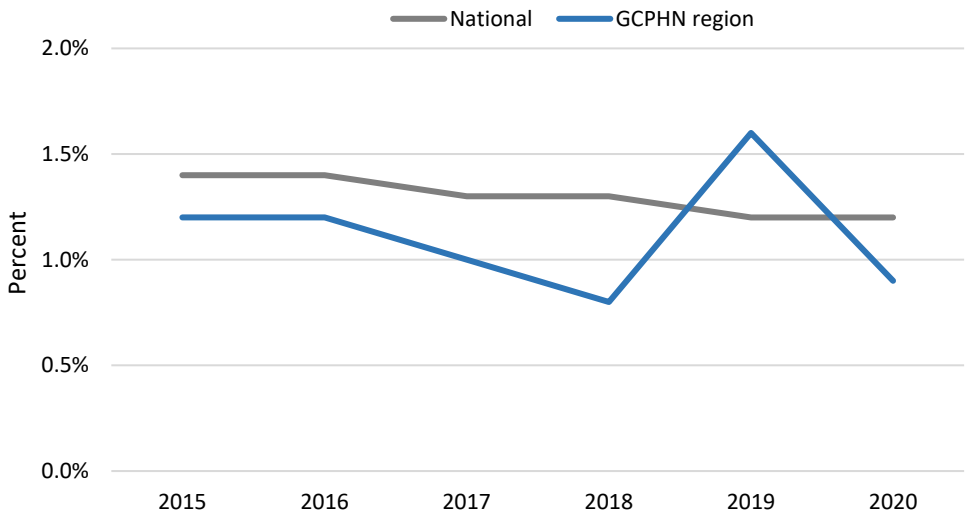
Source: PHIDU, Social Health Atlas, http://phidu.torrens.edu.au/social-health-atlases/data

Low birthweight

Low birthweight newborns are at greater risk of poor health, disability, and death compared to babies of healthy weight. Factors that affect low birthweight include maternal age, illness during pregnancy, low socioeconomic status, harmful behaviours such as smoking or excessive alcohol consumption, poor nutrition during pregnancy and poor antenatal care[2].

The percentage of live births that were low birthweight (born at or after 40 weeks gestation who weighed less than 2,750 grams) in 2020 the GCPHN region was 0.9%, which was lower than the national rate of 1.2%. Both the GCPHN region and national rates have decreased from 2015 to 2020. Data on child and maternal health in the GCPHN region compared to Queensland for Aboriginal and Torres Strait Islander population can be seen on subsequent pages.

Figure 5. Percentage of live births that were low birthweight Nationally and in the GCPHN region, 2015 to 2020



Source: Australian Institute of Health and Welfare 2022. National Core Maternity Indicators. Cat no. PER 95. Canberra: AIHW.

Smoking during pregnancy

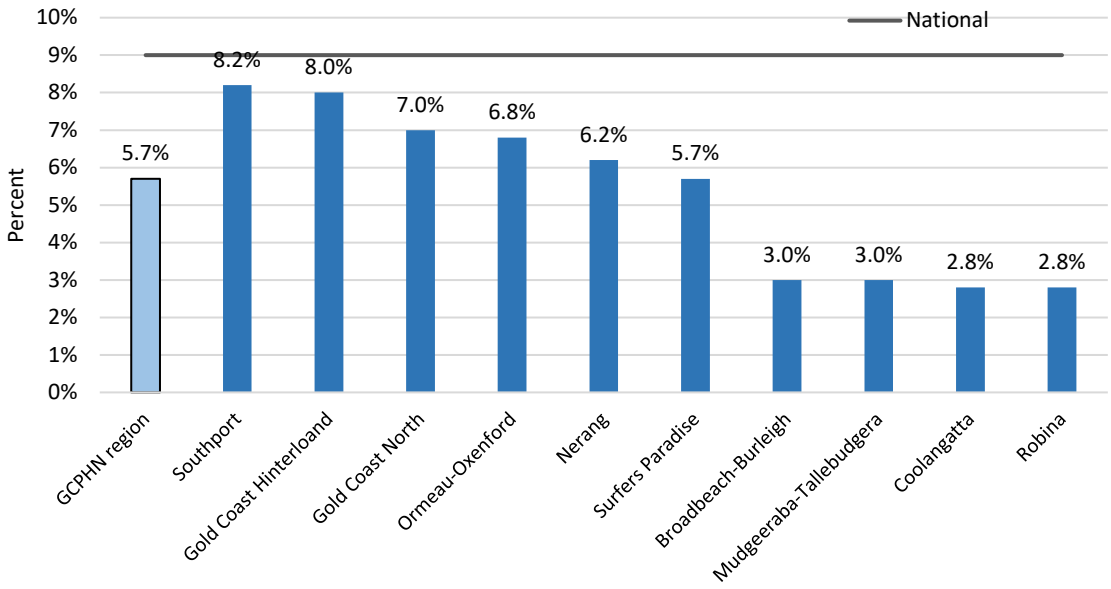
Smoking while pregnant exposes the mother and their unborn child to an increased risk of health problems. The percentage of women who smoked during pregnancy in the GCPHN region in 2018-2020 (5.7%) was lower compared to the national rate (9.0%). Both the national and GCPHN region's rate has decreased in recent years.

The GCPHN region's rate has decreased from 7.1% in 2016-2018 to 5.7% in 2018-2020. Southport had the highest percentage of women who smoked while pregnant in 2018-2020 with 8.2% while Coolangatta and Robina had the lowest with 2.8% (Figure 6).

Data on child and maternal health on the Gold Coast compared to Queensland for Aboriginal and Torres Strait Islander population can be seen on subsequent pages.

[2] Goldenberg RL & Culhane JF 2007. Low birthweight in the United States. American Journal of Clinical Nutrition 85:584s-90s

Figure 6. Percentage of women smoking in the first 20 weeks of pregnancy, Gold Coast SA3 regions, 2018-2020



Source: Australian Institute of Health and Welfare 2022. National Core Maternity Indicators. Cat no. PER 95. Canberra: AIHW.

Substance abuse among pregnant women

Substance use among pregnant women is a concern as drugs can cross the placenta and lead to a range of health problems, including abnormal fetal growth and development. Data from the National Drug Strategy Household Survey 2019'(NDSHS) indicated[3]:

- In 2019, nearly two thirds of women abstained from alcohol while pregnant, up from 56% in 2016 and 40% in 2007.
- 55% consumed alcohol before they knew they were pregnant, and this declined to 14.5% once they knew they were pregnant (down from 25% in 2016).

Perinatal depression

The perinatal period can be a volatile time and addressing the complex needs of the mother and baby both as individuals and a dyad is essential to ensure the best possible outcomes. Recognising symptoms early and seeking help minimises the risk of potentially devastating outcomes for new parents and their baby[4].

Data from 2010 showed that one in five mothers of children aged 24 months or less had been diagnosed with depression in Australia. More than half of these mothers reported that their diagnosed depression was perinatal (that is, the depression was diagnosed from pregnancy until the child's first birthday[5]). Data on perinatal depression in the GCPHN region is limited but nationally, perinatal depression was more commonly reported among mothers who:

- were younger (aged under 25)

[3] Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW

[4] Deloitte Access Economics. (2012). the cost of perinatal depression in Australia – Final report. Available from: https://www.deloitteaccesseconomics.com.au/uploads/File/PANDA%20Exec%20Summ%20pdf.pdf

[5] Australian Institute of Health and Welfare, 2010 Australian National Infant Feeding Survey

- were smokers
- came from lower income households
- were overweight or obese
- had an emergency caesarean section

Data extracted through PATCAT from 158 general practices in the GCPHN region from April 2020 to March 2021 showed there was a total of 1,773 active patients with a coded postnatal depression. Of these, 80% were females aged 25 to 44 years old.

Psychological Services Program

The Psychological Services Program provides short term psychological interventions for financially disadvantaged people with non-crisis, non-chronic, moderate mental health conditions or for people who have attempted, or at risk of suicide or self-harm. This program targets several underserviced groups including children.

From July 2021 to June 2022 there were 1,620 referrals and 6,999 sessions delivered.

Table 1. Number of persons accessing Psychological Services Program on the Gold Coast, 2021-22.

	Referrals		Sessions	
	Number	Percentage	Number	Percentage
Adult Suicide Prevention	1,056	65.2%	4,909	70.1%
Children	235	14.5%	849	12.1%
Aboriginal and Torres Strait Islander	111	6.9%	383	5.5%
Homeless	55	3.4%	197	2.8%
CALD	47	2.9%	248	3.5%
Perinatal	68	4.2%	215	3.1%
LGBTIQAP+	48	3.0%	197	2.8%
General (COVID19 Response)	0	0	0	0
Total	1,620		6,999	

Source: PIR-FIXUS

Young mothers

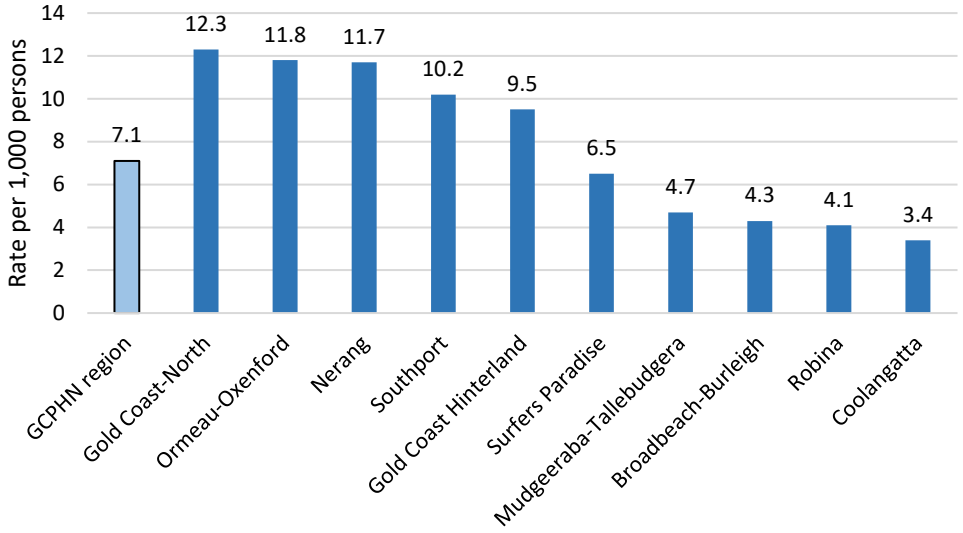
In the GCPHN region in 2015, 124 women who gave birth were aged younger than 20 years. Of these mothers, 24.2% stated that they smoked at any time during their pregnancy and 12.7% gave birth to low birthweight babies (<2,500grams)[6] .

Gold Coast-North SA3 region had the highest birth rate per 1,000 women aged younger than 20 years with 12.3 births while Coolangatta had the lowest birth rate with 3.4 per 1,000 women (Figure 7).

[6] Teenage mothers in Australia, 2015, https://www.aihw.gov.au/reports/mothers-babies/teenage-mothers-in-australia-2015/data

Younger mothers (under 20 years of age) were less likely to breastfeed (65 % exclusive breastfeeding at discharge) and more likely to use instant formula (11%)[7].

Figure 7. Birth rate per 1,000 women aged younger than 20 years, Gold Coast SA3 regions, 2015



Source: Teenage mothers in Australia, 2015

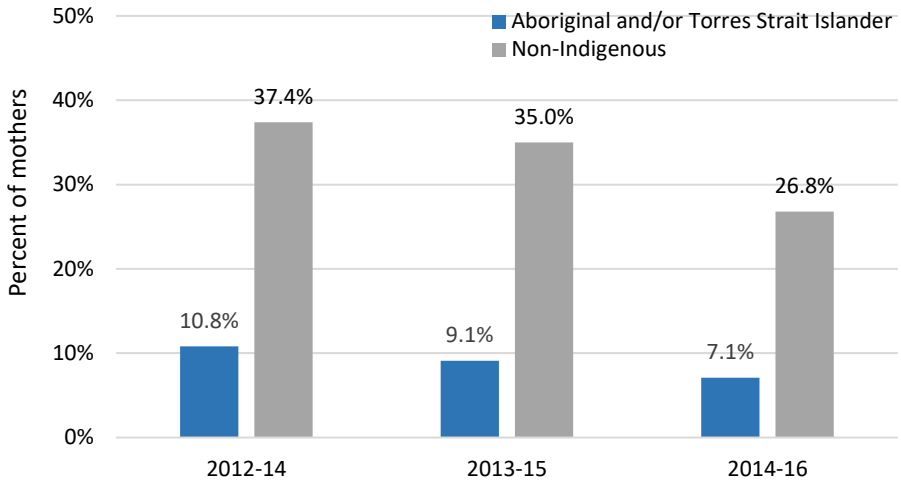
Aboriginal and Torres Strait Islander mothers

Among Aboriginal and Torres Strait Islander women in the GCPHN region who gave birth in 2014-2016, 26.8% reported that they smoked during pregnancy, compared to 7.1% of non-Indigenous women in the region (Figure 8).

This number is below the national rate of 45.2% and the Gold Coast rate has decreased from 37.4% in 2012-2014 while the national rate has decreased from 47.6% in 2012-2014.

[7] Department of Health. Queensland infant feeding survey 2014: current results, sociodemographic factors, and trends. Queensland Government: Brisbane; 2016

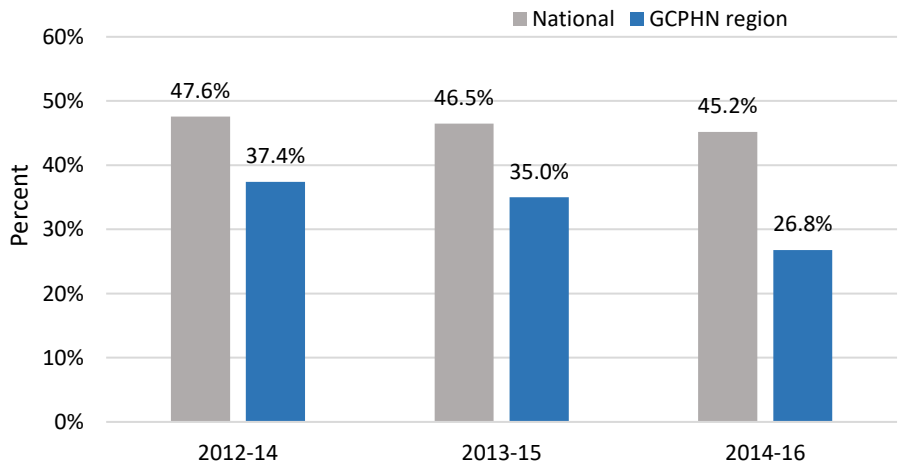
Figure 8. Percentage of Aboriginal and Torres Strait Islander women and non-Indigenous women who have birth and smoked during pregnancy, Gold Coast, 2012-2016



Source: AIHW Child and maternal health 2014-16 via my healthy communities

While the percentage of Aboriginal and Torres Strait Islander women in the GCPHN region who smoked is high compared to non-Aboriginal and Torres Strait Islander women, it's lower compared to the national rate of 45.2%. The GCPHN region's rate has decreased from 37.4% in 2012-2014 while the national rate has decreased from 47.6% in 2012-2014 (Figure 9).

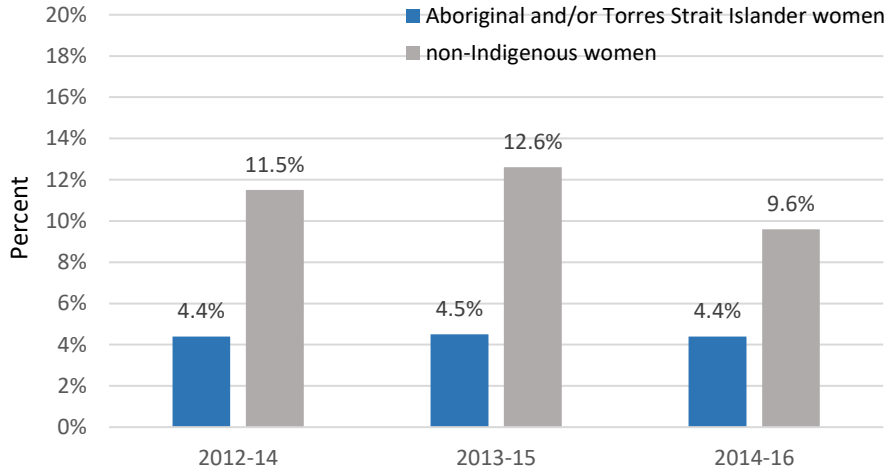
Figure 9. Percentage of Aboriginal and Torres Strait Islander women who gave birth and smoked during pregnancy, national and Gold Coast, 2012-16



Source: AIHW Child and maternal health 2014-16 via my healthy communities

The percentage of live births that were low birthweight (<2,500 grams) among Aboriginal and Torres Strait Islander women was 9.6%, compared to 4.4% of non-Indigenous women in the GCPHN region in 2014-2016 (Figure 10).

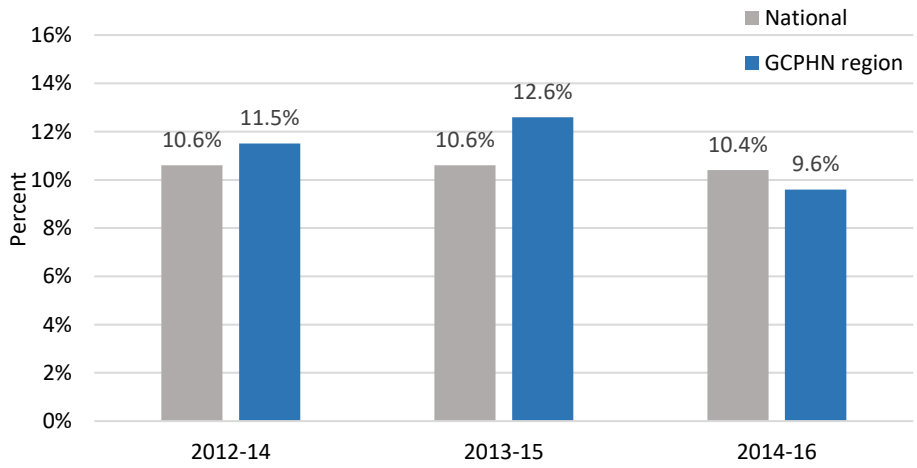
Figure 10. Percentage of Aboriginal and Torres Strait Islander women and non-Indigenous women on the GCPHN region who had low birthweight babies, 2012-16



Source: Child and maternal health in 2014-16 via my healthy communities, https://www.myhealthycommunities.gov.au/national/npdc002#indicator-year-low-birthweight-babies-aboriginal-and-torres-strait-islander-women-2014-2016

Although the percentage of live births that were low birthweight among Aboriginal and Torres Strait Islander women in the GCPHN region is high compared to non-Aboriginal and Torres Strait Islander women, it is lower compared to the national rate of 10.4% (Figure 11).

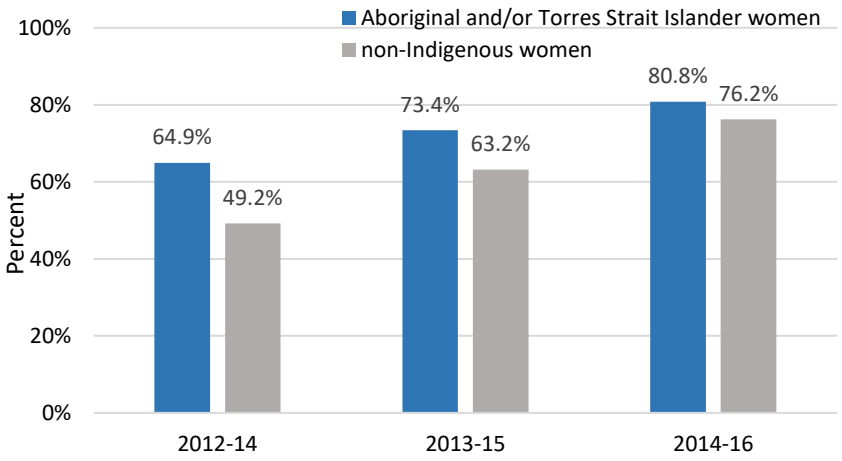
Figure 11. Percentage of live births that were low birthweight among Aboriginal and Torres Strait Islander women on the Gold Coast, 2012-16



Source: Child and maternal health in 2014-16 via my healthy communities

The percentage of Aboriginal and Torres Strait Islander women who gave birth and had at least one antenatal visit in the first trimester in the GCPHN region was 76.2% compared to 80.8% of non-Aboriginal and Torres Strait Islander women in 2014-2016 (Figure 12).

Figure 12. Percentage of Aboriginal and Torres Strait Islander women and non-Indigenous women who had at least one antenatal visit in the first trimester, Gold Coast, 2012-16

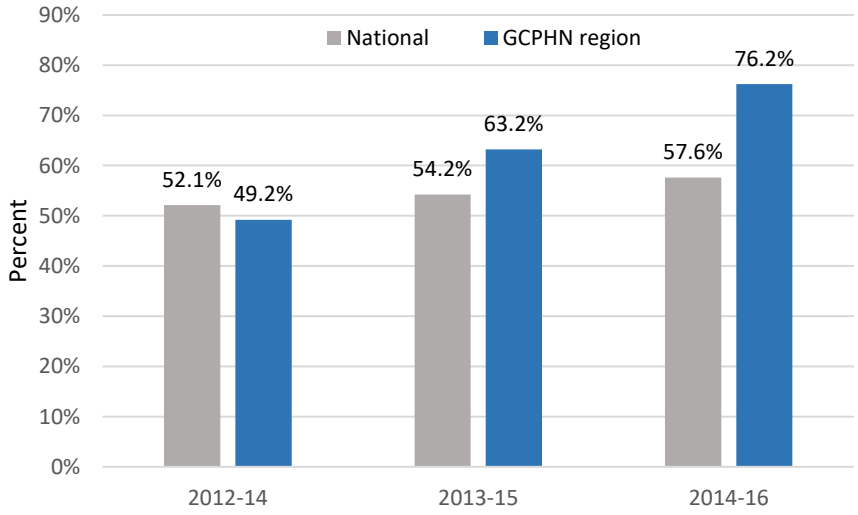


Source: Child and maternal health in 2014-16 via my healthy communities

In the Gold Coast region, the percentage of Aboriginal and Torres Strait Islander women who gave birth and had at least one antenatal visit in the first trimester is lower compared to non-Indigenous women, however, higher compared to the national rate of 57.6%.

This percentage in the GCPHN region has increased by over 13% each year over the past three years from 49.2% in 2012-2014 to 76.2% in 2014-2016 (Figure 13).

Figure 13. Percentage of Aboriginal and Torres Strait Islander women who gave birth and had at least one antenatal visit in the first trimester, nationally and Gold Coast, 2012-16



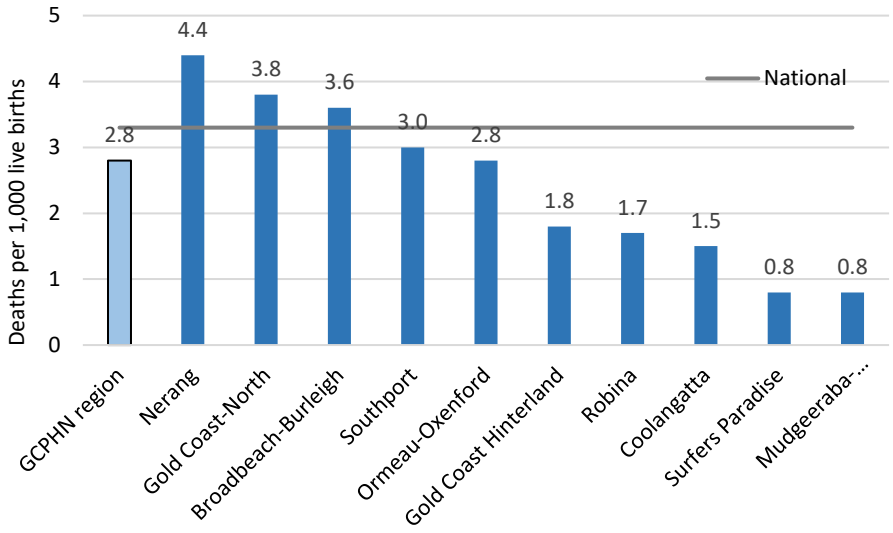
Source: Child and maternal health in 2014-16 via my healthy communities

Infant mortality

Measures of infant mortality provide insight into the socio-demographic and lifestyle factors into which Australian children are born and how these affects both life and death chances. Child mortality also provides a key measure of the effectiveness of the health system in maternal and perinatal health including insight into how well the system is working.

In 2014-16, the overall mortally rate in the GCPHN region for children aged less than one year was 2.8 per 1,000 live births, compared to the national rate of 3.3 per 1,000 live births. In the GCPHN region, Nerang had 4.4 deaths per 1,000 live births while Mudgeeraba-Tallebudgera and Surfers Paradise had 0.8 deaths per 1,000 live births (Figure 14).

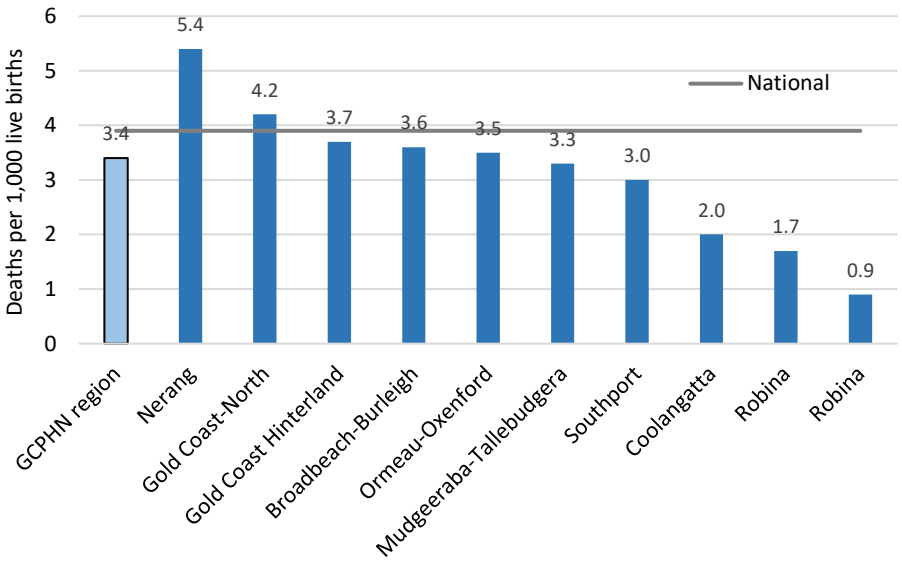
Figure 14. Mortality among infants aged less than one year old per 1,000 live births, Gold Coast SA3 regions, 2014-2016



Source: Child and maternal health in 2014-16 via my healthy communities

The mortality rate for children under 5 years old in the GCPHN region was 3.4 deaths per 1,000 live births, which is slightly lower compared to the national rate of 3.9. Nerang had 5.4 deaths per 1,000 live births while Robina had 0.9 deaths per 1,000 live births (Figure 15).

Figure 15. Mortality among infants aged less than five years per 1,000 live births, Gold Coast SA3 regions, 2014-16



Source: AIHW National Perinatal Data Collection 2012 to 2016, AIHW National Mortality Database 2010 to 2016

Dental health

Good oral health in childhood contributes to better wellbeing and improved dental outcomes in adulthood, such as less decay and the loss of fewer natural teeth.

In 2016-17, GCPHN region's rate per 100,000 people for dental hospitalisations for children aged 0-9 years was 775 compared to Queensland State at 675 per 100,000 people per year[8].

Australian early development census

A person's health and emotional wellbeing have their roots in early childhood.

The Australian Early Development Census (AEDC) provides a national measurement to monitor Australian children's development. With five sets of AEDC national data collected, progress can be tracked to determine if regions are working towards improving the development of Australian children. The AEDC measures the development of children in Australia in their first year of full-time school. The AEDC measures across five domains:

- physical health and wellbeing
- social competence
- emotional maturity
- language and cognitive
- communication skills and general knowledge

[8] The health of Queenslanders 2018, Report of the Chief Health Officer Queensland

Table 2. Percentage of developmentally vulnerable children, Gold Coast SA3 regions, 2021

Region	Physical health and wellbeing	Social competence	Emotional maturity	Language and cognitive	Communication skills /general knowledge	One or two domains	Two or more domains	Children accessed (number)
Queensland	11.6%	10.6%	10.0%	8.4%	9.1%	24.7%	13.2%	61,441
Gold Coast SA4	8.8%	8.8%	8.5%	5.9%	7.1%	20.4%	10.3%	6.910
Broadbeach-Burleigh	6.3%	6.4%	6.6%	3.1%	5.3%	16.3%	6.6%	639
Coolangatta	7.3%	6.5%	7.4%	3.2%	5.1%	16.7%	8.0%	627
Gold Coast North	9.7%	11.7%	9.3%	6.4%	10.0%	23.6%	11.4%	580
Gold Coast Hinterland	5.6%	5.1%	5.6%	1.5%	3.5%	14.7%	4.0%	198
Mudgeeraba-Tallebudgera	6.9%	7.9%	9.5%	3.8%	4.0%	18.2%	8.3%	521
Nerang	10.7%	11.4%	10.2%	7.3%	8.7%	24.3%	13.5%	859
Ormeau-Oxenford	10.0%	9.7%	9.3%	7.6%	7.6%	22.1%	11.8%	2,118
Robina	6.0%	6.5%	4.8%	3.7%	5.6%	13.9%	8.1%	569
Southport	10.6%	7.6%	8.2%	6.8%	8.4%	22.4%	10.8%	526
Surfers Paradise	9.5%	11.0%	10.6%	8.8%	9.2%	24.9%	13.2%	273

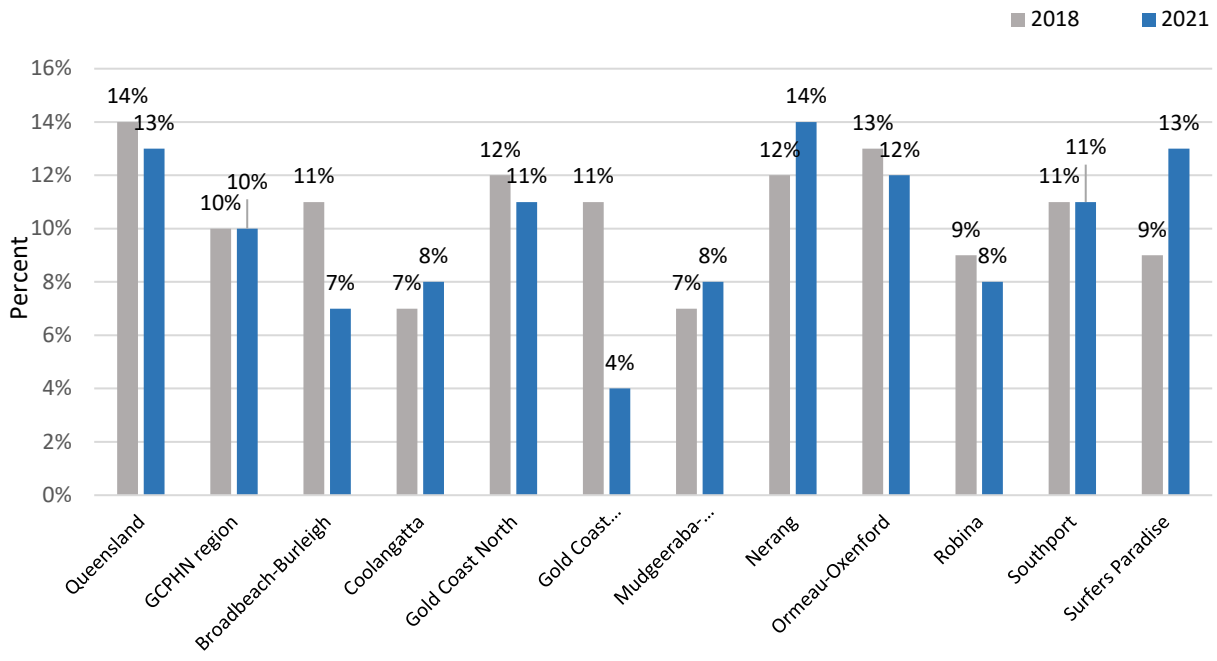
Source: Australian Early Development Census, Public table by statistical Area Level (SA3), 2009-2018

In 2021, 6,910 children participated in the AEDC in the GCPHN region, of which 20.4% were developmentally vulnerable in one or two domains. And 10.3% were vulnerable in two or more domains. These percentages were below the Queensland average (24.7% and 13.2%, respectively).

The AEDC has been completed by children from 2009 and there have been five censuses in this time. Figure 16 and 17 show rates of children who were developmentally vulnerable across one or two, or two or more domains across the Gold Coast SA3 regions between 2018 and 2021.

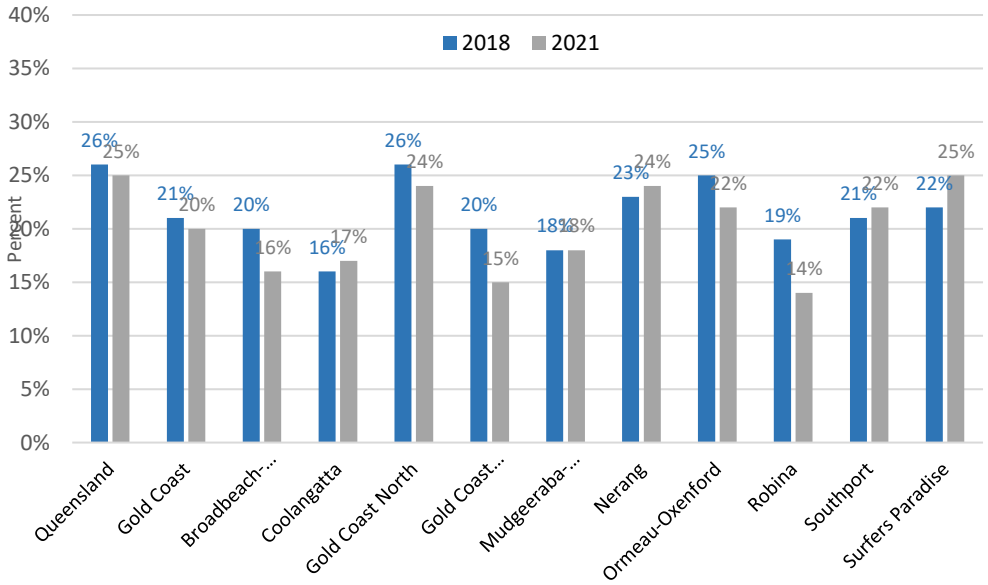
Five of the ten SA3 regions reduced their percentage of children that were developmentally vulnerable. Surfers Paradise had the largest increase from 22% to 25% for one or two domains, and 9% to 13% from for two or more domains.

Figure 16. Percentage of children who were developmentally vulnerable across two or more domains, Queensland, GCPHN SA3 regions, 2018-2021



Source: Australian early development censes, 2009- 2018

Figure 17. Children who were developmentally vulnerable across one or two domains, Gold Coast SA3 regions, 2018-2021



Source: Australian early development censes, 2018-2021

Influenza

Influenza is a highly contagious disease that peaks in winter months. It is usually prevented by vaccination and treated by managing symptoms. Influenza can affect anyone but is especially serious for pregnant women, babies and older people.

In 2017, the Gold Coast Public Health Unit surveyed hundreds of women who gave birth at the Gold Coast University Hospital and found that 71% of mothers were aware that they should have a flu shot during pregnancy, and of those,51% had the immunisation. When pregnant there is a triple benefit of having the flu shot - you can protect yourself, protect your unborn child and give your baby antibodies to fight influenza when it is born[9].

Overweight and obesity

The percentage of children that were overweight and obese in 2017-2018 in the GCPHN region was 23.4%[10]. This number is below the Queensland rate (26.2%) and is the lowest among the seven PHNs in Queensland.

COVID-19

COVID-19 Unmasked (Young Children) was an online study launched in Australia to help understand the mental health impacts of the pandemic on young children aged 1 to 5 and their families.

Survey was conducted between May and July 2020, with 776 caretakers completing the survey. Most respondents were mothers (93%). Families living in major cities, and university-educated parents with higher-than-average incomes, were overrepresented in the sample.

Survey results provided a good picture of how young children and their families cope with the pandemic, in Australia:

- one in four children are experiencing higher than average levels of anxiety symptoms,
- 5 to 10% of children may need specialised mental health support,
- one in five parents are struggling with moderate to severe anxiety, depression, or stress,
- young children are most affected by not seeing friends and family.

The survey also compared changes in young children and parents' emotional and behavioural wellbeing for those that did (Victorians) and did not (all other States and Territories) go through a second lockdown. In Victoria:

- Children who experienced the second lockdown in Victoria were 2 to 5-times more likely to show emotional and behavioural difficulties than children in other states.
- Between 27 and 44% of parents who experienced the second lockdown reported a significant increase in mental health difficulties in comparison to other states.
- Victorian children and families require higher levels of social and psychological support.

[9] Gold Coast Health, https://www.goldcoast.health.qld.gov.au/about-us/news/flu-shots-now-available-ahead-winter-flu-season
[10] The health of Queenslanders 2018, Report of the Chief Health Officer Queensland

Service system

Service	Number in GCPHN region	Distribution	Capacity
General Practices (Antenatal visits)	212	Clinics are generally distributed across the GCPHN region with the majority located in coastal and central areas.	• Confirmation of pregnancy • Immunity against infections that may affect the baby • Urine test (for evidence of diabetes or pre-eclampsia) • Progress of the baby (heartbeat, movements) • Progress of the mother, including emotional state • Antenatal visits are monthly until week 28, each two weeks from week 30 to 36 and weekly thereafter • Hospital visits usually occur for an initial assessment and then at week 32 and week 41
Antenatal clinics at hospitals	4	2 in Southport, 1 in Tugun and 1 in Benowa	• As listed above
Childbirth parenting classes	2	Tugun and Southport	• Pregnancy and process of birth • Pain relief and induction of labor • Assisted birth and cesarean section • Parenting the first few weeks
Lavender Mother and baby unit	1	Gold Coast University Hospital	• Four bed specialist state-wide acute service. • Specialist care for women who require admission to hospital for significant mental health difficulties in the first year following childbirth. • General Practitioners (GPs), Obstetricians, Pediatrician, Psychiatrist and Mental Health Services can refer patients to the unit.
Uniting Care (ECEI)	1	Carrara	• Determine the best support for child and family. • Identify information, community-based and mainstream supports that can be used to support child. • If required, can help request NDIS access and once confirmed, work with family to develop a plan.

			• Help with the implementation of the plan.
Child Development Service (CDS)	1	Southport	• The CDS is a community based, multidisciplinary health service involved in the assessment and management of children aged 0-10 years referred with problems of developmental, such as communication, movement, emotions, behavior or socialization.
Early learning Program (Kalwun),	1	Burleigh	• Central community point for those with young children to build and develop relationships, support each other and access important child and parent related information with a strong cultural connection held weekly. • Kalwun Jarjums playgroups is for parents/carers of Aboriginal and Torres Strait Islander children aged 0-5 years
Family participation program (Kalwun)	1	Kalwun	• The Family Participation Program (FPP) is here to help you and your family if you are dealing with child protection matters and the Department of Child Safety. • The FPP is for Aboriginal and Torres Strait Islander families with children and young people under the age of 18 years
Family wellbeing program (Kalwun)	1	Kalwun	• Kalwun's Family Wellbeing Service delivers timely, effective support to Gold Coast families with children and young people under the age of 18 years. • Kalwun's Family Wellbeing Service works with Aboriginal and Torres Strait Islander families with children unborn to 18 years of age.
Foster and kinship care	1	Kalwun	• The Kalwun Foster and Kinship Care service recruits, trains and assesses Aboriginal and Torres Strait Islander carers.
Jarjums playgroup	1	Burleigh	• Kalwun Jarjums Playgroup supports and enhances learning in young children with a strong emphasis on

			play-based learning are also welcome. • Kalwun Jarjums Playgroup is for parents/carers of Aboriginal and Torres Strait Islander children aged 0–5 years.
Birth Suites	4	2 in Southport, 1 in Benowa and 1 in Tugun	• Collaborative multidisciplinary approach to provide midwifery to all women with both low risk and high-risk pregnancies. • The facilities enable early discharge home for women and babies who have an uncomplicated birth. This allows a more family centered approach and promotes birth as a normal life event. • Home visiting team provide ongoing support with infant feeding and early parenting needs.
Community Child Health Clinics	8	Southport, Coomera, Upper Coomera, Helensvale, Nerang, Labrador, Robina, Palm Beach	• Health and developmental checks • Hearing assessment and referral (four years and over) • Feeding and nutritional support/information • Education and support groups • Parenting interventions to enhance parenting • Bedwetting program • Information and advice for parents for healthcare referrals • Indigenous health workers support Aboriginal and Torres Strait Islander families to access a variety of relevant services delivered
School interventions	111	State schools throughout Gold Coast	• State schools offer support and other services for children while they are in state schools
Paediatricians	32	Paediatricians generally distributed across the Gold Coast, with the majority located in coastal and central areas	• Manage the health of children, including physical, behavior and mental health issues. • Trained to diagnose and treat childhood illness, from minor health problems to serious disease.
Child Youth and Family Health	8	Southport, Coomera, Upper Coomera,	• Health advice for infants from birth to four years

		Helensvale, Nerang, Labrador, Robina, Palm Beach	• Home visiting by referral • Breastfeeding clinic, practical assistance • Parent education groups- an informal setting to discuss health issues, guest speakers attend • Weigh and monitor infant progress between routine clinic visits.
Community immunisation clinics, Gold Coast Health	6	Helensvale, Carrara, Upper Coomera, Burleigh, Robina and Southport	• Drop in - no appointments required. • Free for people with Medicare card to attend the clinic. • Vaccines on the National Immunisation Program Schedule QLD are provided free. • Other vaccines incur a cost.
Emergency departments (ED)	5	Southport and Robina (public) Southport, Benowa and Tugun (private)	• Private health insurance is required to access private EDs. • Limited integration with general practice data. Residents near boarders may also use nearby hospitals such as Tweed District Hospitals, Logan and Beaudesert.
Dedicated GP immunisation clinics	3	Labrador, Canungra and Mermaid Beach	• These clinics provide a separate waiting area, no appointment is required and does not need to be a patient of the clinic.
Psychological Services Program (PSP), Child (0-12) stream. Focus is moderate.	20 contracted organisations	Providers are available across the GCPHN region.	• The majority of child and youth mental health services focus on aged 12-25 with eligibility cut offs varying within the age bracket.
Psychological Services Program (PSP), Perinatal depression.	20 contracted organisations	Providers are available across the GCPHN region.	
Neurodevelopment Exposure Disorder Service (FASD) clinic	1 (1 of 2 in country)	Gold Coast University Hospital	• Diagnosis of Fetal Alcohol Syndrome Disorder caused by fetal alcohol exposure. • Each condition and its diagnosis are based on the presentation of features that are unique to the individual and may be physical, developmental and/or neurobehavioral. • Health professionals at the clinic include Paediatrician, Clinical Psychologists, Neuopsychologists, and Speech language pathologists,

			Physiotherapists, Occupational Therapists, Social Worker, and Nurse Navigator. • GPs, Paedistricians, Other medical specialist, Psychologists, Allied Health professionals, Child protection service, Education Departments and Justice Departments can refer to the service.
Day care	228	Day cares are spread throughout the Gold Coast	• Day care provides professional care for children aged 6 weeks to 5 years. • Some long day care centers offer Kindergarten or preschool programs.
Parenting programs for behaviour management	10 providers of varying programs. One online program	Parenting programs are spread across the Gold Coast	• Run regularly, some are limited to the clients of the service.

Consultation

The following key findings emerged through the consultation process with service providers, community members and people working closing with service providers in the GCPHN region who work with mothers and young children:

- Major issues that were identified:
    - postnatal depression
    - immunisation rates on the GCPHN region
    - GCPHN region has limited services for mothers and their children
    - If a service is not located near public transport, can be a barrier which can prevents access
    - families not having a regular GP or a regular general practice which they attend
    - extreme and excessive behaviours from a much earlier age in a preschool/school setting
    - long wait times into child related support services (FASD)
- Specific services that are missing or needs that are not met:
    - services that support parents with before and after school care
    - service providers need education on what other services are available to possibly refer to a lack of wrap around support
- Affordable assessments for autism diagnosis to apply for NDIS continues to be a big gap affecting families and children with long term access to NDIS packages. A diagnosis is required for an application, but many families cannot afford the outlay Department of Children, Youth Justice and Multicultural Affairs cannot cover these costs within their limited budget scope.
- Carers further report lack of information sharing from health professionals, for example, appointment letter and text reminder sent to the Child Safety Officer not the carer.
- Access to low-cost cognitive assessments is extremely limited. 1year+ waitlist for university clinics. Schools occasionally will support but they do not accept GP referral, only teacher referrals based on learning needs. Private fees are $2000-3000. Some services such as the public funded Child protection Unit have requested that child has a cognitive assessment before receiving paediatric assessment by the unit. Department of Child Safety, Youth and Women has very limited resources per child and limited.
- Service gaps that prevent children receiving timely services e.g., lack of publicly funded speech pathology.
- Fetal alcohol spectrum disorder (FASD) assessments for 7-10-year-olds has a 2-year waitlist.
- Griffith University Health clinics have the potential to move towards a multidisciplinary team care-based student clinic.
- Medicare funded services (mental health treatment plan) do not cover assessment cost.
- Allied health is not remunerated by Medicare for participation in case conferencing reducing opportunities for multidisciplinary approaches to complex care.
- Misdiagnosis of trauma as ADHD and ASD.
- Specific groups of mothers and children up to 6 years that have issues accessing services on the Gold Coast include:
    - low socioeconomic groups
    - those with limited access to transport
    - mother and child both have mental delay and complex needs

GCPHN's Community Advisory Council (September 2019)

- Current process of mother and baby being followed-up by a midwife at home after birth was supported by CAC members.
- CAC members noted that parenting grandparents do not receive all the same assistance currently and suggested that follow-up and support services need to "follow the baby".
- More prevention should be undertaken with mothers on post-natal depression to prevent the depression becoming severe.
- New mothers should have their mental health assessed in the pre and postnatal stages.
- Long wait times through NDIS for speech pathology etc.
- Confusion around support for children with a suspected disability and early childhood intervention services with NDIS.
- Long wait times, significant costs, limited number of clinicians leads to delays in assessment and effects subsequent access to services such as speech pathology.

The GCPHN's Clinical Council (August 2019)

- It is unclear what services are available for mothers with postnatal depression.
- It is difficult for GPs to identify mothers who may be taking drugs while pregnant.
- Building stronger communication channels between paediatricians and GPs.
- Speech therapy and occupational therapy are hard to access on the Gold Coast in terms of cost and wait times.
- Cognitive health assessments are highly priced with a long wait time.
- The importance of shared care with children diagnosed with Fetal Alcohol Spectrum Disorder.
- Chance to upskill general practice nurses and registrars on immunisations.

Service provider consultation

- Provision of services targeted at mums living with a mental health issue/illness.
- Low general practice referral to Early Childhood Early Intervention (ECEI), children being missed for early intervention as once in school it's too late:
  - The GP may be the only services that picks up on development delay if child is not attending preschool.
  - Parents' concerns on labelling their children may impact on their accessing NDIS partner ECEI.

Persistent Pain

Local health needs and service issues

- There are high rates of musculoskeletal conditions in Southport, Coolangatta, Ormeau-Oxenford, and Gold Coast-North.
- Pain management frequently focusses on medication.
- High levels of opioid dispensing across Gold Coast Primary Health Network region, particularly in Southport.
- Limited awareness and support for prevention and self-management of persistent pain.
- Suboptimal focus on multidisciplinary and coordinated care.
- Concerns for potentially ineffective and unnecessary treatments for persistent pain.

Key findings

- Gold Coast Primary Health Network (GCPHN) region's rate of people with musculoskeletal system diseases is slightly below the national rate.
- Close to one third of GCPHN region population with a musculoskeletal condition had a management plan in the last year with their general practitioner (GP).
- Rate of Pharmaceutical Benefits Scheme prescriptions dispensed for opioid medicines is above the national rate on the GCPHN region and has been increasing in recent years.
- Gold Coast Emergency Department (ED)'s presentations for low back pain are most frequent among the 30-49 year olds.
- GCPHN region's rate for MBS-funded services for CT imaging of the lumbar spine is above the national and Queensland rate.

Persistent pain

Persistent pain is pain that lasts beyond normal healing time after injury or illness - generally three to six months. It is a common and complex condition, and the pain experienced can be anything from mild to severe. The defining characteristic of chronic pain is that it is ongoing and experienced on most days of the week.

While prevalence data on persistent pain at a regional level is limited, it was estimated that around one in five Australians aged 45 years and over reports having persistent pain. Persistent pain is often linked to chronic musculoskeletal conditions, which have a slightly lower prevalence in the GCPHN region compared to national rates. However, an ageing population combined with predictions that the prevalence of musculoskeletal conditions will rise in Australia over the next few decades means that there is likely to be increasing cases of persistent pain in the GCPHN region.

Persistent pain has a large effect on a person's life and on the Australian economy more broadly. The financial cost of persistent pain in 2018 was an estimated $73.2 billion[1]. This included:

- $48.3 billion (66%) for productivity costs, reflecting the impact on a person's ability to work, work performance and employment outcomes.
- $12.2 billion (17%) for direct health system costs (where known cause and unknown cause of chronic pain estimates are the same).

There are increasing concerns about the trend in prescribing opioid medications, dependency, and addiction issues and possible long-term adverse effects. Rates of opioid medication prescriptions in the GCPHN region are slightly higher than the national average.

Recommended treatment for persistent pain promotes self-management and involves an integrated multidisciplinary approach. There are several specialist pain clinics and a range of primary care providers in the GCPHN region, but consultation indicates issues exist with service access and coordination.

An initiative delivered by GCPHN found that an integrated self-management model of care can lead to improved perceptions on pain, health service access, safe and effective medication use, ability to perform everyday activities and coping, as well as a reduction in hospitalisations.

Prevalence

Measuring how many people have chronic pain in Australia is difficult[2]. Pain is a subjective experience, and the few national data sources that include measures of chronic pain use different definitions.

In 2016, it was estimated that around one in five Australians aged 45 years and over reported having persistent pain[3]. Persistent pain increased with increasing age, to almost one in four adults (24%) aged 85 and over. If this rate were to remain stable today, a crude estimate would be that 51,000 residents of the GCPHN region aged 45+ have reported having persistent pain based on 2016 census population.

According to the Bettering the Evaluation and Care of Health (BEACH) study, more people are seeing GPs for persistent pain. Between 2006-2007 and 2015-2016, the rate of GP visits for chronic back pain or unspecified

[1] Pain Australia 2019c. The cost of pain in Australia. Canberra: Deloitte Access Economics. 2019.
[2] Pain Australia 2019b. National Pain Strategy. Canberra: Pain Australia. Viewed 25 November 2019.
[3] ABS 2017. Survey of Health Care, Australia 2016. ABS cat. No. 4343.0. Canberra: ABS. Findings based on AIHW analysis of ABS microdata.

chronic pain were managed during the visit increased 67%, representing about 400,000 more encounters for both conditions[4].

There are many conditions that cause persistent pain, with most being chronic musculoskeletal conditions such as osteoarthritis, back and neck pain, osteoporosis, and fibromyalgia. In Australia, the burden of disease attributed to musculoskeletal conditions is ranked second amongst all chronic health conditions in terms of years of healthy life lost due to disability. Modelling conducted in 2013 by Arthritis and Osteoporosis Victoria[5] predicated the prevalence of arthritis and other musculoskeletal conditions in Australia:

- As Australia's population ages over the next two decades, the prevalence of musculoskeletal conditions will rise significantly.
- By 2032, it is projected that the number of cases of arthritis and other musculoskeletal conditions will increase by 43% to 8.7 million, affecting 30.2% of the population.
- The number of people with osteoarthritis and osteoporosis is projected to increase the fastest (58% and 50% growth, respectively), however back problems will remain the most prevalent condition.
- The age group with the most cases of arthritis and other musculoskeletal conditions is currently 55-64 years, however this will change to the 75+ age group by 2032.

Musculoskeletal conditions

In 2014-2015, 166,059 adult residents in the GCPHN region were living with a musculoskeletal condition, accounting for a rate of 29.1 per 100 people, which was slightly lower than the national rate of 29.9. A regional breakdown of the number and rate of people living with musculoskeletal condition can be seen in Table 1.

Table 1. Estimated number of people with musculoskeletal system diseases, 2014-2015

Region	Number	Age-standardised rate per 100 people
National	6,858,779	29.9
Gold Coast SA4	166,059	29.1
Broadbeach-Burleigh	19,542	28.4
Coolangatta	17,306	29.6
Gold Coast- North	21,655	29.5
Gold Coast Hinterland	5,847	28.2
Mudgeeraba-Tallebudgera	9,537	29.4
Nerang	19,378	29.4
Ormeau-Oxenford	29,715	29.6
Robina	14,332	29.3
Southport	16,718	29.9
Surfers Paradise	12,029	28.2

Source: Public Health Information Development Unit (PHIDU), Torrens University. Social Health Atlas of Australia: Primary Health Networks. Extracted 17-07-19.

[4] Britt H, et al. (2016) A decade of Australian general practice activity 2006–07 to 2015–16. General practice series no. 41.
[5] Arthritis and Osteoporosis Victoria (2013). A problem worth solving.

Of the 166,059 residents in the GCPHN region living with a musculoskeletal condition, 72,906 or about 44% of cases have a form of arthritis. Due to the complex nature of persistent pain, it is often unclear whether persistent pain is the cause or the result of socioeconomic disadvantage. GCPHN region has a relatively older age profile compared to the national average, which indicates that levels of persistent pain could increase in the GCPHN region in the coming years.

Persistent pain has a significant negative effect on the quality of life and contributes to wide economic costs. Financial modelling conducted in 2007 estimated that the total cost of persistent pain was $10,846 per person. It is reasonable to assume these costs have increased over the last decade due to the increase in the average age of the population. Around 20% of costs impact the health system, including inpatient or outpatient hospital services, primary care, pharmaceuticals, and residential aged care[6].

Over half of the cost of chronic pain is borne by individuals and their families and friends, with loss of productivity being a significant contributory factor. Over 90% of people with severe pain report some level of interference with the ability to work in both paid employment and housework.

Rates of paid employment for people with arthritis and other musculoskeletal conditions are 3.5% lower than the general population. Back pain and arthritis are the most common causes for people aged 45-64 years to leave the workforce, accounting for around 40% of forced retirements[7].

Persistent pain has been shown to lead to depression, anxiety spectrum disorders and suicide. The nature of persistent pain means that it can restrict self-management, particularly a person's capacity to manage their weight through physical activity. This can lead to comorbidities such as type 2 diabetes and cardiovascular problems. Older people experiencing persistent pain with comorbidities are likely to be taking multiple medications, which places them at a greater risk of an adverse drug event[8].

Musculoskeletal conditions – local data

Analysing data extracted from GCPHN's PATCAT system[9] as of March 2022[10], of the 587,244 active patients (three visits in the past two years), 16% (n=92,914) had coded musculoskeletal condition. Of the those, 42% were males and 58% were females. People aged 60 to 79 made up 54% of all people in the GCPHN region with a coded musculoskeletal condition. Table 2 breakdowns the different types of musculoskeletal conditions include inflammatory arthritis, bone disease, osteoporosis, and osteoarthritis of all active patients.

[6] MBF Foundation (2007) the high price of pain: the economic impact of persistent pain in Australia. Report conducted by Access Economics in collaboration with the Pain Management Research Institute - The University of Sydney/Royal North Shore Hospital.
[7] Schofield et al. (2012) Quantifying the productivity impacts of poor health and health interventions, Health Economics, University of Sydney.
[8] National Health Survey. Australian Bureau of Statistics, 2017-2018.
[9] PAT CAT is a web-based interface that aggregates de-identified General Practice data for population health management and research programs.
[10] Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the GCPHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

Table 2. Active population with coded musculoskeletal condition as of March 2022.

	Number	Rate
Active population	587,244	
Active population with a coded musculoskeletal condition	92,914	16%
Active population with a coded Inflammatory arthritis	12,174	13%
Active population with a coded musculoskeletal other	21,479	23%
Active population with a coded bone disease	72,488	78%
Active population with a coded osteoporosis	31,347	34%
Active population with a coded osteoarthritis	52,982	57%

Source: Gold Coast Primary Health Network PATCAT tool, Includes active patients with a coded diagnosis of at least one, inflammatory arthritis, musculoskeletal other, bone disease, osteoporosis and/or osteoarthritis.

Musculoskeletal conditions – risk factors

There are several risk factors associated with the onset and management of chronic musculoskeletal conditions that cause persistent pain. These include age, obesity, physical inactivity, smoking and co-morbidities such as cardiovascular disease and mental health conditions. Persistent pain is also more likely to be experienced by people in low socioeconomic groups.

Based on GCPHN's PATCAT System, Table 3 highlights risk factors for musculoskeletal condition as of March 2022 among general practices in the GCPHN region. Please note, not all risk factors are recorded in general practices medical software.

Table 3. Active population risk factors for musculoskeletal condition, Gold Coast, as of March 2022

	Number	Rate
Active population	587,244	
Low BMI	58,213	9.9%
Vitamin D deficiency	11,400	1.9%
Smoking	63,153	10.7%
High alcohol intake	65,726	11.2%
Calcium deficiency	48	0.1%
Fracture (minimal trauma)	6,230	1.1%
Chronic kidney disease	7,815	1.3%
Multiple myeloma	328	0.6%

Source: GCPHN PATCAT

Service utilisation

Pain Australia, the peak advocacy body for pain-related conditions in Australia, estimates that less than 10% of people with persistent non-cancer pain gain access to effective care, even though current knowledge would allow 80% to be treated effectively if there was adequate access to pain services[11].

[11] Pain Australia (2016). Prevalence and the Human and Social Cost of Pain, Pain Australia Fact Sheet 2.

Data from the BEACH study of general practice in Australia found that persistent pain affects around one in five patients attending GP consultations and increases with age, which is consistent with broader population estimates. Around 86% of patients managed persistent pain with at least one medication, with that rate increasing to 93.4% of patients in the 65 years and over age group. In this age group, about a third of those prescribed medications for management of persistent pain included opioids (including low dose combination products).

Opioids such as codeine and oxycodone are often prescribed to relieve and treat pain symptoms. According to a report published by Australian Commission on Safety and Quality in Health Care[12] into the prescribing and dispensing of opioid medicines:

- Current evidence does not support using opioid therapy for chronic pain,
- The prescribing of opioids for chronic pain is increasing,
- Evidence is growing of the adverse effects of long-term use of opioids.

This report found considerable variation in the levels of prescribing opioids across regions of Australia with no apparent explanation for the cause. A 2016 report by the Alcohol and Drug Foundation[13] stated that the number of fatalities from drug overdoses by pharmaceutical opioids in Australia has risen significantly over the past decade. The report suggests that opioids are overused and overprescribed and is causing increases in the rates of drug dependency, injury, and death.

Data from GCPHN's PATCAT system shows that as of March 2022, of the 88,098 patients with a coded musculoskeletal condition, over 50% had been prescribed pain relief medication. Table 4 gives a breakdown of medications prescribed and uptake of GP Management Plan (GPMP) and Team Care Arrangements (TCA) care plans in the past 12 months.

Table 4. People with a musculoskeletal condition, medication prescribed and management, Gold Coast, March 2022

	Number	Rate
Active population	587,244	
People with a coded musculoskeletal condition	88,098	15%
People with a coded musculoskeletal condition and prescribed mental health medication	33,701	38%
People with a coded musculoskeletal condition and prescribed pain relief medication	48,748	55%
People with a coded musculoskeletal condition and prescribed musculoskeletal medication	30,610	35%
People with a coded musculoskeletal condition and GPMP in the last year	54,751	61%
People with a coded musculoskeletal condition and TCA in the last year	52,115	58%

Source. GCPHN PATCAT, mental health medication includes and Antipsychotic, Antidepressants, Anxiolytic, Mood Stabilisers and Stimulants. Pain relief medication includes NSAIDs, COX 2, Narcotics / Opioids, Paracetamol. Musculoskeletal medication includes Gout preparations, Osteoporosis, DMARDS.

Pharmaceutical Benefits Scheme

Statistics from the Pharmaceutical Benefits Scheme (PBS) indicate that 65,681 prescriptions for opioids were filled across the GCPHN region in 2016-2017 per 100,000, up from 59,939 prescriptions in 2013-2014, an increase of over 9%. The rate was higher in the GCPHN region compared to national rate. Table 5 below provides a breakdown of opioid prescriptions dispensed across GCPHN's sub-regions. The sub-region with the highest rates of opioid per 100,000 people use was Southport.

[12] Australian Commission on Safety and Quality in Healthcare, the First Australian Atlas of Healthcare Variation.
[13] Alcohol and Drug Foundation (2016) Is there a pill for that? The increasing harms from opioid and benzodiazepine medication, Prevention Research.

Table 5. Age-standardised rate of PBS prescriptions dispensed for opioid medicines per 100,000 people, Gold Coast SA3 region, 2013–2014 to 2016-2017

Region	Age-standardised rate per 100,000 people, 2013-2014	Age-standardised rate per 100,000 people, 2016-2017
National	55,123	58,595
Gold Coast SA4	59,939	65,681
Broadbeach-Burleigh	55,050	61,740
Coolangatta	59,592	64,090
Gold Coast- North	64,000	69,981
Gold Coast Hinterland	60,279	68,729
Mudgeeraba-Tallebudgera	60,082	66,132
Nerang	59,844	68,019
Ormeau-Oxenford	62,761	69,950
Robina	51,875	54,078
Southport	73,571	77,673
Surfers Paradise	52,337	58,214

Source: ACSQHC, Australian Atlas of Healthcare Variation

Unnecessary treatments

Concerns have also been raised about potentially ineffective and unnecessary treatments, such as medical imaging for chronic back pain and surgical interventions for osteoarthritis. Table 6 shows the rate of CT scans performed for low back pain was higher in all GCPHN sub-regions than Queensland and Australian averages.

Table 6. Age-standardised rate of MBS-funded services for CT imaging of the lumbar spine per 100,000 people, Gold Coast SA3 region, 2013–14

Region	Age-standardised rate per 100,000 people
National	1,282
Queensland	1,381
Broadbeach-Burleigh	1,597
Coolangatta	1,786
Gold Coast-North	1,879
Gold Coast Hinterland	1,798
Mudgeeraba - Tallebudgera	1,641
Nerang	1,683
Ormeau - Oxenford	1,841
Robina	1,598
Southport	1,935
Surfers Paradise	1,584

Source: ACSQHC, Australian Atlas of Healthcare Variation

The Australian Commission on Safety and Quality in Health Care (ACSQHC) suggests that the rate at which GPs refer patients with low back pain for diagnostic imaging, particularly CT scans, may be excessive based on current guidelines and potentially exposing patients to radiation unnecessarily. Modelling done by PricewaterhouseCooper (PWC) predicted annual savings to the MBS because of dis-incentivising unnecessary imaging for chronic low back pain to be over $100 million.

Surgical interventions

Similarly, ACSQHC has identified that the rates at which some surgical interventions are being used to treat conditions associated with persistent pain vary widely across locations, indicating possible over-reliance in lieu of conservative treatments. Such interventions include lumbar spinal fusion and spinal decompression for low back pain, and knee arthroscopy or replacement for osteoarthritis. Table 7 below shows that rates of hospitalisations for these procedures are generally higher than national averages across the GCPHN region.

Table 7. Age and sex-standardised rate of hospitalisations for selected surgical interventions per 100,000 people aged 18 years and over, Gold Coast SA3 region, all data 2014-15 except knee arthroscopy (2012-2013)

Region	Knee arthroscopy (55 years and over)	Knee replacement	Lumbar spinal decompression	Lumbar spinal fusion
National	560	257	81	26
Queensland	496	266	75	30
Broadbeach - Burleigh	562	217	67	37
Coolangatta	663	268	67	37
Gold Coast - North	578	293	70	43
Gold Coast Hinterland	501	238	104	38
Mudgeeraba - Tallebudgera	685	267	70	37
Nerang	460	293	74	48
Ormeau - Oxenford	573	298	73	43
Robina	511	285	70	35
Southport	604	252	62	37
Surfers Paradise	589	257	71	43

Source: ACSQHC, Australian Atlas of Healthcare Variation

Low back pain

Estimates from the Australian Bureau of Statistics 2017-2018 National Health Survey estimate that around 4 million Australians (16% of the population) have back problems. It is estimated that 70-90% of people will suffer from lower back pain in some form at some point in their life[14]. Back problems include a range of conditions linked to the bones, joints, connective tissues, muscles, and nerves of the back.

From July 2019 to June 2020 there were 1,115 presentations to Emergency Departments (EDs) at public hospitals in the GCPHN region for low back pain of which females consisted of 53% of patients while male presentations were 47%. The age group with the largest rate of presentations to public EDs in the GCPHN region for low back pain was 30-39 years old's (17%) and 40-49-year-olds (17%).

[14]Back problems, Australian Institute of Health and Welfare, 2019.

Table 8. Presentations to Gold Coast Public Hospitals Emergency Departments with back issues, 2019-20

Age cohort	Number of ED presentations with low back issues	Rate of ED presentations among age cohorts for low back pain
0-19	54	5%
20-29	162	15%
30-39	194	17%
40-49	190	17%
50-59	180	11%
60-69	128	11%
70-79	120	11%
80+	87	8%

Source: Queensland Emergency data, January 2018 to July 2019.

Opioid prescriptions for persistent pain

Codeine has historically been Australia's most used opioid[15]. From February 2018, Australians can only purchase codeine in Australia with a prescription, before then, Australians could buy low strength (up to 15mg per tablet) in combination with paracetamol, ibuprofen and aspirin over the counter at pharmacies. Higher strength codeine has always required a prescription.

One in five in five Australians aged 45 years and older had chronic pain in 2016. During the two past decades, opioids have been pushed to treat chronic pain, expanding the patient base from palliative care and cancer patient. In Australia, dispensing of these opioids rise 15-fold between 1992 and 2014, with around 16% of the Australian population prescribed an opioid annually as of 2019[16;17]. For further information on opioids please see the Alcohol and other drugs needs assessment.

Data extracted through GCPHN's Primary Sense data extraction and Population Health Management Clinical Audit Tool identified that the GCPHN region's rate of increasing opioid prescriptions mirrors national trends of the 81 general practices submitting data through the tool[18].

Clients may present to a pain management program for assistance for opioid reduction to support their GPs recommendation. Feedback from providers in the GCPHN region has indicated these clients did not want to attend alcohol and other drug services and preferred to consider a pain program as their primary reason for being on high dose opioids was due to underlying chronic pain conditions.

[15] Degenhardt L, Gisev N, Cama E, Nielsen S, Larance B, Bruno R. The extent and correlates of community-based pharmaceutical opioid utilisation in Australia. Pharmacoepidemiol Drug Saf. 2016;25(5):521-538. doi:10.1002/pds.3931.

[16] Blanch B, Pearson SA, Haber PS. An overview of the patterns of prescription opioid use, costs and related harms in Australia. Br J Clin Pharmacol. 2014; 78(5):1159-1166. doi:10.1111/bcp.12446.

[17] Lalic S, Ilomäki J, Bell JS, Korhonen MJ, Gisev N. Prevalence and incidence of prescription opioid analgesic use in Australia. Br J Clin Pharmacol. 2019; 85(1):202-215. doi:10.1111/bcp.13792.

[18] GCPHN Primary Sense is a highly advanced IT tool that will support general practices to make timely decisions for better health care for their respective populations. Primary Sense is loaded onto the practice's server and de-identified data is exacted and securely transferred to the Primary Sense database in Azure for analysis. Patient information is provided back via an app on practices desktop based on practices selections. Primary Sense enhances the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time. Currently 81 General Practices submit data to the Primary Sense tool and this data is coded by the Clinician at the point of information input.

COVID-19 and persistent pain

Throughout the outbreak of COVID-19, many Gold Coast Health patients who had previously been attending the Persistent Pain Centre at Robina used virtual consultations to help manage their persistent pain. The virtual clinics improve the consultation experience for both patients and the medical teams overseeing their care by allowing patients to wait for the telehealth video conference appointment in the own home without having to worry about getting to clinic. An additional benefit of the telehealth model is the medical team can see the patient within their home environment and watch them do everyday task. As of the 12 June 2021, the persistent pain clinic at Gold Coast Health had over 700 telehealth consultations since the COVID-19 pandemic began.

Service system

Services	Number in GCPHN region	Distribution	Capacity discussion
General Practice	212	Clinics are generally distributed across GCPHN region, with the majority located in coastal and central areas.	• 855 GPs in the GCPHN region. • Average number of GPs per general practice: 4.2. •
Turning Pain into Gain program, Gold Coast PHN	1	Physical service at Varsity Lakes. Education sessions mobile across various locations including Southport, Robina and Kirra.	• No cost but limited places in each program. • Must be referred by a GP. • Previous increases in funding led to an increase in patients able to access program and decreased cost per person. • 292 Clients referred, enrolled and received the service in 2018-2019. • There is currently a wait time of around 4-5 weeks. • Increasing demand—more GPs referring into the program each year. • 2015-2016 evaluation shows positive outcomes in ability to perform everyday activities and self-management, and 78% reduction in hospitalisations. The 2016-2017 data showed a statistically significant reduction in morphine equivalent use.
Interdisciplinary Persistent Pain Centre, Gold Coast Health	1	Physically located at Robina.	• No cost to access. • Eligibility criteria include impairment, no ongoing investigations or claims, no acute psychiatric condition and residing within catchment area • Gold Coast Health specialist wait list is long and approximately eight – twelve months.
Persistent Pain and Rehabilitation Clinic, Griffith University	1	Physically located at Southport.	• Fee-for-service, rebate available through private health or chronic disease management plan. • Multi-disciplinary team care approach involving

			physiotherapy, exercise physiology, dietetics, and psychology.
The Pain Centre of Excellence, based at Spendelove Private Hospital	1	Physically located at Southport.	• Multi-disciplinary approach including pain and rehab specialists, OTs, pharmacists, and physios. • Treatment available as either a day patient or inpatient. • Program completed over two weeks with outpatient follow up for up to three months. • Cost fully covered by private insurance. • Anyone experiencing pain for more than three months can apply.
Chronic Pain Rehabilitation Unit, Pindara Private Hospital	1	Located at Benowa. Also, services John Flynn Private Hospital (Tugun) and Gold Coast Private Hospital (Southport).	• 11-bed chronic pain inpatient service. • Pain specialists and rehabilitation consultants work with allied health services including physio, OT and exercise physiology.
Arthritis Queensland Infoline	State- wide	Phone service	• Free call Mon-Fri, 8.30am-4pm. • Can arrange free, individualised information pack for self or family.
Precision Brain, Spine and Pain Centre	1	Southport	• Focus on the treatment of spinal problems and other pain-causing conditions.
Anglicare Better Health with Self- Management	1	Delivered at Southport and Robina	• Self-referral or a GP referral. • Free to any HACC eligible individuals/or their partner or carer. • Course teaches participants skills in day-to-day management of chronic conditions. • Two- and half-hour workshops run once a week, over a period of six weeks. • Not specific to persistent pain.
Pain Management Network, NSW Agency for Clinical Innovation	National	Online resource	• Focus on self-management for chronic pain. • Tailored content for youth and spinal cord injury pain.

			• Information available for health professionals.
Supporting Kids in Pain (SKIP) program	1	Not-for-profit organisation Based in Brisbane with outreach held on Gold Coast.	• Free program for children under 14. • Requires GP or pediatrician referral. • Self-management program involving assessment, education, and follow-up. • Multidisciplinary approach including pediatricians, psychologists, physios, OTs.

Consultation

Attendees at the Collaborating for Better Pain Management event for GPs and allied health professional held by GCPHN in June 2017 expressed a desire for more training related to pain, specifically:

- developing integrated care systems in primary care,
- referral pathways,
- back pain, and
- role specific evidence-based treatment practices.

The GCPHN Clinical Council (October 2017)

- Wait time for the Gold Coast Health multidisciplinary service and private service is very long.
- Pain specialists are an important component of any multidisciplinary team and there are limited specialists.
- People who feel they have run out of options to manage chronic pain often present to the emergency department and, if admitted, as chronic pain does not ever fully resolve, patients are reluctant to be discharged.
- Changes to make codeine prescription only is likely to increase demand for primary care which could lead to better overall management for people.
- Inadvertent overdose for pain relief medication including codeine and paracetamol are quite regular presentations at emergency department.
- Limited system infrastructure to feed back to general practice of people who are potentially doctor shopping and being prescribed high doses of pain relief medication.

The GCPHN Community Advisory Council (October 2017)

- Confirmed persistent pain is seen as a significant issue.
- There is a perception GP focus a lot on medication to manage persistent pain, rather than a more holistic approach. This was seen to pose significant risks of addiction to medications for people with persistent pain.
- Persistent pain required a multidisciplinary approach, focused on holistic care of the patient including mental health as there is a strong link between depression and pain.
- Complex and perhaps inconsistent language across different service providers leads to confusion for consumers (what is chronic, acute, persistent).
- Importance of existing programs like Active and Healthy and other exercise options.
- Long wait times for some services and limited benefit once seen.

Feedback from stakeholders

- A barrier to services is transport for patients, socio economic factors and the ability to manage pain while accessing public transport.
- Concern on waitlist for people with persistent pain to access services with patients reporting that they remain on the list having waited at least six months.
- Changes to medication availability has created concern and inconvenience for some people with persistent pain.

- Increase in information request reported by provider for people with sub-acute pain, early intervention services may provide value for money.
- Need to include a family-based model i.e., family and patient holiday programs.

Feedback from service providers

- Extra services are required in Southport which is a high-rate area for persistent pain client.
- Better links and access options for people living with persistent pain to mental health services including assistance in applying to the NDIS.
- Common barriers experienced by this cohort are increased levels of depression and anxiety, isolation, limited access to community supports and links and issues with transport to access services.
- This cohort requires robust referral pathways that provide flexible options for access to services and epically assistance with NDIS applications.
- High referral numbers are indicative of significant need with pain management programs in the region.
- Service demand for chronic pain management remains high. Sub-acute pain program has also experienced good service uptake.

Chronic disease

Local health needs and service issues

- Limited systems to support care coordination for people with a chronic condition.
- Minimal focus on prevention, early identification, and self-management of chronic disease.
- High numbers of people with chronic disease in Ormeau-Oxenford and Gold Coast North SA3 regions.
- Rate of potentially preventable hospitalisations in the Gold Coast Primary Health Network region is above the national rate, with top conditions being:
    - urinary tract infections
    - iron deficiency anaemia
    - chronic obstructive pulmonary disease cellulitis
    - vaccine preventable conditions
- Rates of people in the Gold Coast Primary Health Network region with chronic obstructive pulmonary disease and asthma are above the national rate.

Key findings

- Rates of people in the GCPHN region with diabetes mellitus, heart, stroke, or vascular disease were below the national rate in 2017-18.
- Rates of people in the GCPHN region with chronic obstructive pulmonary disease and asthma were above the national rate in 2017-18.
- One quarter of the total active patients (n=152,683) in general practices have two diagnosed conditions (diabetes, respiratory, cardiovascular, renal impairment and mental health).
- Rate of people with chronic disease risk factors for people aged 18 and over in the GCPHN region was above the national rate for high blood pressure, current smoker, inadequate fruit intake, and harmful alcohol intake. Rates of people with obesity and being physically inactive were lower than national average.
- Number of MBS services claimed for General Practitioner Management plans among residents of the GCPHN region was above the national rate in 2018-19.
- Rate of potentially preventable hospitalisations for chronic conditions in the GCPHN region was above the national rate in 2017-2018 across all conditions except for congestive cardiac failure and rheumatic heart disease.

Chronic Disease

While certain non-modifiable factors such as age, genetics, gender, and ethnicity can contribute to chronic diseases, many conditions can be prevented or managed by addressing common modifiable risk factors. These include smoking, obesity, excessive alcohol intake, physical inactivity, poor nutrition, and high blood pressure.

Addressing modifiable risk factors and improving the coordination of care for people with a chronic condition may prevent them from being hospitalised. Reducing potentially preventable hospital (PPH) admissions is a national Primary Health Network (PHN) priority. Effective clinical management of the condition combined with health service coordination, patient health literacy, self-management and variations in healthcare can contribute to better chronic disease outcomes.

The population in the GCPHN region has a higher relative standard of health when compared to Australian averages. However, rates of cardiovascular disease across the GCPHN region are higher compared to national levels. Coronary heart disease and cerebrovascular disease were in the top three leading causes of death in the GCPHN region, both of which are related to modifiable risk factors and effective chronic disease management. The GCPHN region recorded a higher rate of PPH due to chronic disease compared to the national rate. The number of MBS-funded items claimed by GPs for chronic disease management in the GCPHN region has been increasing steadily in recent years and is above the national rate.

The community and stakeholders from the service system recognise that there are issues relating to community capacity and development, service access, health professional capacity and capability development, coordination and integration and system barriers that are required to be addressed through a variety of measures.

Health status

People with reported chronic disease

When compared to national averages, the population in the GCPHN region has a high relative standard of health. The proportion of adults who self-reported excellent, very good or good health in the GCPHN region in 2017-2018 was 88.4%, compared to the national average of 86.2%.

The proportion of adults who reported having a long-term health condition in the GCPHN region in 2017-18 was less than the national average at 43.1% and 50.1%, respectively. The GCPHN region's rate has decreased from 45.6% in 2015-16. There was no marked difference in life expectancy at birth for males or females in the GCPHN region compared to the national average for all people (82.6 vs 82.1 years), with life expectancy slightly higher for females mirroring national trends.

Table 1. Number and age-standardised rate (ASR) per 100 of people with reported chronic diseases, by type and SA3 region, 2017-2018

Region	Diabetes Mellitus		Heart, stroke and vascular disease		Chronic obstructive pulmonary disease		Asthma	
	Number	ASR	Number	ASR	Number	ASR	Number	ASR
National	1,182,600	4.9	1,156,500	4.8	598,800	2.5	2,705,100	11.2
Gold Coast	24,382	3.9	26,796	4.3	20,890	3.4	68,400	11.4
Broadbeach-Burleigh	2,630	3.6	3,120	4.1	2,597	3.6	6,816	10.5
Coolangatta	2,645	4.1	2,909	4.3	2,335	3.8	6,524	11.6
Gold Coast- North	3,707	4.2	3,890	4.3	2,618	3.3	8,201	11.7
Gold Coast Hinterland	757	3.2	877	3.8	743	3.4	2,182	11.1
Mudgeeraba-Tallebudgera	1,101	3.3	1,258	4	1,086	3.3	3,792	10.6
Nerang	2,938	4.3	3,127	4.5	2,532	3.7	8,558	12.1
Ormeau-Oxenford	4,222	4	4,651	4.7	3,827	3.3	15,203	11.5
Robina	1,874	3.7	2,232	4.4	1,668	3.2	5,719	11.4
Southport	2,538	4.1	2,862	4.5	2,259	3.7	7,073	11.7
Surfers Paradise	1,970	3.8	1,870	3.7	1,460	3.0	4,332	9.8

Source: PHIDU, social health atlases by primary health networks. This data set is a component of the minimum data set.

There are several findings from these data:

- Higher numbers of people living with chronic diseases in the SA3 areas of Ormeau-Oxenford, and Gold Coast North.
- The rate of diabetes mellitus was lower than the national rate in all SA3 regions in the GCPHN region.
- The rate of heart, stroke and vascular diseases was lower than the national average in all SA3 regions in the GCPHN region.
- The rate of chronic obstructive pulmonary diseases was higher in the GCPHN region compared to the national rate.
- The rate of asthma in the GCPHN region was comparable to the national rate.

Asthma

Asthma is a common chronic condition that affects the airways. People with asthma experience episodes of wheezing, shortness of breath, coughing, chest tightness and fatigue due to widespread narrowing of the airways. Around 2.7 million Australians (11% of the total population) have asthma based on self-reported data.

In 2017-2018, self-assessed health status among people with asthma aged 15 and over was, on average, worse than among those without asthma. People with asthma were less likely to describe themselves as having excellent health compared with people without asthma (11% and 23%, respectively). In the same way, people with asthma were more likely to describe themselves as having poor health compared with people without asthma (7.4% and 3.0%, respectively).

Analysis data of GCPHN's PATCAT[1] system shows that as of March 2022, of the 587,244 active patients (three visits in the past two years) 9.3% (n=54,572) had a coded asthma diagnosis. Table 2 shows the active population with asthma diagnoses with management plans claimed or medications prescribed.

Table 2. Patients with coded asthma diagnosis and GPMP/TCA/COC claimed in the last year or asthma medication prescribed, March 2022

	Number	Rate
Active population	587,244	
People with coded asthma diagnosis	54,572	9.3%
People with asthma and GP management plan (GPMP) claimed in the last year	20,192	37.0%
People with asthma and team care arrangements (TCA) claimed in the last year	18,082	33.1%
People with asthma prescribed antiasthmatic	40,964	75.1%

Source: GCPHN PATCAT

Diabetes

Diabetes is a chronic condition marked by high levels of glucose in the blood. The main types of diabetes are Type 1, Type 2 and gestational. Type 2 diabetes is the most common form and is largely preventable by maintaining a healthy lifestyle.

- **Type 1 diabetes:** lifelong autoimmune disease that usually has onset in childhood or early adolescence. A person with Type 1 diabetes requires daily insulin replacement to survive.
- **Type 2 diabetes:** The most common form of diabetes. It involves a genetic component but is largely preventable and is often associated with lifestyle factors including physical inactivity, poor diet, being overweight or obese, and tobacco smoking.
- **Gestational diabetes:** is characterised by glucose intolerance of varying severity that develops or is first recognised during pregnancy, mostly in the second or third trimester. It usually resolves after the baby is born but can recur in later pregnancies and significantly increases the risk of developing Type 2 diabetes in later life, both for the mother and the baby.

The proportion of people in the GCPHN region aged 18 years and over registered in the National Disability Services with Type 2 diabetes in 2018 was 4.4% which was below the national rate of 5.9%. From 2015-16 to 2017-18 the proportion of people in the GCPHN region who were hospitalised with Type 2 diabetes as the principle and/or additional diagnoses was 3,766 per 100,000 people which was below the national rate of 4,208 per 100,000 people. The proportion of deaths from Type 2 diabetes as the underlying and/or an associated cause was 29 deaths per 100,000 people in the GCPHN region, which was below the national rate of 37 per 100,000 people.

Analysing data extracted from GCPHN's PATCAT system as of March 2022, of the 587,244 active patients (three visits in the past two years) 5.0% (n=29,166) had a coded diabetes diagnosis which mirrors national

[1] PAT CAT is a web-based interface that aggregates de-identified General Practice data for population health management and research programs.

rates. Table 3 highlights active population with coded diabetes diagnoses, management plans claimed, HbA1C results and medications prescribed.

Table 3. Patients with coded diabetes diagnosis and GPMP/TCA/SIP claimed in the last year and HbA1C results, March 2022

	Number	Rate
Total population	587,244	
People with coded diabetes diagnosis	29,166	5.0%
People with coded diabetes type 1	2,804	9.6%
People with coded diabetes type 1 who had a HbA1C result recorded in the last year	1,618	57.7%
People with coded diabetes type 2	22,771	78.1%
People with coded diabetes type 2 and HbA1C result recorded in the last year	16,229	71.3%
People with coded gestational diabetes	4,244	14.6%
People with diabetes and a GPMP claimed in the last year	19,432	66.6%
People with diabetes and TCA claimed in the last year	18,764	64.3%
People with diabetes prescribed oral or injectable antidiabetic medication	23,930	82.0%

Source. GCPHN PATCAT

Chronic kidney disease

Chronic kidney disease (CKD) is defined as the presence of impaired or reduced kidney function lasting at least three months. CKD is common, costly, and often detected too late to be reversible, but is largely preventable because many of its risk factors – high blood pressure, tobacco smoking, overweight and obesity and impaired glucose regulation – are modifiable.

The modelled prevalence of people in the GCPHN region aged 18 years and over with CKD in 2011-12 was 10.5% which was below the national proportion of 11.3%. In 2017-18, the proportion of people in the GCPHN region hospitalised with CKD as the principle and/or additional diagnoses was 1,517 per 100,000 people which was above the national rate of 1,480 per 100,000 people. The proportion of deaths from CKD as the underlying and/or an associated cause was 73 per 100,000 people in the GCPHN region, which was above the national rate of 71 per 100,000 people.

Based on GCPHN's PATCAT system which captures de-identified patient data submitted by registered general practices throughout the GCPHN region, as of March 2022, of the 587,244 active patients (three visits in the past two years), 1.3% (n=7,517) had a coded CKD diagnosis. Table 4 shows numbers of people with a CKD diagnosis and management recorded.

Table 4. Patients with coded CKD diagnosis and management in the last year, Gold Coast, March 2022

Measure	Number	Rate
Total Population	587,244	
Target Population	7,517	1.3%
Blood Pressure (last 12 months) - Recorded	5,819	77.4%
Blood Pressure (last 12 months) - Recorded - At Target	3,295	43.8%
Blood Pressure (last 12 months) - Recorded - Not at Target	2,524	33.6%
Blood Pressure (last 12 months) - Not Recorded	1,698	22.6%
BMI (last 12 months) - Recorded	4,001	53.2%
BMI (last 12 months) - Recorded - At Target	989	13.2%
BMI (last 12 months) - Recorded - Not at Target	3,012	40.1%
BMI (last 12 months) - Not Recorded	3,516	46.8%
HbA1c (for Diabetes) (last 12 months) - Recorded	1628	21.7%
HbA1c (for Diabetes) (last 12 months) - Recorded - At Target	889	11.8%
HbA1c (for Diabetes) (last 12 months) - Recorded - Not at Target	739	9.8%
HbA1c (for Diabetes) (last 12 months) - Not Recorded	550	7.3%
LDL (last 12 months) - Recorded	3,379	45.0%
LDL (last 12 months) - Recorded - At Target	2,011	26.8%
LDL (last 12 months) - Recorded - Not at Target	1,368	18.2%
LDL (last 12 months) - Not Recorded	4,138	55.0%
T Cholesterol (last 12 months) - Recorded	6,000	79.8%
T Cholesterol (last 12 months) - Recorded - At Target	2,098	27.9%
T Cholesterol (last 12 months) - Recorded - Not at Target	3,902	51.9%
T Cholesterol (last 12 months) - Not Recorded	1,517	20.2%
Smoking - Recorded	7,267	96.7%
Smoking - Recorded - At Target	6,817	90.7%
Smoking - Recorded - Not at Target	450	6.0%
Smoking - Not Recorded	250	3.3%

Source. PATCAT, Target population is patients >= 15 years with a CKD diagnosis and without a history of renal dialysis or kidney transplant

One in three Australians have an increased risk of CKD. Risk factors for developing CKD include people who:

- have diabetes
- have high blood pressure
- have established heart problems (heart failure or heart attack) or have had a stroke
- are obese with a body mass index (BMI) 30 or higher
- have smoked or is a current smoker
- are 60 years or older
- are of Aboriginal or Torres Strait Islanders origin

Analysis of GCPHN PATCAT data shows that as of March 2022, of the 587,244 active patients in general practices (three visits in the past two years), 39.5% (n=231,868) had a recorded risk factor for CKD (Table 5).

Table 5. Patients with a risk factor recorded for CKD, Gold Coast, March 2022

Measure	Number	Rate
Total population	587,244	
Target population	231,868	39.5%
Smoking	62,649	27.0%
Diabetes (Dx, HbA1c>=6.5%, BSL>11.1 or FBG>7)	30,295	13.1%
Hypertension (Dx or BP>140/90)	134,895	58.2%
Obesity (BMI>30)	83,345	35.9%
CVD diagnosis	26,912	11.6%
Indigenous and age>30	5,273	2.3%

Source: PATCAT, Target population is patients >= 15 years without a CKD diagnosis AND with one or more risk factors.

Cardiovascular disease

Cardiovascular disease (CVD) is a major cause of disease and death in Australia. CVD is preventable in many cases, as several its risk factors are modifiable:

- overweight and obesity
- tobacco smoking
- high blood pressure
- high blood cholesterol
- insufficient physical activity
- poor nutrition
- diabetes

Two most common forms of CVD are heart attack/angina and stroke. Other forms of CVD are heart failure, cardiomyopathy, peripheral vascular disease, hypertensive disease, acute rheumatic fever, and congenital heart disease.

The modelled prevalence of heart, stroke, and vascular disease among adults in 2017-18 aged 18 years and over was 5.5%of people in the GCPHN region which was below the national rate of 6.2%. In 2017-2018, the rate of people who were hospitalised with CVD as the principal diagnosis was 2,487 per 100,000 people, which was above the national rate of 2,342 per 100,000 people. The proportion of deaths from CVD as the underlying cause was 173 per 100,000 among people in the GCPHN region, which was below the national rate of 183 per 100,000 people.

The cardiovascular event risk table displays data as the percentage risk of cardiovascular event in five years' time. It is a guide only based on de-identified patient data submitted to registered general practices throughout the GCPHN region extracted from GCPHNs Primary Sense tool. The CVD risk is calculated based on the Framingham Risk Equation. The risk assessment[2] uses demographic information such as age, gender and ethnicity and lipid and blood pressure measures combined with smoking habits to calculate the likelihood of a cardiovascular event in the next five years.

Table 6 displays the five-year risk of cardiovascular event tool. As of August 2022, there were 191,872 active patients (three visits in the last two years) that were calculated as having either, low, medium, high and automatic high risk as having low risk of a cardiovascular event in the next five years.

[2] Refer to Appendix 2 for definition

- low risk: 64.7% or 124,136 active patients,
- medium risk: 11.5% or 22,209 active patients,
- high risk: 7.9% or 15,104 active patients,
- automatic high risk: 15.9% or 30,405 active patients.

Table 6. Five-year risk of cardiovascular event, 159 practices in Gold Coast, August 2022

Measure	Number	Percent
Total Population	653,578	
Target Population	191,872	29.4%
High Risk > 15%	15,104	7.9%
35 - 39	0	0.0%
40 - 44	13	0.1%
45 - 49	84	0.6%
50 - 54	443	2.9%
55 - 59	1047	6.9%
60 - 64	1073	7.1%
65 - 69	1,775	11.8%
70 - 74+	10,669	70.6%
Medium Risk 10 - 15%	22,209	11.6%
35 - 39	11	0.0%
40 - 44	104	0.5%
45 - 49	466	2.1%
50 - 54	1,243	5.6%
55 - 59	2,354	10.6%
60 - 64	3,132	14.1%
65 - 69	3,834	17.3%
70 - 74+	11,065	49.8%
Low Risk < 10%	124,136	64.7%
35 - 39	10903	8.8%
40 - 44	14143	11.4%
45 - 49	17,420	14.0%
50 - 54	19,999	16.1%
55 - 59	17,045	13.7%
60 - 64	14,723	11.9%
65 - 69	11,450	9.2%
70 - 74+	18,453	14.9%
Automatic High Risk	30,405	15.9%

35 - 39	551	1.8%
40 - 44	595	2.0%
45 - 49	709	2.3%
50 - 54	1,099	3.6%
55 - 59	1,206	4.0%
60 - 64	4,573	15.0%
65 - 69	5,007	16.5%
70 - 74+	16,665	54.8%

Source: Primary Sense (159 practices)

Coronary heart disease

Coronary heart disease is the most common form of CVD. There are two major clinical forms—heart attack and angina. Heart attack is a life-threatening event that occurs when a blood vessel supplying the heart itself is suddenly blocked, causing damage to the heart muscle and its functions. Angina is a chronic condition in which short episodes of chest pain can occur periodically when the heart has a temporary deficiency in its blood supply.

Analysing data extracted from GCPHN's PATCAT system shows that as of March 2022, of the 587,244 active patients in the region (three visits in the past two years), 3.4% (n=20,015) had coded coronary heart disease. Table 7 highlights people with coded coronary heart disease diagnoses, risk factors recorded, and management.

Table 7. Patients with coded coronary heart disease, risk factors and management recorded, Gold Coast, March 2022

	Number	Rate
Total Population	587,244	
People with coded coronary heart disease diagnosis	20,015	3.4%
People with CHD and smoking status recorded	19,338	96.6%
People with CHD and blood pressure recorded	18,106	90.5%
People with CHD and LDL recorded	16,161	80.7%
People with coronary heart disease and a GPMP in the last year	12,168	60.8%
People with coronary heart disease and a TCA in the last year	11,408	57.0%

Source: PATCAT

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is a preventable and treatable lung disease characterised by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. GPs are often the first point of contact for people who develop COPD. According to Bettering the Evaluation and Care of health (BEACH) survey, in the ten-year period from 2006–07 to 2015–16, the estimated rate of COPD management in general practice was around 0.9 per 100 encounters.

As of March 2022, of the 587,244 active patients in the region (three visits in the past two years), 2.3% (n=13,401) had a coded COPD diagnosis. Table 8 highlights people with coded COPD diagnoses, risk factors recorded and management.

Table 8. Patients with coded COPD diagnosis, risk factors and management recorded, Gold Coast, March 2022

	Number	Rate
Total population	587,244	
People with coded chronic obstructive pulmonary disease diagnosis	13,401	2.3%
People with COPD and smoking status recorded	13,095	97.7%
People with COPD and blood pressure recorded	12,049	89.9%
People with COPD and a GPMP in the last year	8,287	61.8%
People with COPD and TCA in the last year	7,845	58.5%

Source: PATCAT

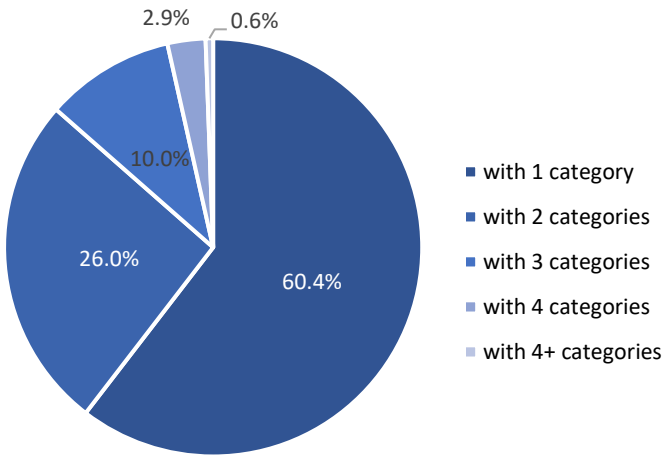
Comorbidities

Comorbidity refers to the occurrence of two or more diseases at one time. While the existence of these multiple health conditions may be unrelated, in many instances—and particularly in relation to chronic diseases—there is often some association between them. Further, a range of chronic diseases share common risk factors. Understanding more about comorbidities can provide vital information for prevention, management and treatment of chronic diseases.

Based on GCPHN's PATCAT system, as of March 2022, of the 587,244 active patients in the region (three visits in the past two years) 49% (n=287,634) had at least one condition. The five conditions that are included in this report are:

- diabetes
- respiratory
- cardiovascular
- renal impairment
- mental health

Figure 1. Comorbidities among active patients at Gold Coast general practices, March 2022



Source: GCPHN PATCAT

Chronic disease and mortality

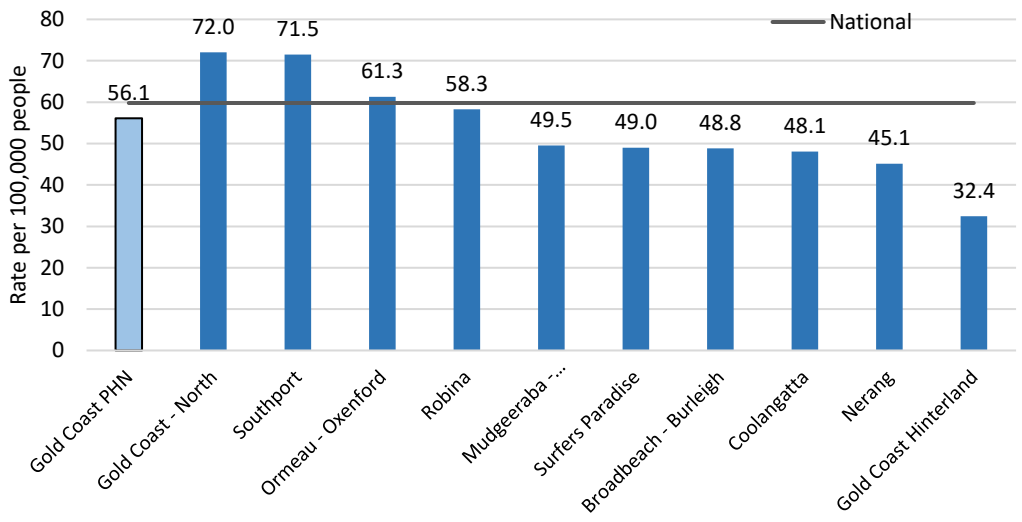
Among the leading five causes of death in the GCPHN region from 2015-2019, four were chronic diseases.

The leading five causes of death in the GCPHN region during 2015-2019 mirrored the national trend:

1. Coronary heart disease (n=2,203 or 11.8% of all deaths),
2. Dementia and Alzheimer disease (n=1,697 or 9.1% of all deaths),
3. Cerebrovascular disease (n=1,208 or 6.5% of all deaths),
4. Lung cancer (n=1,088 or 5.8% of all deaths),
5. Chronic obstructive pulmonary disease (n=788 or 4.2% of all deaths).

Coronary heart disease was the leading cause of death for all Australians including residents of the GCPHN region, between 2015 and 2019 with 2,203 deaths. In the GCPHN region the age-standardised rate of deaths due to coronary heart disease was 56.1 per 100,000 persons which was slightly below the national rate of 59.8. Gold Coast-North had the highest rate (72.0 per 100,000 people) while Gold Coast Hinterland had the lowest (32.4 per 100,000).

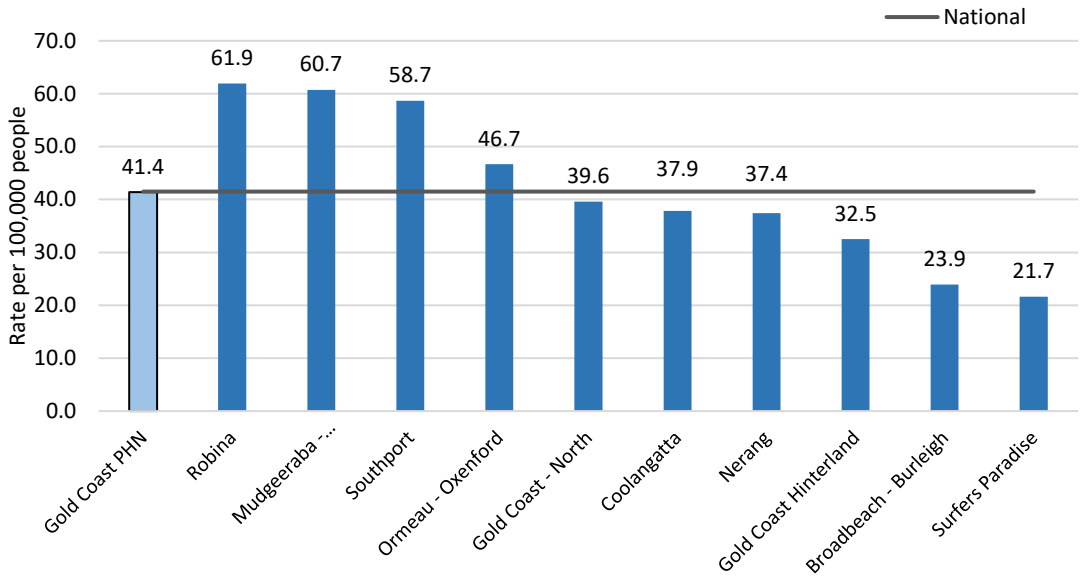
Figure 2. Age-standardised rate for deaths by coronary heart disease, Gold Coast SA3 regions, 2015-19



Source: AIHW (Australian Institute of Health and Welfare) 2021. MORT (Mortality Over Regions and Time) books: Statistical Area Level 3 (SA3), 2015–2019.

The second leading cause of death in the GCPHN region was dementia including Alzheimer's disease, which accounted for 1,697 deaths between 2015 and 2019.

Figure 3. Age-standardised rate of deaths by dementia including Alzheimer disease, Gold Coast SA3 regions, 2015-19



Source: AIHW (Australian Institute of Health and Welfare) 2021. MORT (Mortality Over Regions and Time) books: Statistical Area Level 3 (SA3), 2015–2019.

Lifestyle-related risk factors

Several lifestyle-related risk factors can increase the likelihood of developing chronic diseases. Understanding the levels of these risk factors within the population can provide an indication of future chronic disease burden and the level of need for health interventions focused on prevention, early identification, and management. Chronic disease risk factors include:

- tobacco smoking
- obesity
- excessive alcohol consumption
- physical inactivity
- poor nutrition
- high blood pressure

The rate at which several modifiable risk factors for chronic disease are present across each sub-region of the GCPHN region is shown in Table 9.

Table 9. Age-standardised rates of chronic disease risk factors per 100 people aged 18 years and over, Gold Coast SA3 region, 2017-2018

Region	High blood pressure	Obesity	Current smoker	Harmful alcohol intake	Physically inactive	Inadequate fruit intake
Australia	22.8	31.3	15.1	16.1	66.1	51.3
Gold Coast SA4	23.5	30.4	16.3	18.8	62.2	52
Broadbeach-Burleigh	23	27.8	15.7	21.2	57.7	52.7
Coolangatta	23.2	29.5	16.7	22.6	58.0	51.0
Gold Coast - North	23.3	27.6	17.4	17.0	62.7	52.5
Gold Coast Hinterland	23.0	33.9	12.9	21.4	63.9	51.0
Mudgeeraba-Tallebudgera	23.4	30.1	12.6	19.0	61.2	53.0
Nerang	23.7	32.3	17.4	18.2	65.2	50.8
Ormeau-Oxenford	23.9	35.9	15.7	18.3	65.1	51.0
Robina	23.7	29.3	15.6	17.7	62.3	53.0
Southport	23.6	27.8	17.1	16.1	65.1	51.6
Surfers Paradise	23.2	24.9	15.2	18.9	56.3	55.1

Source: PHIDU based on National Health Survey 2017-18

This data above shows that rates of obesity, smoking and harmful alcohol intake are comparable or higher for the GCPHN region than national levels, but lower on physical inactivity. Rates of high blood pressure and obesity are particularly high in Ormeau-Oxenford.

It should be noted that most data on chronic disease risk factors comes from self-report surveys which have inherent limitations. There is some inconsistency across different population measures. For example, the Queensland Chief Health Officer (CHO) prepares a 'Health of Queenslanders' report every two years based on survey data. The estimate of the smoking rate for the GCPHN region in the 2018 CHO report was 9.8% which is quite different to the levels in Table 9 obtained from the National Health Survey by the Australian Bureau of Statistics.

These discrepancies are likely due to several factors such as different data items (i.e., 'daily' smoker versus 'current' smoker), different samples and possible changes over different survey periods. In addition, it should be noted that the obesity rate on the Australian Institute of Health and Welfare's My Healthy Communities website is also based on the National Health Survey which is 22.8%, lower than the national average of 27.9%. The 2018 Health of Queenslanders Report estimated the obesity rate for the GCPHN region as 16.4% lower than the state average of 30.2% and the lowest in the state.

Medicare Benefits Schedule

There are several chronic disease management items listed on the Medicare Benefits Schedule (MBS) that enable GPs to plan and coordinate the healthcare of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. Table 10 provides statistics from Medicare Australia on the number of chronic disease management items claimed by GPs in the GCPHN region between 2015-16 to 2020-21.

This data shows services relating to the preparation, coordination, and review of a GP Management Plan for patients with a chronic or terminal medical condition. Services also include the coordination and review of Team Care Arrangements and contribution to Multidisciplinary Care Plans.

Table 10 identifies the number of MBS services per 100 people claimed for GP chronic disease management plans from 2015-2016 to 2020-2021. The GCPHN region's rate in 2020-21 was 47.7 services per 100 people which was above the national rate of 40.4. This rate has increased from 34.7 services per 100 people in 2015-16 which mirrors national trends.

Gold Coast-North SA3 region has had the highest rate of MBS services for GP chronic disease management plan per 100 people from 2015-16 to 2019-20.

Table 10. Number of MBS services per 100 people for GP chronic disease management plan, 2014-15 to 2020-21

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
National	30.3	33.4	36.4	37.6	37.7	40.4
Gold Coast SA4	34.7	38.8	41.7	44.1	45.5	47.7
Broadbeach - Burleigh	33.4	36.6	38	41	47.1	51.0
Coolangatta	36.6	41.7	43.6	43.9	45.9	49.1
Gold Coast - North	47.5	52.1	57.3	60.2	58.6	59.5
Gold Coast Hinterland	39.9	41.3	45.8	47	47.6	51.3
Mudgeeraba - Tallebudgera	30.1	34.4	34.5	38.1	41.0	42.7
Nerang	29.3	34.6	36.1	38.7	40.7	42.5
Ormeau - Oxenford	33.7	38.9	41.6	43.2	42.4	43.5
Robina	31.1	34.3	37.3	41.3	44.2	48.3
Southport	36	38.9	42.5	45.8	47.1	49.0
Surfers Paradise	29	31.3	36.8	39.8	42.1	44.5

Source: Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits claims data 2014–15, 2015–16, 2016–17, 2017–18 and 2018-19. Data are mapped to patients Medicare residential address.

Potentially Preventable Hospitalisations

Potentially preventable hospitalisations (PPH) are hospital admissions that potentially could have been prevented by timely and adequate healthcare in the community. The term PPH does not mean that a patient admitted for that condition did not need to be hospitalised at the time of admission. Reducing hospitalisations for these conditions might involve vaccination, early diagnosis, and treatment, and/or good ongoing management of risk factors and conditions in community settings. There are 22 conditions for which hospitalisations is considered potentially preventable across three broad categories:

- chronic
- acute
- vaccine-preventable

Table 11 shows that the GCPHN region had a higher rate of PPHs for chronic conditions when compared to Australia (1,209 vs. 1,130 per 100,000 people).

Table 11. Rate of potentially preventable hospitalisations for selected chronic conditions per 100,000 people, national and Gold Coast, 2019-2020

Condition	Gold Coast	National
All chronic conditions	1,209	1,130
Angina	92	89
Asthma	103	114
Bronchiectasis	37	24
Congestive cardiac failure	223	225
Chronic obstructive pulmonary disease	161	195
Diabetes complications	185	195
Hypertension	80	43
Iron deficiency anaemia	309	227
Nutritional deficiencies	4	3
Rheumatic heart disease	14	15

Source: Australian Institute of Health and Welfare 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20.

Many presentations to Gold Coast EDs for iron deficiency are referred by general practice. There is cause for further investigation to determine if iron deficiency is the reason for referral, or if people are being referred to determine the underlying cause of iron deficiency (i.e., gut bleeding)[3].

Care coordination

Care coordination is a term used to describe working with patients to develop a comprehensive plan that helps patients take more control of their health and achieve their goals. Care coordination is for patients with a chronic condition or multiple conditions, at risk of admission to hospital, or with complex needs (which includes the social determinants of health). It is a patient centered approach that involves a timely coordination of health, community and social services to meet the patient's needs. It is a partnership between the patient, carers and providers.

A survey found that patients in five developed countries, including Australia, were "at risk for deficiencies in care coordination, communication failures and medical errors"[4]. Although most patients get their chronic disease care from a single general practice, the lack of a formal relationship leaves GPs uncertain about the extent of their responsibility for ongoing care and care coordination, particularly in the area of psychosocial care[5].

Care coordination is further hindered by gaps between general practice, hospital, community health and non-government organisations in different sectors of the healthcare system, often with conflicting boundaries and without shared lines of accountability.

[3] *AIHW (Australian Institute of Health and Welfare) 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2017-2018*

[4] Blendon R, Schoen C, DesRoches C, et al. Common concerns amid diverse systems: health care experiences in five countries. *Health Aff (Millwood)* 2003; 22: 106-121.

[5] Oldroyd J, Proudfoot J, Infante FA, et al. Providing healthcare for people with chronic illness: the views of Australian GPs. *Med J Aust* 2003; 179: 30-33.

Service system

Services	Number in the GCPHN region	Distribution	Capacity discussion
General practices	212	Clinics are generally well spread across the GCPHN region; majority in coastal and central areas	• GP services include preparation of chronic disease management plans, team care arrangements, medication prescribing and management, health checks and plan review.
Special interest general practices	24	Peppered throughout the GCPHN region	These practices offer a limited range of services such as skin cancer checks, cosmetic clinics and other specific health areas.
My Heath for Life	State-wide programs	Currently 6 providers (may expand) and telephone option	• Evidence-based lifestyle modification program provided by trained facilitators including dietitians and exercise physiologists, who have a keen interest in preventive health.
COACH and Get Healthy services, Queensland Health	State-wide programs	Free phone services	• Both programs focus on reducing avoidable admissions through prevention and self-management. • Get Healthy service provides advice and coaching on leading a healthy lifestyle by qualified health coaches • COACH Program involves qualified health coaches discussing treatment with patients with a diagnosed chronic condition (e.g. medication compliance, risk factor management, follow-up appointments with physicians). • Reported referrals into COACH are very low on the Gold Coast. However,

			limited capacity to accept new referrals.
Quitline	Region-wide	Phone service	• Focus on promoting self-management skills. • Provides care, education and support for people with diabetes and their carers as well as community education (e.g. schools, community groups). • Multidisciplinary service for inpatients and outpatients. • No information online regarding eligibility or access.
Diabetes resource centre, Gold Coast Health	4	Palm Beach, Southport, Robina and Helensvale	• Focus on promoting self-management skills. • Provides care, education and support for people with diabetes and their carers as well as community education (e.g. schools, community groups). • Multidisciplinary service for inpatients and outpatients. • No information online regarding eligibility or access.
Community programs, City of Gold Coast	Region-wide	Varied locations (parks, sports centres, community centres)	• Range of free and low-cost physical activity and healthy eating programs. • There is low referral to these programs from healthcare providers.
National Prescribing Service (NPS)	National	Phone or online	• Free clinical e-audits to help GPs review prescribing for patients with certain conditions compared with best practice guidelines. • NPS Medicinewise have produced a free application to assist

			consumers with managing their medications. (MedicineList+) • NPS also operate a help line to answer consumer questions about medicines.
VIP Diabetes	1	Runaway Bay	• Targeted allied health and coordination for people with diabetes. • Referral required from GP, self-referrals will be directed to involve GP. • Home medicine review is free for people with a Medicare card and who are referred by their GP for a review. • GP case conference Medicare funded. • Insulin support programs are fully funded.
Diabetes Queensland	2	Helensvale and Robina	• Self-referral • Targets newly diagnosed—new registration on national diabetes patient register will trigger an invite. • Free to those with a Medicare card.
Other private and NGO services	Various	Various	• There are a number of services offering support for people with chronic disease. • Service types include medication management and review, care coordination, care planning, self-management, allied health, nursing, respite, peer support, social and community activities. • Access is varied with many fee-for-service, some claimable through Medicare or other avenues

			(e.g. DVA, aged care, disability services). • Limited information available on the demand for and outcomes of these services.
Community Health Services Gold Coast Health	3	Robina Health Precinct Southport Health Precinct Helensvale Community Centre	

Consultation

This information has been collated from various sources including: 2017 GCPHN Primary Care Opinion Survey, GCPHN Primary Health Care Improvement Committee, direct liaison with general practice staff, GCPHN Community Advisory Council.

Community capacity and development

Many factors complicate one's capacity to self-manage their chronic condition, including cultural barriers, homelessness, alcohol and drug use, obesity, socio-economic status, health literacy and knowledge of available support.

Stakeholders suggest that improvements in community capacity could enhance chronic disease early identification, self-management and medication management, specifically:

- More support from health professionals is required for people to manage their own health, navigate the current system and empower them to share ownership of personal health outcomes.
- Patients want support from GPs and health teams to make management decisions and goals that are realistic for their individual circumstances, moving from a medical model of care planning to a patient focused model.
- Gold Coast Health held a community jury in June 2017 specifically focused on the topic of obesity. The jury determined that obesity should be a priority for all key agencies, citing stigma as a key issue. In addition, collaboration was across agencies was recommended.
- Early education is required to ensure that patients fully understand the long-term nature of chronic disease and are not waiting to access services until their condition is acute.
- Clearly communicating the benefit of prevention and engaging in your healthcare. Many GPs use health assessments (particularly 75+) as opportunity to raise issues such as advanced care planning, some patients may be reluctant to have health assessments because they don't see the immediate value. For people who work, they may be unwilling to prioritise a health assessment, when they don't feel unwell or have concerns, over work and other family commitments.

Service access

Stakeholders suggested that improved service access is required to ensure effective management of chronic disease, including:

- Enhanced access to chronic disease screening and early identification via age-appropriate health checks, particularly health checks for those at risk of developing *cardiovascular* disease and type 2 diabetes for those aged 40-49 years old. A barrier to this has been participation because individuals may not prioritise proactive health checks.
- Simplified criteria and referral pathways to enable access to chronic disease self-management courses and programs.
- Engagement with pharmacies to enhance the role they play in supporting chronic disease management.
- Eliminating cost barriers to enable patients to access care in general practice or the community, for example:
    - Some wound care clients are not able to afford treatment in the community setting and are returning back to the hospital for further follow up.

- Limited fully subsidised chronic pain programs exist to manage pain in the community setting and prevent hospitalisations.
- The cost of the wound management products (consumables such as particular bandages and dressings) that are used to treat the patient is a barrier to delivery of these services by general practice.

Health professional capacity and capability development

Stakeholders consistently report the need for capacity and capability development amongst health professionals in the GCPHN region relating to multidisciplinary team care approaches, collaborative planning and case conferencing.

- Chronic disease management including holistic and lifestyle approaches (as opposed to prescribing medication).
- Awareness-raising about the kinds of services already available to support people with chronic conditions.
- Chronic pain and pain management (e.g., integrated care systems in primary care, referral pathways, back pain, and role specific evidence-based treatment practices).
- Each professional needs to own their own gaps in service delivery, by identifying where there are gaps in their service delivery based on evidence and guidelines available and addressing the issues.
- There have been many improvements in recent years in pharmacological treatments for iron deficiency administered through general practice, education and upskilling for general practice could be required.
- The cost for the consumables for iron deficiency is a problem for general practice which can limit delivery of these services.
- In the 2017 GCPHN Primary Care Opinion Survey the following were identified most frequently for future education:
  - GPs – wound management, emergency medicine women's health.
  - General practice nurses - wound management, diabetes, chronic disease, and COPD.
- Funding for Allied Health professionals is inadequate for long term management.
- Need for greater focus on managing and preventing chronic disease using exercise. In both the hospital system and in private practice, utilising Exercise Physiology to decrease the health burden that comes with progression of chronic health conditions. Not limited to cardiovascular disease, diabetes, neurological conditions and musculoskeletal issues including back pain and 0steoarthritis.

Coordination and integration

Stakeholders report that:

- Care coordination does not always effectively engage the person and their family. A full briefing will help to ensure information understood and actions required known.
- Service access and coordination is being hindered by suboptimal information sharing between hospital and primary care including lack of timeliness of discharge summaries and outpatients.
- Fragmentation between services at primary and tertiary levels of the health system creates difficulties for communication and information sharing between providers and also with patients. This is particularly evident in discharge planning and procedures.

- Further developments and enhancements for digital health, including data integration may improve care coordination.
- Wound care services lack clearly defined pathways, formalised linkages and information sharing between different providers.
- Chronic disease risk stratification processes could be better implemented to:
    - target and identify patients with increasing risk of hospitalisation, particularly for diabetes complications, pyelonephritis and COPD.
    - ensure engagement and effective treatment with patients at a stage before their condition becomes acute.
    - Pulmonary rehabilitation is an effective evidence-based treatment for COPD, and it is currently quite readily accessible.

System barriers

Common barriers reported by stakeholders at a system level include:

- GPs are currently not remunerated adequately for non-contact time spent planning and supporting care for patients with chronic conditions.
- Difficult to identify at risk patients through current software systems making practice care difficult.
- Case conferencing MBS items are not well utilised.
- Similarly, the current Practice Nurse Incentive Payment does not sufficiently support practice nurses to invest time in care-coordination for patients with chronic disease.
- GP management plans have limitations, such as:
    - plans requested for access to team care arrangement have limited emphasis on review to ensure goals and actions are addressed by patients.
    - plans are not always individualised or patient-centred meaning that goals and actions set are not achievable or meaningful to patients.
- GPs are less engaged to lead or participate in quality improvement activities than general practice nurses or practice managers. For example, feedback from general practice is that preparing for healthcare homes is challenging as non-clinical contact is not funded (for staff doing the work).

Community Advisory Council (July 2021)

Gold Coast PHN utilised the Community Advisory Council as an engagement mechanism to discuss emerging issues relating to chronic disease in the GCPHN region. Key issues and themes raised included:

- Lack of preventative healthcare and early intervention initiatives.
- Programs addressing physical health and healthy lifestyle changes, such as My Health for Life are difficult to access.
- Some preventative healthcare programs aren't widely known and would be great to hear about from doctors as suggestions to improve lifestyle factors.
- Should be more free services offered when the person needs lifestyle changes prior to after the condition has escalated.
- Transition from hospital to primary care can be confusing, leaving the consumer lost in the system.
- A focus on a holistic team approach to managing chronic illness.
- Value of peer mentors or advocates to walk alongside chronically ill people.

Appendices

Appendix 1 – MBS item numbers for types of chronic disease plan / care

Description	MBS items
Chronic Disease Management (CDM) – GP management plan	721, 229, 92024, 92068, 92055, 92099
CDM - Team Care Arrangement	723, 230, 92025, 92069, 92056, 92100
Asthma Cycle of Care	2546, 2547, 2552, 2553, 2558, 2559, 2664, 2666, 2668, 2673, 2675, 2677, 265, 266, 268, 269, 270, 271

Appendix 2 – Calculation of CVD risk

The information on CVD event risk is derived from the 2012 publication *National Vascular Disease Prevention Alliance. Guidelines for the management of absolute cardiovascular disease risk* which is available from the websites of the members of the National Vascular Disease Prevention Alliance (Heart Foundation, National Stroke Foundation, Diabetes Australia and Kidney Health Australia).

The Framingham Risk Equation (FRE) predicts the risk of a cardiovascular event over the next 5 years. The calculation can be found in the Absolute CVD Risk Resources at www.cvdcheck.org.au. The calculation excludes patients who have:

- Age: Non ATSI 74*, ATSI 74 (Risk for patients who have age>74 is calculated using age=74)
- Condition: CVD

The data items used in the calculation are:

- age
- gender
- systolic BP (mm Hg)
- total cholesterol (Mg/dL) HDL (Mg/dL)
- smoking status (Smoker/Non-smoker)
- diabetes ECG-LVH (always set to 0)
- ECG-LVH: ECG (Echocardiogram) is a test and LVH (Left Ventricular Hypertrophy) is a condition that is detected by this test. If LVH is detected as definite this value in the FRE is set to 1, otherwise it is set to 0.

Currently the outcomes of this test are not recorded as a coded value in the clinical software packages and therefore cannot be extracted. Hence, this value is always set to 0. CV Event Risk displays data as a breakdown of the % 5 Year Risk of a Cardiovascular Event: >=30%, 25-29%, 20-24%, 16-19%, 10-15%, 5-9% and <5%.

Family and Domestic violence

Local health needs and services issues

- There is a lack of clear health pathways within primary care for domestic and family violence victims and perpetrators.
- Some health professionals do not understand dynamics of domestic violence.
- Family and domestic violence can have severe consequences on child development.
- People who experience domestic violence have higher rates of mental health issues.
- Not many mental health clinicians have a high degree of understanding of domestic violence issues.

Key findings

- General practices are well placed to screen for domestic violence, which would provide opportunity for intervention before escalating to significant harm.
- While the GCPHN region has lower rates of reported domestic violence compared to the total Queensland, the number of reported domestic violence related incidents has increased in recent years.
- General practitioners can screen for domestic violence and assist in referral to domestic violence services however this is not currently happening across most practices.
- Out-of-pocket cost may limit access to services for women experiencing domestic violence.
- Many mental health clinicians do not have specialised knowledge of domestic violence dynamics and services for domestic violence perpetrators are limited.
- Several health issues have been linked to exposure to partner violence, such as:
    - depressive disorder
    - anxiety
    - sufficient self-harm
    - alcohol use disorders
- Women experience violence at much higher rates.
- Some population groups are more vulnerable for experiencing domestic violence including:
    - children
    - young women
    - older people
    - persons with a disability
    - people from a culturally and linguistically diverse backgrounds
    - LGBTIQ+ people
    - people from socioeconomically disadvantaged area

Family, domestic, and sexual violence

Family, domestic, and sexual violence is a major national health and welfare issue that can have lifelong impacts for victims and offenders. It affects people of all ages and from all backgrounds, but primarily women and children who often display including behavioural, emotional, and cognitive-functioning problems as a result. The Australian Bureau of Statistics (ABS) 2016 Personal Safety Survey estimated that 2.2 million Australian adults have been victims of physical behaviour and/or sexual violence from a partner since the age of 15[1].

Family violence refers to violence between family members, typically where the offender uses power and control over another person. The most common and widespread cases occur in intimate (current or previous) partner relationship and are usually referred to as domestic violence.

Sexual violence refers to behaviours of a sexual nature carried out against a person's will. It can be committed by a current or previous partner, other people known to the victim, or strangers.

Some groups of people are more vulnerable:

- children
- young women
- older people
- persons with disability
- people from culturally and linguistically diverse backgrounds
- LGBTIQ+ people
- people in rural and remote Australia
- people from socioeconomically disadvantaged area

Contributing factors

Many factors contribute to and influence family, domestic and sexual violence[2]. These elements relate to victims and offenders and include relationship dynamics, families and communities and geographic and political environments[3]. Contributing factors include:

- Cultural values and beliefs: masculinity linked to dominance and toughness, and strict gender roles.
- Social factors: unemployment, socioeconomic status, social and geographic isolation.
- Situational factors: male dominance in the family, intimate partner conflict, alcohol and other substance use/
- Personal history: witnessing intimate partner violence as a child, being abused during childhood or witnessing domestic violence[4,5].

The underlying drivers of family, domestic and sexual violence can replicate inequalities in the distribution of power, resources and opportunity between females and males[6]. Communities with attitudes reflecting greater levels of gender equality generally have lower rates of domestic, family, and sexual violence[7].

[1] ABS 2017c. Personal safety, Australia, 2016. ABS cat. no. 4906.0. Canberra: ABS
[2] EC (European Commission) 2010. Domestic violence against women report. Special Eurobarometer 344. Brussels: EC.
[3] ABS 2013c. Defining the data challenge for family, domestic and sexual violence. ABS cat. no. 4529.0. Canberra: ABS.
[4] Heise L 1998. Violence against women: an integrated, ecological framework. New York: Sage Journals. 2
[5] Edleson, J. L. (2019, August 1). *Children's witnessing of adult domestic violence*. SAGE Journals.
[6] Cox P 2015. Violence against women in Australia: additional analysis of the ABS Personal Safety Survey, 2012. Sydney: ANROWS.
[7] UNIFEM (United Nations Development Fund for Women) 2010. Investing in gender equality: ending violence against women and girls. New York: United Nations Entity for Gender Equality and the Empowerment of Women (UN Women).

A study completed in South Australia interviewed a random sample of 6,000 adults aged 18 years and over. In total, 17.8% of the sample reported some form of domestic violence by a current or an ex-partner[8]. Factors which increased the likelihood of experience with domestic violence included:

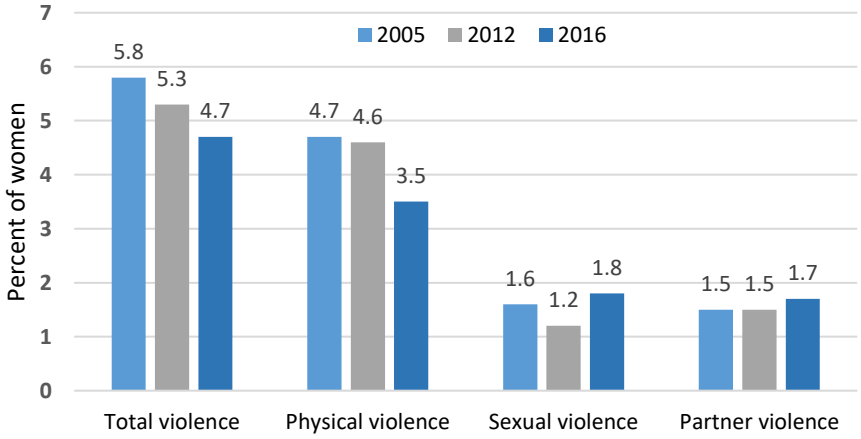
- low household income,
- unemployment or part time employment,
- health variables such as poor self-reported health status and alcohol abuse problems.

Rates of violence over time

Data from a 2016 ABS survey indicates that partner violence (including physical and/or sexual violence from a current or previous partner) have remained steady over the last decade. During the same time, there have been recorded declines in total rates of violence [9,10,11].

Rates of partner violence against women increased from 1.5% in 2005 to 1.7% in 2016. Rates of partner violence against men also increased during this time, from 0.4% in 2005 to 0.8% in 2016.

Figure 1. Proportions of Australian women aged 18 and over who had experienced physical, sexual and partner violence in the 12 months prior, 2005, 2012 and 2016



Source: Family, domestic, and sexual violence in Australia: continuing the national story in 2019. Australian Institute of Health and Welfare

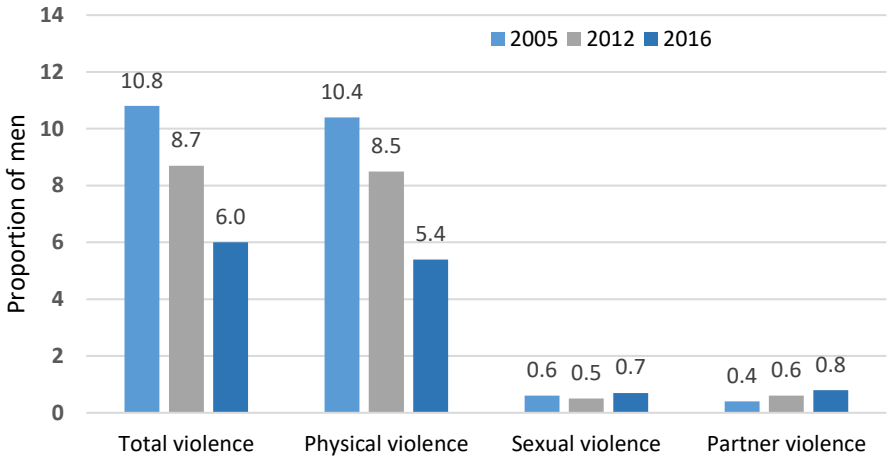
[8] Dal Grande, E., Hickling, J., Taylor, A., & Woollacott, T. (2007, September 25). *Domestic violence in South Australia: a population survey of males and females*. https://onlinelibrary.wiley.com/doi/10.1111/j.1467-842X.1998.tb01496.x

[9] ABS (Australian Bureau of Statistics) 2006. Personal safety, Australia, 2005 (reissue). ABS cat. no. 4906.0. Canberra: ABS.

[10] ABS 2013. Personal safety, Australia, 2012. ABS cat. no. 4906.0. Canberra: ABS

[11] ABS 2017. Personal safety, Australia, 2016. ABS cat. no. 4906.0. Canberra: ABS

Figure 2. Proportion of Australian men aged 18 and over who had experienced physical, sexual and partner violence in the 12 months prior, 2005, 2012 and 2016

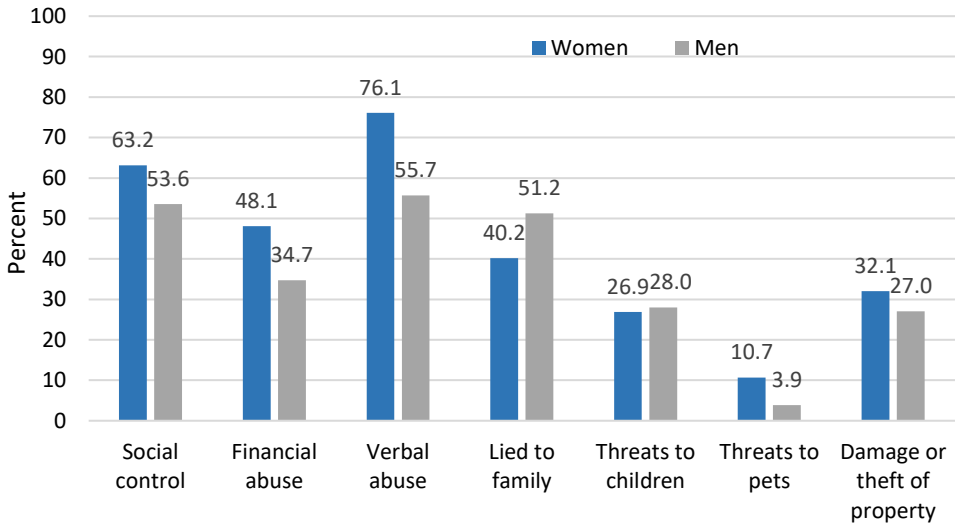


Source: Family, domestic, and sexual violence in Australia: continuing the national story in 2019. Australian Institute of Health and Welfare

Emotional abuse

Almost 23% of women and 16% of men have suffered emotional abuse from a current or previous partner since the age of 15[12]. Verbal abuse was the most common behaviour experienced by both men and women who had been emotionally abused by a previous partner. Threats to children and lies to family were more common behaviours among men.

Figure 3. Emotionally abusive behaviours experienced by Australian adults aged 18 and over from their most recently abusive partner, by sex, 2016



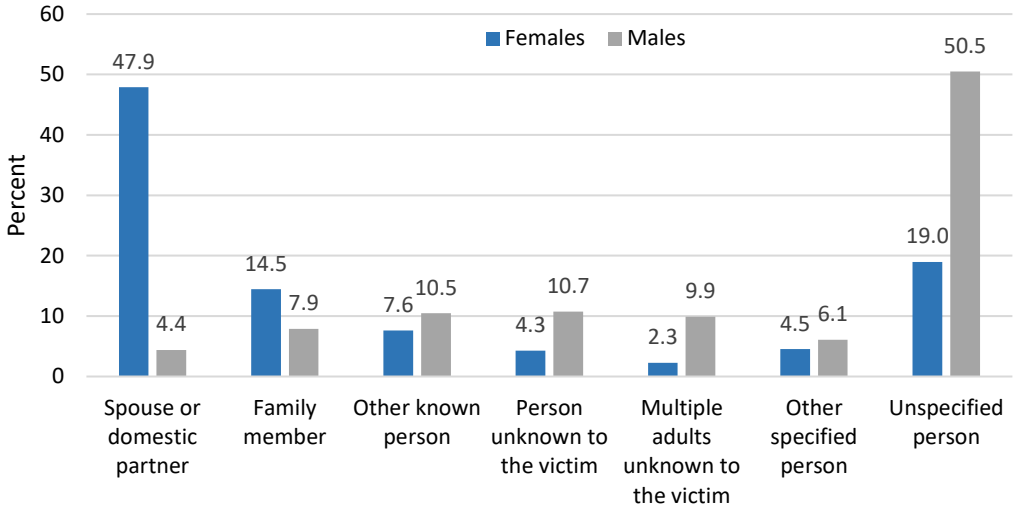
Source: ABS 2018. Personal Safety Survey, 2016, ABS cat. no. 4906.0. Findings based on use of ABS Table Builder data.

[12] ABS 2017. Personal safety, Australia, 2016. ABS cat. no. 4906.0. Canberra: ABS

Hospitalisations for assault

In 2016-2017, 29% of the 21,400 hospitalisations for assault injuries in Australia were a result of family and domestic violence. Of the family and domestic violence-related assault hospitalisations, the offender was reported as a spouse or domestic partner in 66% of assaults and as another family member in 33% of assaults[13].

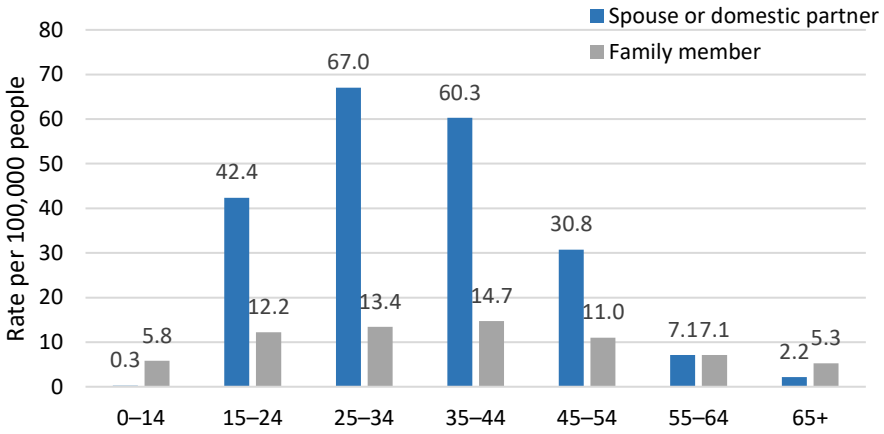
Figure 4. Assault hospitalisations in Australia, adults aged 15 and over, by relationship to perpetrator and sex, 2016-17



Source: AIHW National Hospital Morbidity Database

In 2016-17, Australian women had a significantly higher rate of hospitalisation for assault by a spouse or partner compared to men. Rates were highest for women aged 25-34 (67 per 100,000) and then fell noticeably to 2.2 per 100,000 for women aged 65 and over. Amongst males, hospitalisations were higher for assaults committed by family members compared to spouse or domestic partner.

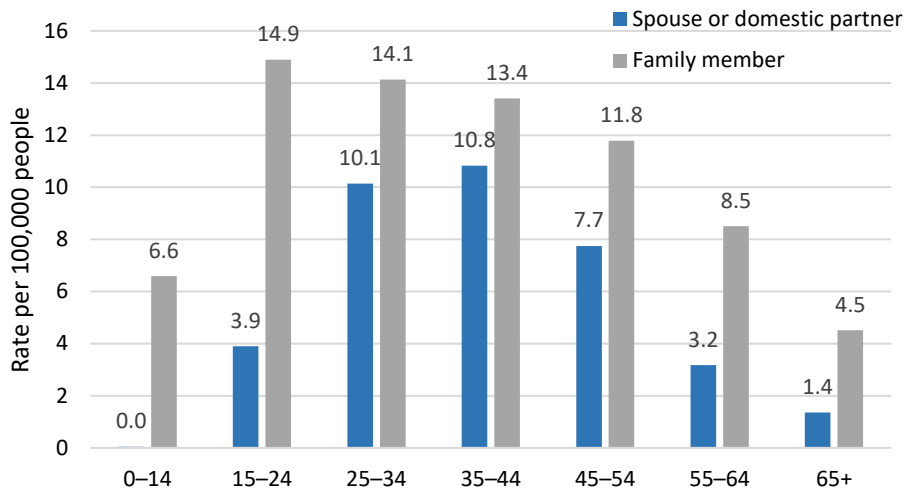
Figure 5. Rate per of Australian female hospitalisations for family or domestic violence assaults, by relationship to perpetrator and age, 2016-17



Source: AIHW National Hospital Morbidity Database

[13] AIHW 2018d. Trends in hospitalised injury, Australia 1999–20000 to 2014–15. Injury research and statistics series no. 110. Cat. no. INJCAT 190. Canberra: AIHW.

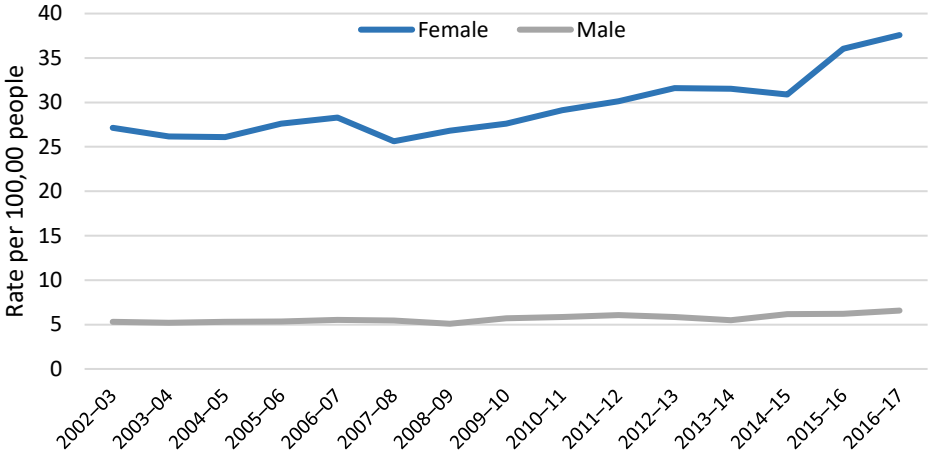
Figure 6. Rate per 100,000 people of Australian male hospitalisation for family or domestic violence assaults, by relationships to perpetrator and age, 2016-2017



Source: AIHW National Hospital Morbidity Database

Hospitalisations of women assaulted by a spouse or partner continue to rise at an average of 2.8% per year between 2002-03 to 2016-17 in Australia, when the rate increased from 27 to 38 hospitalisations per 100,000 population. For males, the rate was relatively stable during this time, increasing from 5.3 to 6.6 hospitalisations per 100,000 population.

Figure 7. Age-standardised rate of assault hospitalisations where the perpetrator was a spouse or partner, by sex, 2002-13 to 2016-17



Source: AIHW National Hospital Morbidity Database

Burden of disease

Burden of disease measures the impact of living with illness and injury and dying prematurely. The 2015 Australian Burden of Disease study projected the amount of disease burden that could be avoided if no female aged 15 and over in Australia were exposed to intimate partner violence. The impact of this risk factor

was estimated only for women, as the evidence in past literature to identify the causally linked diseases and the amount of increased risk was available only for women[14,15].

Six diseases were causally linked to exposure to partner violence:

- depressive disorder
- anxiety conditions
- alcohol use disorders
- early pregnancy loss
- homicide and violence (injuries due to violence)
- suicide & self-inflicted injuries

In 2015, for females aged 15 and over in Australia, partner violence contributed to:

- 223 deaths (0.3% of all deaths) in Australia,
- 1.6% of the burden of disease and injury

Mental health conditions were the largest contributor to the burden, with depressive disorders making up the greatest percentage (43%) followed by anxiety disorders (30%). Partner violence was ranked as the third leading risk factor contributing to total disease burden for women aged 25–44, behind child abuse and neglect during childhood, and illicit drug use[16].

Family violence among Aboriginal and Torres Strait Islander people

Family violence is the preferred term for violence within Aboriginal and Torres Strait Islander communities, as it covers the extended family and relationships in which violence can occur. It remains a critical social policy issue, placing a huge burden on communities, especially on women and children[17]. The removal from land and cultural dispossession over the past 200 years have resulted in social, economic, physical, psychological, and emotional problems for Indigenous Australians. Family violence against Indigenous Australians must be understood as both a cause and effect of social disadvantage and intergenerational trauma.

Aboriginal and Torres Strait Islander Australians experience family violence at higher rates than the non-Indigenous people. Aboriginal and Torres Strait Islander peoples are more likely to be hospitalised due to family violence, more likely to be murdered by a family member, and more likely to have their children removed, compared with non-Indigenous people[18].

Aboriginal and Torres Strait Islander adults are disproportionately affected by family violence:

- In 2016–17, Aboriginal and Torres Strait Islander females aged 15 and over were 34-times as likely to be hospitalised for family violence as non-Indigenous females, with 8 per 1,000 (n=2,200) Aboriginal and Torres Strait Islander females hospitalised, compared to 0.2 in 1,000 (n=2,400) non-Indigenous females.
- Aboriginal and Torres Strait Islander males were 27-times more likely to be hospitalised for family violence as non-Indigenous males, with 3 per 1,000 (n=730) Indigenous males hospitalised, compared with 0.1 per 1,000 (n=990) non-Indigenous males.

[14] Ayre J, Lum on M, Webster K & Moon L 2016. Examination of the burden of disease of intimate partner violence against women: final report, 2011. Sydney: Australian National Research Organisation for Women's Safety.
[15] GBD 2016 Risk Factors Collaborators 2017. Global, regional, and national comparative risk assessment of 84 behavioural, environmental, and occupational, and metabolic risks or clusters of risks, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. The Lancet 390:1345–422.
[16] AIHW (Australian Institute of Health and Welfare) 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia, 2015. Australian Burden of Disease series no. 19. Cat. no. BOD 22. Canberra: AIHW.
[17] Closing the Gap Clearinghouse 2016. Family violence prevention programs in Indigenous communities. Resource sheet no. 37 produced by the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare and Australian Institute of Family Studies.
[18] AIHW 2018b. Family, domestic and sexual violence in Australia, 2018. Cat. no. FDV 2. Canberra: AIHW.

Domestic violence among lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+)

Until recently, intimate partner violence within LGBTIQAP+ relationships was largely unacknowledged until recently and limited research was available on this topic[19]. The Australian Research Centre for Health and Sexuality conducted a national demographic and health and welling survey of 5,476 LGBTIQAP+ people and found significant levels of partner violence[20]. Around 28% of male-identifying respondents and 41% female-identifying respondents reported having been in an abusive relationship.

A smaller study of 390 LGBTIQAP+ respondents in Victoria, also conducted by the Australian Research Centre for Health and Sexuality[21], found that just under a third of respondents had been involved in a same-sex relationship where they were subject to abuse by their partner:

- 78% of the abuse was psychological and 58% involved physical abuse,
- lesbian women were more likely than gay men to report having been in an abusive same sex relationship (41% and 28% respectively),
- 28% had experienced sexual assault within a same sex-sex relationship.

Elder abuse

Elder abuse takes a myriad of forms, including psychological abuse, financial abuse, physical abuse, and sexual abuse, and often a combination of these. Like family violence, elder abuse is about one person having power and control over another person.

In 2018, 16.4% of people aged 65 and over in the GCPHN region (n=101,783) reported experiencing elder abuse, which was slightly above the Queensland rate of 15.4%.

In Australia, the available evidence suggest that prevalence varies across abuse types, with psychological and financial abuse being the most common. A population-based study to identify the prevalence of elder abuse (women only) is the Australian Longitudinal Study of Women's Health 2014[22]. This study is based on a random sample of women with the oldest cohort (n = 5,561) being born between 1921 and 1926. When this cohort was surveyed in 2011 (at age 85-90), the findings suggested that 8% had experienced being exposed to abuse, with name calling and put-downs being the most common forms. A similar level of prevalence was evident for this cohort in a preceding wave, conducted in 2008 (age 82-87), and slightly lower prevalence levels were found at younger ages (70-81 years). Measures the researchers used to assess neglect indicate a relatively stable prevalence rate of about 20% across waves, from ages 70-75 and 85-90 years.

In Queensland, calls to the Elder Abuse Prevention Unit (EAPU) have increased in recent years, from just over 200 in 2000-01 to nearly 1,300 in 2014-15[23]. The calls were mostly in relation to female victims (68% female, 31% male and 1% unknown). Perpetrators were males in 50% of calls and females in 45% (unknown 5%). Children were the largest groups of perpetrators reported (31% sons, 29% daughters), with 10% of cases perpetrated by other relatives.

[19] Calton, J., Cattaneo, L. B., Gebhard, K. T. (2015). Barriers to help seeking for lesbian, gay, bisexual, transgender, and queer survivors of intimate partner violence. Trauma, Violence and Abuse.
[20] Pitts, M., Smith, A., Mitchell, A., & Patel, S. (2006). Private lives: A report on the health and wellbeing of GLBTI Australians. Melbourne: Australian Research Centre in Sex, Health & Society.
[21] Leonard, W., Mitchell, A., Patel, S. & Fox, C. (2008). Coming forward: The underreporting of heterosexist violence and same sex partner abuse in Victoria. Bundoora, Victoria: Australian Research Centre in Sex, Health and Society.
[22] Australian Longitudinal Study on Women's Health. (2014). 1921-26 cohort: Summary 1996-2013. Callaghan, NSW & Herston, Qld: University of Newcastle and the University of Queensland.
[23] Spike, C. (2015). The EAPU helpline: Results of an investigation of five years of call data. Report for the International Association of Gerontology and Geriatrics Asia & Oceania Regional Congress 2015.

In 2014-15, the most reported type of abuse to the EAPU helpline was financial abuse, accounting for 40% of cases. In 2012-13, the most common type of reported abuse was psychological abuse.

Technology

As outlined in the Domestic and Family Violence Protection Act 2012 (Appendix 1), unauthorised surveillance of a person is a form of domestic violence. Studies have indicated this can be assisted with technology including phones, computers, and social networking[24,25]. Technology can create a sense of the perpetrator's presence and aims to isolate, punish and humiliate their victims.

Reported offences

The below tables and figures highlight the number of reported domestic violence cases reported through police officers and private domestic violence orders recorded by Queensland Police. GCPHN acknowledges that the below data tables and figures are a under representation as not all incidents are reported.

In 2019 there was 2,976 reported domestic violence applications, including 2,260 from police and 716 through private applications.

Domestic violence indicator

The rate of reported offences by domestic violence indicator (police officers' perception that the incident was related to domestic violence) has increased for all assault, sexual offences and other offences against the person on the Gold Coast Police District from 2015 to 2019, as seen in Table 1.

Table 1. Number of offences by domestic violence indicator per 100,000 people, Gold Coast, 2015-19

	2015	2016	2017	2018	2019	Change 2015 to 2019 (%)
Assault	31	229	213	238	284	89%
Grievous assault	<5	<5	<5	<5	<5	50%
Serious assault	21	111	104	113	119	82%
Serious assault (other)	<5	18	18	19	24	88%
Common assault	6	99	87	103	138	96%
Sexual offences	<5	8	7	6	11	91%
Rape and attempted rape	<5	<5	<5	<5	7	86%
Other sexual offences	0	<5	<5	<5	<5	100%
Other offences against the person	7	35	44	46	51	86%
Kidnapping and abduction	<5	<5	<5	<5	<5	60%
Stalking	<5	10	6	6	6	67%
Life endangering acts	<5	23	36	35	39	95%

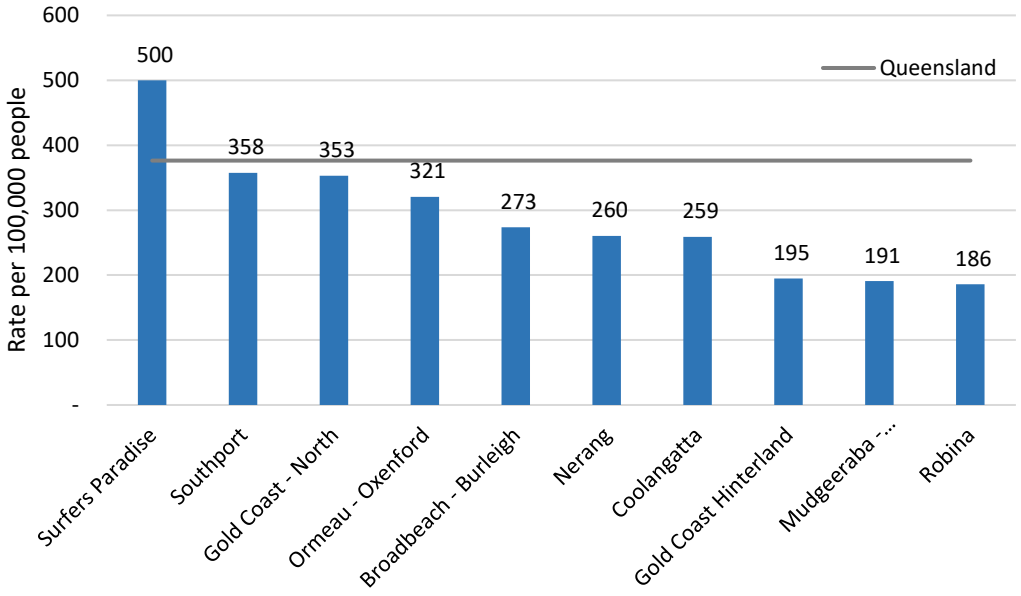
Source: Queensland Police Service

[24] Woodlock, D. (2016, May 12). *The abuse of technology in domestic violence and stalking, 2017*. SAGE Journals.
[25] Briggs, C. (2018, September). *Australian Journal of child and family health nursing - An emerging trend in domestic violence: Technology-facilitated abuse (Health collection) -*

Domestic violence – police applications

Police can apply for a Domestic Violence Order where they reasonably believe that there is sufficient reason to act and there is sufficient evidence to determine that the aggrieved person requires protection.

Figure 8. Rate of Domestic Violence Orders – police applications, Gold Coast SA3 regions, 2020



Source: Queensland Police Service

Table 2. Number of Domestic Violence Orders – police applications, Gold Coast SA3 regions, 2019-20

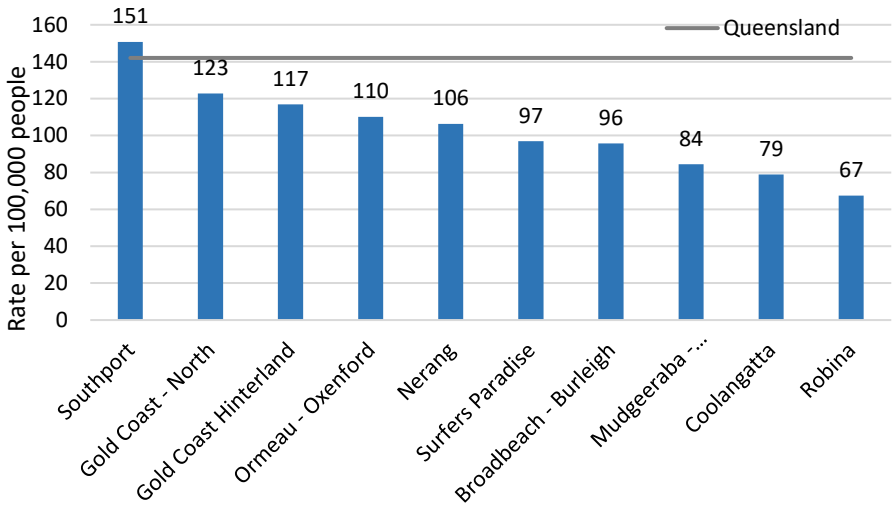
Region	2019	2020	Change from 2019 to 2020 (%)
Queensland	20,479	19,495	-4.8%
Gold Coast SA4	2,261	1,973	-12.7%
Broadbeach - Burleigh	203	183	-9.9%
Coolangatta	170	151	-11.2%
Gold Coast - North	274	253	-7.7%
Gold Coast Hinterland	53	40	-24.5%
Mudgeeraba - Tallebudgera	85	70	-17.6%
Nerang	272	191	-29.8%
Ormeau - Oxenford	564	518	-8.2%
Robina	139	105	-24.5%
Southport	253	230	-9.1%
Surfers Paradise	248	232	-6.5%

Source: Queensland Police Service

Domestic violence – private applications

A private application for a Domestic Violence Order can be made by any member of the public who considers themselves to be at risk within their relationship and feel that their current situation warrants this type of protection.

Figure 9. Rate of Domestic Violence Orders – private applications, Gold Coast SA3 regions, 2020



Source: Queensland Police Service

Table 3. Number of Domestic Violence Orders – private applications, Gold Coast SA3 regions, 2019-20

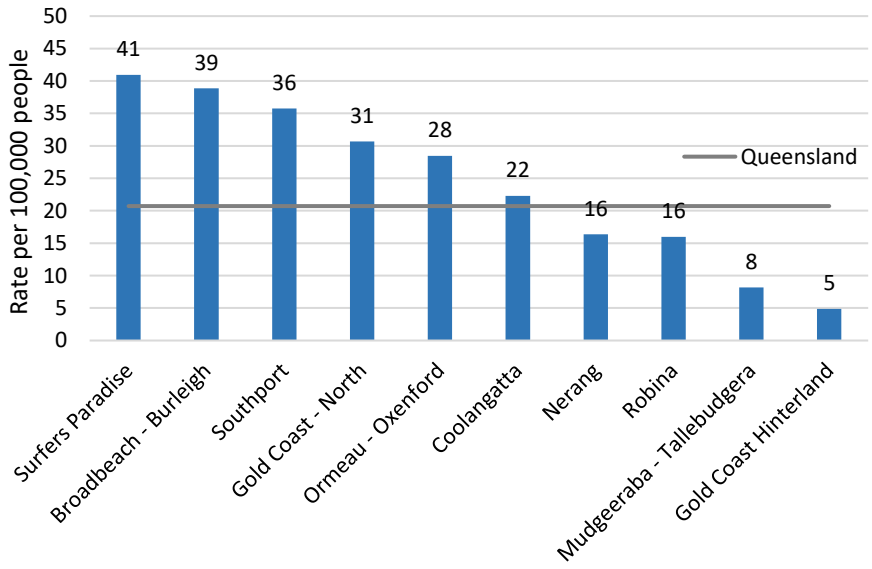
Region	2019	2020	Change from 2019 to 2020 (%)
Queensland	8,239	7,358	-10.7%
Gold Coast SA4	719	689	-4.2%
Broadbeach - Burleigh	53	64	20.8%
Coolangatta	57	46	-19.3%
Gold Coast - North	80	88	10.0%
Gold Coast Hinterland	33	24	-27.3%
Mudgeeraba - Tallebudgera	30	31	3.3%
Nerang	100	78	-22.0%
Ormeau - Oxenford	195	178	-8.7%
Robina	41	38	-7.3%
Southport	95	97	2.1%
Surfers Paradise	35	45	28.6%

Source: Queensland Police Service

Strangulation in a domestic setting

In 2020, the rate of strangulation in the domestic setting in the GCPHN region is above the Queensland rate of 20.7 per 100,000 people. Surfers Paradise had the highest number of strangulations reported to police – 41 per 100,000 people in 2020.

Figure 10. Rate per of strangulation in a domestic setting, Gold Coast SA3 regions, 2020



Source: Queensland Police Service

Table 4. Strangulation in a domestic setting, Queensland and Gold Coast, 2019-20

	2019	2020	Change from 2019 to 2020 (%)
Queensland	1042	1073	3.0%
Gold Coast	190	174	-8.4%

Source: Queensland Police Service

Between 1 July 2010 and 30 June 2014, there were 152 intimate partner homicides in Australia that followed an identifiable history of domestic violence. Most of these homicides involved a man killing his female partner (80%)[26].

[26] Australia's National research organisation for Women's Safety. (2019). Domestic Violence and family violence lethality: The facts about intimate partner homicide. Sydney.NSW: ANROWS

Service system

Services	Number in the GCPHN region	Distribution	Capacity
Domestic Violence Prevention Centre (DVPC) Gold Coast (07 5591 4222 or 07 5532 9000)	1	Gold Coast	The DVPC provides a wide range of programs to support women and their children affected by domestic violence and family violence and work with men who perpetrate domestic and family violence.
Kalwun Family and Domestic Violence Support Program (07 5520 8600)	1	Kalwun Medical Centres	Kalwun family and domestic violence program supports and empowers families escaping and recovering from violence and abuse. Women and children escaping family and domestic violence are eligible.
Gold Coast Centre against sexual violence	1	Gold Coast	Feminist, not for profit, charitable organisation providing free counselling, advocacy, information and practical support, as well as therapeutic and educational groups for women who have experienced sexual violence at any time in their lives.
Support Assessment Referral Advocacy (0405 065 544)	1	Gold Coast	Supports women and their children from culturally and linguistically diverse backgrounds affected by domestic and family violence.
DV Connect Womensline (1800 811 811)	Phone	Australia wide	Telephone hotline for women, their children and pets experiencing domestic violence. Womensline offers emergency transport and accommodation as well as crisis counselling and interventions.
Elder Abuse Helpline- Queensland Only (1300 651 192)	Phone	Australia wide	9am-5pm, Monday to Friday, free and confidential advice for anyone experiencing elder abuse or who suspects someone they know may be experiencing elder abuse.
1800RESPECT (188 737 732)	Phone	Australia wide	24-hour national sexual assault, family and domestic violence counselling line for any Australian who has experienced, or at risk, of family and domestic violence and/or sexual assault.
Men's Referral Service (1300 766 491)	Phone	Australia wide	This service from No to Violence offers assistance, information and counselling to help men who use family violence.
Mensline Australia (1300 789 978)	Phone	Australia wide	Supports men and boys who are dealing with family and relationship difficulties. 24/7 telephone and online support and information service for Australian men
Kids Help Line (1800 551 800)	Phone	Australia wide	Free, private and confidential, telephone and online counselling service specifically for young people aged between 5 and 25 in Australia.

Aboriginal Family Domestic Violence Hotline (1800 019 123)	Phone	Australia wide	Victims Services has a dedicated contact line for victims of crime who would like information on victims' rights, how to access counselling and financial assistance.

Consultation

Gold Coast Local Level Alliance

Key issues raised at the Gold Coast Local Level Alliance are listed below:

- Local GPs are advocating for funding in the northern corridor for DV. GPs indicated they have had a large client base that is seeking psychological support for DV given the recent DV tragedies.
- Some GCPHN commissioned providers have indicated they have seen an increase of clients with family and/or domestic violence presentations to services.
- Noticeable increase in crisis calls and walk-ins specifically pertaining to women fleeing DV situations, seeking immediate support.
- Lack of safe accommodation for women, children's and their pets which is often a factor influencing someone to stay in this situation.
- Not often crisis housing will facilitate a pet to stay
- Impact of COVID-19 on increasing DV presentations needs to be considered.

GCPHN Community Advisory Council (July 2020)

What are major health issues that relate to domestic violence that are not currently being addressed on the Gold Coast?

- A lot of DV is from kids to parents, as these kids are under 18 there is no reporting due to parents not wanting to have the family engaged in child protection services. Kids seem to be repeating these behaviours as this is all they have ever known, and it is considered normal. Early intervention with children should be implemented when families visit their local doctor or service for help to:
    - avoid children adopting violent tendencies,
    - avoid children self-harming and development of mental health issues,
    - avoid emergency department admissions.
- Lack of accommodation/safe spaces for women and children.
- The psychosocial support needs of those experiencing domestic and family are currently under-supported due to limitations of GP Mental healthcare plans and similar programs, particularly for those with limited financial capacity to pay for out-of-pocket cost.
- Low-income families experience more domestic violence, and this seems to be a snowball effect from limited earnings, time poor from working for low wages creates fatigue and the feelings of no progression, leading to frustration and aggression.
- More education and early intervention are necessary to avoid ED admissions.
- The impacts of domestic violence on child development and the early onset of chronic disease, mental health issues and self-harming.
- Data show women are the most affected, however men also require safe spaces.

Are there any access issues to services or regions on the Gold Coast that lack services?

- There is a need for more men's behaviour change groups.
- Community attitudes need to change for change to occur on an individual basis and this is something to which more attention should be paid too.
- Adverse childhood experiences and their impacts are still under-acknowledged in the way we design and deliver services and this area requires more attention, due to the multitude of ways in which it impacts children in later life if they're subjected to adversities.
- Women and children need to be moved to safety houses if they suspect men can be dangerous.
- Holistic care to all members of domestic violence.
- Early intervention and empowering men and women at a young age may encourage respect and equality.
- Culturally and linguistically diverse and Aboriginal and Torres Strait Islander people need focus.

Domestic Violence Integrated Response (August 2020)

Domestic Violence Integrated Response (DVIR) which is a collection of about 16 organisations that primarily work in the DFV 'system', these are Police, Queensland Corrective Services, DJAG, Youth Justice, Child Safety, Centrelink, Department of Housing, Refuges, Queensland Health, Department of Education, Legal Aid, Multicultural Families Organisation and domestic violence prevention centre. As a group they meet monthly and largely look at improving the coordination of system responses.

In August 2020, they provided the following feedback:

- Based on evidence and research (Centre for innovative Justice Paper), DVIR is focussed on perpetrator interventions and looks to create doorways for men into services. Healthcare services are one of the limited number of points that could be a door for response required.
- Women tend to use GP and health services more than men. Often health services become aware and get involved in DV situations when there is a crisis. It would be better if DV could be identified earlier or outside of a crisis through proactive response.
- One thing any services who are supporting people in this area need to be aware of is unintended consequences. For example, if a person presents to GCH for DV related injuries would including this information in a discharge summary to GP assist or cause more issues.
- DVIR members noted several issues with private psychologists:
    - Many do not understand the complexity of DV, and many may see it as "marriage counselling" which it is not.
    - If domestic violence is pathologised, it does not make women safer, in fact it can provide "reasons/excuses", important to remember a lot of people drink/take drugs/ have anxiety - not all of them commit DV. They are escalating factors not the whole problem.
    - GPs and private psychologists can become unconscious allies for perpetrators because they focus on treating the individual.
- Also need to consider other general practice staff e.g., nurse and even reception staff. They are often placed to pick up on issues.
- GPs do not always book interpreters when they need to. Some doctors who speak other languages and have patients from those countries will refer women to multicultural support services.
- "Bomb drop training" is not helpful – it should be integrated into the work they do.
- Telehealth consults has provided some insights into family life not otherwise seen. Things going on in the background etc. that flag potential DV situations.

GCPHN Clinical Council (August 2020)

- GPs screen for domestic violence, and it can be a safe place for victims. There are resources available for GP's (White book).
- GPs will ask questions to their patients regarding domestic violence as part of their continued care, it's a longitude relationship with GPs.
- It builds the GP's confidence having conversations with their patient regarding family and domestic violence.
- Unclear health pathways within Primary Care for DV victims and perpetrators, what is the next step to take for a client who is a victim of domestic violence from their GP.
- Some GPs in the group use DV connect as a referral source, challenging to find support and in particular legal support.
- GPs in the group have no preferred psychologists that they would refer victims and perpetrators to. Difficult to search for psychologists with a special interest.
- Gap fee is a barrier for victims to seek psychologists.
- When a patient is referred to a psychologist, the psychologists need to deal with the risk and safety work alongside domestic violence services to focus on safety and not just psychological strategies.

- Pharmacists can give current medications for emergency medications, but unaware on where to refer to next.
- The white book is a great source for information for GPs although not reviewed as often due to time constraints, non-GPs in the group interested in the white book and how it can be of assistance.
- Often an issue can be emergency accommodation if victim of DV moves out with kids, churches can be a safe place although can be difficult for families.

Appendix 1 – Definition of domestic violence

Domestic and Family Violence Protection Act 2012 states that:

(1) *Domestic violence* means behaviour by a person (the *first person*) towards another person (the *second person*) with whom the first person is in a relevant relationship that—

(a) is physically or sexually abusive; or

(b) is emotionally or psychologically abusive; or

(c) is economically abusive; or

(d) is threatening; or

(e) is coercive; or

(f) in any other way controls or dominates the second person and causes the second person to fear for the second person's safety or wellbeing or that of someone else.

(2) Without limiting subsection (1), domestic violence includes the following behaviour—

(a) causing personal injury to a person or threatening to do so;

(b) coercing a person to engage in sexual activity or attempting to do so;

(c) damaging a person's property or threatening to do so;

(d) depriving a person of the person's liberty or threatening to do so;

(e) threatening a person with the death or injury of the person, a child of the person, or someone else;

(f) threatening to commit suicide or self-harm so as to torment, intimidate or frighten the person to whom the behaviour is directed;

(g) causing or threatening to cause the death of, or injury to, an animal, whether or not the animal belongs to the person to whom the behaviour is directed, so as to control, dominate or coerce the person;

(h) unauthorised surveillance of a person.

(i) unlawfully stalking a person.

(3) A person who counsels or procures someone else to engage in behaviour that, if engaged in by the person, would be domestic violence is taken to have committed domestic violence.

(4) To remove any doubt, it is declared that, for behaviour mentioned in subsection (2) that may constitute a criminal offence, a court may make an order under this Act on the basis that the behaviour is domestic violence even if the behaviour is not proved beyond a reasonable doubt.

(5) In this section—

Coerce, a person, means compel or force a person to do, or refrain from doing, something.

Unauthorised surveillance, of a person, means the unreasonable monitoring or tracking of the person's movements, activities or interpersonal associations without the person's consent, including, for example, by using technology.

Examples of surveillance by using technology—

- reading a person's SMS messages
- monitoring a person's email account or internet browser history
- monitoring a person's account with a social networking internet site
- using a GPS device to track a person's movements
- checking the recorded history in a person's GPS device

Determinants of heath

Health needs and service issues

- Numerous Statistical Area Level three (SA3) regions in the GCPHN region have a high rate of people who need assistance with a profound or severe disability compared to Queensland rate.
- Language can be a barrier for people accessing health services.
- There is limited social housing available in the GCPHN region.
- Higher risk of poor wellbeing for children with no parents employed.

Key findings

- Gold Coast-North and Southport SA3 regions have the highest rate of people living in most disadvantaged quintiles in the GCPHN region.
- Gold Coast-North and Southport SA3 regions have the highest rate of people who need assistance with a profound or severe disability, the highest rate of unemployment, and the highest rate of families with no parent employed in the GCPHN region.
- Surfers Paradise and Southport SA3 regions have the highest rate of people born in a non-English speaking country.

Determinants of health

Many factors combine to affect the health of individuals and communities. Whether people are healthy or not is determined by their circumstances and environment. Factors such as where one lives, the state of the environment, genetics, income, education level and relationship with friends and family all have significant impacts on health. The determinants of health are "a factor or characteristic that brings about a change in health, either for the better or the worse"[1].

Determinants of health include:

- the social and economic environment
- the physical environment
- the persons individual characteristics and behaviours

Determinants can be categorised into:

- distal determinants: social, environmental, and health services
- proximal determinants: individual

Socioeconomic status and health

There are numerous determinants of health and wellbeing in Australia, and one of these determinants is a person's socioeconomic status. The higher a person's income, education and/or occupation level, the healthier they tend to be. Data shows that people from lower socioeconomic regions are at greater risk of poor health outcomes.

Socioeconomic status is the social standing of an individual as measured as a grouping of education, income and occupation. It has been stated that every level higher of socioeconomic status is related to better health of an individual. There is clear evidence that health and illness are not distributed equally within the Australian population. Variations in health status generally follow a gradient, with overall health tending to improve with improvements in socioeconomic status[2].

The Australian Bureau of Statistics (ABS) broadly defines relative socioeconomic advantage and disadvantage in terms of people's access to material and social resources and their ability to participate in society. A complete measure of all socioeconomic characteristics is the Socio-Economic Indexes for Areas (SEIFA). A SEIFA score is a relative measure and cannot be used to say that an area is (dis)advantaged, only that it is (dis)advantaged relative to other areas in Australia.

The SEIFA table shown below which is created by the ABS after each Census of Population and Housing using area-based population attributes such as low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations (Table 1).

[1] Keleher, H & Murphy, B, 2004, Understanding health: a determinants approach. Edited by Keleher, Helen and Murphy, Bernadette, Oxford University Press, Oxford, England.

[2] Kawachi I, Subramanian SV & Almeida-Filho N 2002. A glossary for health inequalities. Journal of Epidemiology and Community Health 56:647–52

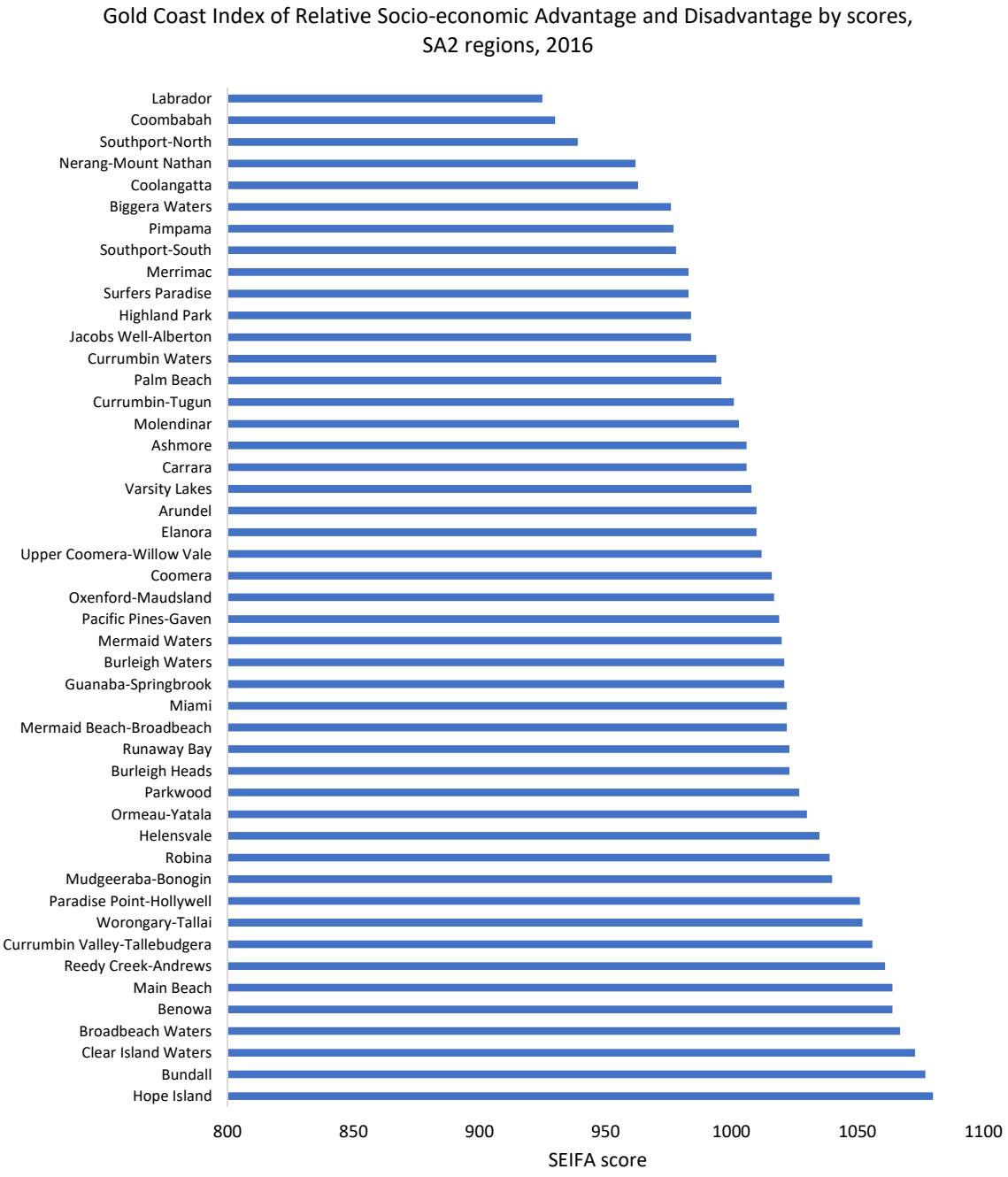
Table 1. Population by Socioeconomic Index for Areas (SEIFA), Gold Coast SA3 regions, 2016

Region	Quintile 1 (most disadvantaged) (%)	Quintile 2 (%)	Quintile 3 (%)	Quintile 4 (%)	Quintile 5 (least disadvantaged) (%)
Australia	20.0%	20.0%	20.0%	20.0%	20.0%
Queensland	20.0%	20.0%	20.0%	20.0%	20.0%
Gold Coast SA4	9.0%	20.1%	24.7%	28.6%	17.6%
Broadbeach-Burleigh	3.4%	14.3%	25.9%	36.3%	20.1%
Coolangatta	5.5%	30.8%	28.6%	24.0%	11.1%
Gold Coast-North	22.6%	28.1%	22.7%	14.2%	12.5%
Gold Coast Hinterland	0.0%	5.0%	42.3%	38.7%	14.0%
Mudgeeraba-Tallebudgera	0.0%	13.7%	9.7%	40.8%	35.8%
Nerang	7.0%	17.5%	26.8%	37.3%	11.4%
Ormeau-Oxenford	4.1%	18.6%	23.8%	28.0%	25.6%
Robina	4.1%	12.6%	32.8%	32.9%	17.6%
Southport	25.9%	21.6%	24.8%	22.9%	4.8%
Surfers Paradise	10.9%	29.9%	14.4%	22.2%	22.6%

Source ABS 2033.0.55.001 Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016, (Queensland Treasury derived. This data set is a component of the minimum data set.

Table 1 breaks down each SA3 within the GCPHN region into five quintiles, from one being most disadvantaged and five being least disadvantaged. Gold Coast-North (22.6%) and Southport (25.9%) had the highest percentage of population in the most disadvantaged quintile, while Mudgeeraba-Tallebudgera (35.8%) had the highest percentage of population among the least disadvantaged quintile.

Figure 1. Index of relative socio-economic advantage and disadvantage by SEIFA scores, Gold Coast SA2 regions, 2016

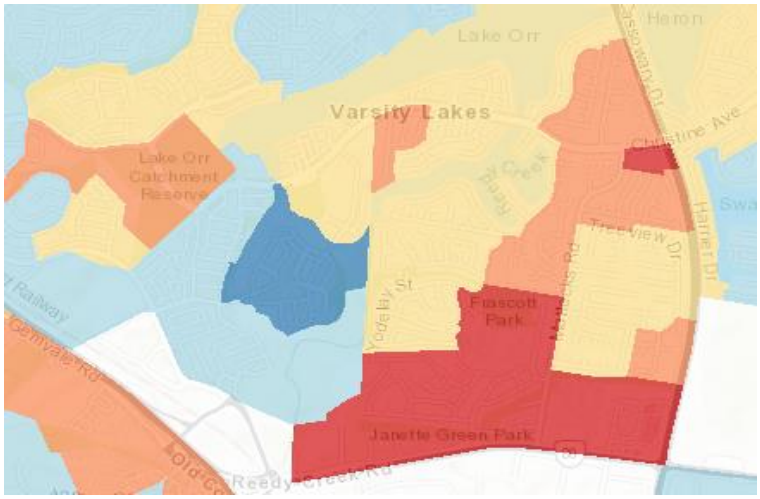


Source: Australian Bureau of Statistics, Socio-Economic Indexes for Australia (SEIFA), 2016. 2033.0.55.001

Figure 1 shows the index of relative socioeconomic advantage and disadvantage (SEIFA scores) mapped to GCPHN's SA2 regions. The SA2s with the highest scores for SEIFA were Hope Island (1080) and Bundall (1077), while Labrador (925) and Coombabah (930) had the lowest SEIFA scores in the GCPHN region.

Analyses of SEIFA scores at the larger geographies (SA3 or SA4) can mask some of the smaller pockets of disadvantage (e.g. at the suburb level) within that region. An example below in Figure 2 shows that a SA3 or SA2 region can be made up of numerous SA1 regions with varying SEIFA scores.

Figure 2. Heat map of SEIFA scores, Varsity Lakes and surrounding SA1 regions, 2016



Source: Australian Bureau of Statistics, Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016

The 2018 Health of Queenslanders report identified that:

- 18% of Queensland adults lived in the most socioeconomically disadvantaged areas compared with 20% in the most advantaged areas in 2016[3].
- Potentially preventable hospitalisations in disadvantaged areas were 84% higher than in the advantaged areas.
- In the most disadvantaged areas, smoking was 2.4-times higher in comparison to the advantaged areas[4].

Social determinants

The World Health Organization describes social determinants as "the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness. The conditions in which people live and are, in turn, shaped by political, social, and economic forces" [5].

Total person income

Higher income and social status are linked to better health. The greater the gap between the richest and poorest people, generally the greater the differences in health[6]. In the GCPHN region in 2021, the median total person income was $39,416 per year, slightly below the Queensland rate of $40,924. Broadbeach-Burleigh SA3 region had the highest median total personal income $45,500, while Southport had the lowest median total personal income with $35,932 per year.

[3] Australian Bureau of Statistics. Population by age and sex, regions of Australia. Cat. no. 3235.0. ABS: Canberra; 2016

[4] Department of Health. Queensland preventive health surveys. Published and unpublished analysis. Queensland Government: Brisbane; 2018. Available: https://www.health.qld.gov.au/research-reports/ population-health/preventive-health-surveys/ results

[5] CSDH (Commission on Social Determinants of Health) 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization

[6] Braveman, P., & Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Reports*, *129*(1_suppl2), 19-31.

Table 2. Median annual income, Queensland, Gold Coast SA3 regions, 2016

Region	Median annual income
Queensland	$40,924
Gold Coast SA4	$39,416
Broadbeach-Burleigh	$45,500
Ormeau-Oxenford	$43,888
Mudgeeraba-Tallebudgera	$42,016
Coolangatta	$41,704
Surfers Paradise	$41,340
Robina	$40,352
Nerang	$40,196
Gold Coast Hinterland	$38,324
Gold Coast-North	$36,140
Southport	$35,932

Source. ABS, Census of Population and Housing, 2016, General Community Profile - G02 and G17

Education

Higher educational achievement can play a significant role in shaping employment opportunities, increase the capability for better decision-making regarding one's health and provide opportunity for increasing social and personal resources that are essential for physical and mental health[7].

Australian Early Development Census

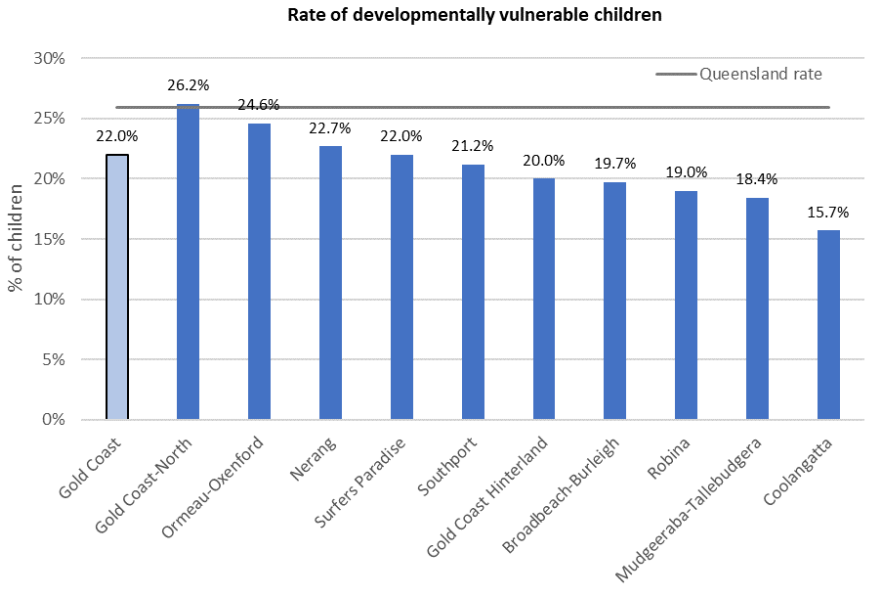
The foundations of adult health are laid in early childhood[8]. The different domains of early childhood development include physical health and wellbeing, social competence communication skills and general knowledge, emotional maturity, and language and cognitive skills. These domains are assessed in the Australian Early Development Census (AEDC) which reports whether children are on track, at risk or developmentally vulnerable across each of the five domains. Children that are developmentally vulnerable demonstrate much lower than average competencies in that domain.

In the GCPHN region in 2018, 22% of children were developmentally vulnerable in one or more domains, which was below the Queensland rate of 25.9%. The social competence domain had the largest percentage of developmentally vulnerable children (10.3%).

Ormeau-Oxenford SA3 region had the largest percentage of developmentally vulnerable children in two or more domains (13.4%) as well as having the highest number of children assessed in the GCPHN region (n=2,234) [9].

[7] Shankar, J., Ip, E., Khalema, E., Couture, J., Tan, S., Zulla, R., & Lam, G. (2013). Education as a Social Determinant of Health: Issues Facing Indigenous and Visible Minority Students in Postsecondary Education in Western Canada. International Journal of Environmental Research and Public Health, 10(9), 3908-3929.
[8] Camargo, K. R. (2011). Closing the gap in a generation: Health equity through action on the social determinants of health. *Global Public Health*, *6*(1), 102-105.
[9] Australian Early Development Census, 2018

Figure 3. Rate of developmentally vulnerable children across one or more domains, Gold Coast SA3 regions, 2018



Source: Australian Early Development Census, 2018. This data set is a component of the minimum data set.

Highest level of schooling

In 2021, there were 337,508 people in the GCPHN region (66.6%) whose highest level of schooling was year 11 or 12. Robina SA3 region had the largest percentage of population whose highest level of schooling was year 11 or 12 (71.2%), and Gold Coast-North SA4 region had the largest percentage whose highest level of schooling was year 8 or below (or did not go to school) with 4%.

Table 3. Highest level of schooling, Queensland, Gold Coast including SA3 regions 2021

	Did not go to school or Year 8 or below		Year 9 or 10 or equivalent		Year 11 or 12 or equivalent	
	Number	%	Number	%	Number	%
Queensland	178,101	4.4%	989,350	24.63%	2,554,330	63.58%
Gold Coast SA4	14,252	2.8%	118,240	23.32%	337,508	66.58%
Broadbeach-Burleigh	1373	2.5%	11217	20.4%	38141	69.3%
Coolangatta	1235	2.7%	12,085	26.0%	29,911	64.5%
Gold Coast-North	2343	4.0%	15,509	26.5%	35,843	61.3%
Gold Coast Hinterland	379	2.4%	4200	26.3%	10267	64.3%
Mudgeeraba-Tallebudgera	620	2.3%	6261	23.7%	18145	68.6%
Nerang	1589	3.0%	14256	26.6%	34686	64.8%
Ormeau-Oxenford	2989	2.6%	28612	24.7%	77113	66.7%
Robina	1153	2.7%	8480	19.8%	30443	71.2%
Southport	1685	3.1%	10608	19.8%	36334	67.9%
Surfers Paradise	899	2.3%	7301	18.7%	26629	68.1%

Source: ABS, Census of Population and Housing, 2021, General Community Profile - G16. This data set is a component of the minimum data set.

Secondary education

It has been reported that young adults who do not engage in secondary education are likely to experience a lower socioeconomic status than those who acquire further education[10]. In the GCPHN region in 2016, 284,084 persons (60.9%) had a non-school qualification, slightly above the Queensland rate of 59.1%. Within the region, Gold Coast Hinterland SA3 had the largest percentage of persons with a non-school qualification (65.6%) while Gold Coast-North and Nerang had the smallest percentage on the Gold Coast (58.9%) of persons with a non-school qualification.

Table 4. Non-school qualification by level of education by SA3, Queensland, Gold Coast SA3 regions, 2016

	Level of education						Persons with a non-school qualification	
	Bachelor's degree or higher		Advanced diploma or diploma		Certificate			
	Number	%	Number	%	Number	%	Number	%
Queensland	693,410	18.3%	330,619	8.7%	807,405	21.3%	2,241,124	59.1%
Gold Coast SA4	80,565	17.3%	48,058	10.3%	102,090	21.9%	284,084	60.9%
Broadbeach-Burleigh	10,738	20.4%	5,423	10.3%	10,877	20.7%	33,224	63.3%
Coolangatta	7,351	16.6%	4,397	9.9%	10,419	23.5%	27,166	61.2%
Gold Coast-North	8,738	15.5%	5,392	9.6%	12,065	21.4%	33,227	58.9%
Gold Coast Hinterland	2,731	18.0%	1,627	10.7%	3,591	23.7%	9,961	65.6%
Mudgeeraba-Tallebudgera	4,912	19.1%	2,871	11.1%	6,132	23.8%	16,119	62.6%
Nerang	7,778	14.5%	5,421	10.6%	12,995	24.3%	31,525	58.9%
Ormeau-Oxenford	12,908	14.1%	9,743	10.6%	22,957	25.1%	54,820	59.8%
Robina	7,997	19.6%	4,452	10.9%	7,889	19.3%	24,747	60.7%
Southport	9,576	19.1%	5,038	10.0%	9,402	18.7%	29,963	59.7%
Surfers Paradise	7,863	21.8%	3,695	10.2%	5,771	16.0%	23,320	64.5%

Source: ABS, Census of Population and Housing, 2016, General Community Profile - G40 and G46b
Note: (a) Includes bachelor's degree, graduate diploma, graduate certificate and postgraduate degree. (b) Includes Certificate, I, II, III and IV and Certificates not further defined responses. (c) Includes inadequately described and not stated level of education responses.

Disability

Disability is defined as resulting "from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others"[11]. Reports have indicated that 35% of people with disabilities report poor or fair health, compared with 5% of people without disabilities[12,13].

Persons with a profound or severe disability are defined as needing help or assistance in one or more of the three core activity areas of self-care, mobility and communication because of a long-term health condition, a disability or old age.

[10] Canadian Council on Learning. State of Learning in Canada: Toward a Learning Future.
[11] United Nations General Assembly 2007, Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly, 24 January 2007, A/RES/61/106,
[12] Kavanagh, A & Krnjacki, L 2012, 'Unpublished analysis of the Survey of Disability and Carers (2009)', confidentialised unit record file, University of Melbourne.
[13] ABS 2010a, ABS sources of disability information, Australia 2003– 2008, information paper (4431.0.55.002), ABS, Canberra

In 2021, the GCPHN region's rate of people with a disability who require assistance was below the Queensland rate (5.5% vs 6.0%). The SA3s regions that were above the Queensland average rate were Gold Coast-North and Southport, while Surfers Paradise had the lowest rate (4.1%).

Table 5. Need for assistance with a profound or severe disability, Gold Coast SA3 regions, 2021

	Need for assistance	
Region	**Number**	**%**
Queensland	309,366	6.0%
Gold Coast SA4	35,066	5.5%
Gold Coast-North	5207	7.5%
Southport	4259	6.6%
Nerang	3989	5.7%
Robina	3008	5.6%
Coolangatta	3026	5.3%
Gold Coast Hinterland	1036	5.1%
Ormeau-Oxenford	8040	5.1%
Mudgeeraba-Tallebudgera	1665	4.6%
Broadbeach-Burleigh	2960	4.5%
Surfers Paradise	1871	4.1%

Source ABS, Census of Population and Housing, 2016, General Community Profile - G18

COVID-19 has greatly impacted the need for assistance and care for a range of Australia's disabled population. The hearing-impaired community have been particularly affected with the large-scale introduction of face masks. Within the current ideology that face masks and PPE are becoming the new normal, the deaf community are finding an increasing number of barriers to communication. Within the hearing-impaired community sign and body language are critical tools utilised in communication, both of which are drastically affected through the introduction of face masks within primary and acute care settings. In 2016, the Australian Institute of Health and Wellbeing (AIHW) reported one in two Australians identified as complete or partially deaf and one in seven reported wearing a hearing aid. These statistics identify that this is a considerable concern for many Australians[14].

The National Disability Insurance Scheme (NDIS) supports eligible Australians who were either born with or acquire a permanent and significant disability. The NDIS funds reasonable and necessary supports and services that relate to a person's disability to help them achieve their goals. 'Reasonable' means the support is most appropriately funded or provided through the NDIS, and 'necessary' means something a person needs that is related to their disability.

Analysing data for the GCPHN region, the number of NDIS participants has increased from 8,552 in December 2020 to 10,729 in December 2021, an increase of 25%. Ormeau – Oxenford SA3 region had the highest participant count as of December 2021 with 3,212 followed by Nerang with 1,298, Table 6 shows all Gold Coast SA3 regions participant count as of December 2021.

[14] Australian Institute of Health and Welfare. (2016). Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

Table 6. NDIS participants, Gold Coast SA3 regions, December 2021

Region	Number
Ormeau - Oxenford	3212
Nerang	1298
Gold Coast - North	1204
Southport	1203
Robina	847
Coolangatta	796
Broadbeach - Burleigh	790
Mudgeeraba - Tallebudgera	624
Surfers Paradise	431
Gold Coast Hinterland	324

Culturally and linguistically diverse populations

The population of the GCPHN region includes many people who were born overseas, have a parent born overseas or speak a variety of languages. Research in several countries with high immigrant populations, including Australia, has found that migrant populations are often healthier than Australian born populations[15], however, the healthy migrant effect can disappear after immigrants have lived in Australia for a long time. A study found that when immigrant groups from non-English speaking countries have been in Australia for more than ten years, their mental health and self-assessed health were worse compared to Australian born individuals[16]. This was more common in immigrants from non-English speaking countries. English proficiency may obstruct an individual's access to health services and have an impact on employment which has broader socioeconomic implications.

[15] Kennedy S, Kidd MP, McDonald JT & Biddle N 2014. The healthy immigrant effect: patterns and evidence from four countries. Journal of International Migration and Integration 16(2):317–32.
[16] Jatrana S, Richardson K & Samba SRA 2017. Investigating the dynamics of migration and health in Australia: a longitudinal study. European Journal of Population. doi:org/10.1007/s10680-017-9439-z

Table 7. Country of birth by SA3, Queensland, Gold Coast including SA3 regions, 2021

	Born in Australia		Born Overseas					
	Number	%	Born in English speaking countries		Born in non-English speaking countries		Total	
			Number	%	Number	%	Number	%
Queensland	3,679,899	71.4%	518,523	10.1%	651,810	12.6%	1,170,333	22.7%
Gold Coast SA4	418,554	65.3%	96,634	15.1%	88,644	13.8%	185,278	28.9%
Broadbeach-Burleigh	44,825	67.5%	8,840	13.3%	8,508	12.8%	17,348	26.1%
Coolangatta	43,962	76.4%	6,402	11.1%	4,115	7.2%	10,517	18.3%
Gold Coast-North	42,463	61.2%	11,267	16.2%	11,373	16.4%	22,640	32.6%
Gold Coast Hinterland	14,502	72.1%	2,999	14.9%	1,395	6.9%	4,394	21.8%
Mudgeeraba-Tallebudgera	25,854	71.8%	5,541	15.4%	3,195	8.9%	8,736	24.2%
Nerang	47,971	68.8%	10,762	15.4%	7,932	11.4%	18,694	26.8%
Ormeau-Oxenford	104,635	66.2%	28,185	17.8%	17,311	11.0%	45,496	28.8%
Robina	33,449	62.1%	8,282	15.4%	9,797	18.2%	18,079	33.5%
Southport	37,082	57.5%	8,431	13.1%	14,206	22.0%	22,637	35.1%
Surfers Paradise	23,882	52.7%	5,912	13.1%	10,782	23.8%	16,694	36.9%

Source: ABS, Census of Population and Housing, 2021, General Community Profile - G01 and G09c. This data set is a component of the minimum data set.
ESB: Based on the main English-speaking countries of UK, Ireland, Canada, USA, South Africa and New Zealand.
NESB: Includes countries not identified individually, 'Inadequately described' and 'At sea' responses.

In 2021 in the GCPHN region, 185,278 (28.9%) of people were born overseas. Within the region, Ormeau-Oxenford had the largest number of persons born overseas with 45,496 persons, and Surfers Paradise had the largest percentage of people born overseas with 36.9%.

The top five English speaking backgrounds and non-English speaking backgrounds for Gold Coast were*:*

English Speaking	Non-English Speaking
New Zealand (7.9%)	China excludes SARs and Taiwan (1.2%)
England (5.2%)	Japan (0.7%)
South Africa (1.2%)	India (0.7%)
Scotland (0.6%)	Philippines (0.7%)
United States of America (0.5%)	South Korea (0.6%)

Environmental determinants

The physical environment in which people live and work can shape their health outcomes throughout their life. Environmental health focuses on the physical, chemical, biological, and social factors which affect people within their surroundings.

Physical environment

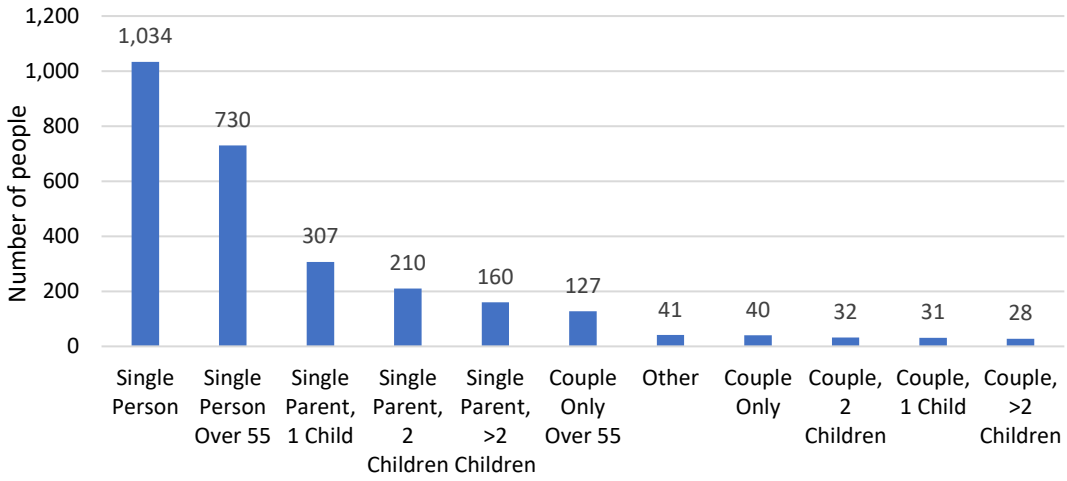
Poor physical home environments may be a potential source of stress for children and produce poor health outcomes[17,18]. Access to appropriate, affordable, and secure housing can limit the risk of being social excluded by factors such as homelessness, overcrowding and poor physical and mental health.

The number of applications for social housing that have been approved, approved-deferred or approved-waiting further information for where the individual associated with the applicant first locational preference in the GCPHN region was, 2,742 in 2019, an increase by 27% from 2,165 in 2018[19].

Of the 2,742 applicants, 28% indicated that they are experiencing one or more of the below circumstances:

- being homeless
- existing housing is makeshift or illegal
- Is fleeing domestic violence.
- Is at risk of violence/abuse from another person
- loss of accommodation due to a residential service or caravan park closure
- their existing housing is temporary and supported accommodation such as refuge, shelter or crisis accommodation.

Figure 4. Family type of applications for social housing, Gold Coast, 2019



Source: Queensland Government Open Data Portal, Social Housing Register

Housing affordability and housing stress

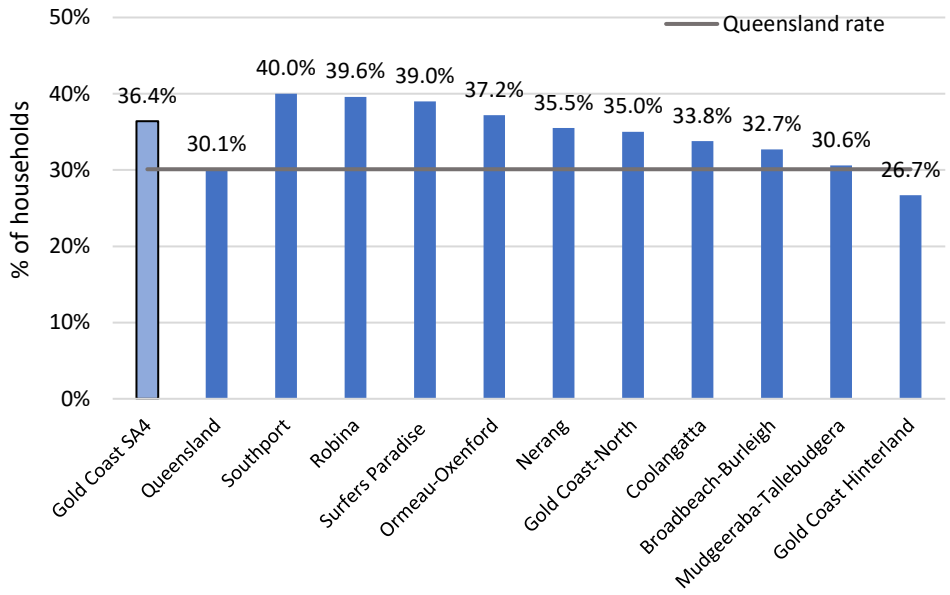
One of the more common measures of housing is the "30/40 rule". Housing affordability is compromised when households in the bottom 40% of income distribution spend more than 30% of their household income on housing, adjusted for household sizes[20.] One Australian study found that experiences common to stressed

[17] Shaw, M. (2004). Housing and Public Health. *Annual Review of Public Health*, *25*(1), 397-418. doi: 10.1146/annurev.publhealth.25.101802.123036
[18] Schmeer, K. K., & Yoon, A. J. (2016). Home sweet home? Home physical environment and inflammation in children. *Social Science Research*, *60*, 236-248. doi: 10.1016/j.ssresearch.2016.04.001
[19] Queensland Government Open Data Portal, Social Housing Register
[20] Yates, J., & Milligan, V. (2007). Housing affordability: A 21st century problem. National research venture 3: Housing affordability for lower income Australians (AHURI Final Report No. 105). Retrieved 28 March 2008, from http://www.ahuri.edu.au/publications/download/nrv3_final_report

renters and stressed recent purchasers included the constant stress associated with the lack of money (which contributed to health problems and stress on family relationships) and financial hardship outcomes (such as children missing out on school activities and adequate healthcare).

In the GCPHN region in 2016, 36.4% of low-income households were under financial stress from mortgage or rent, which was above the Queensland rate of 30.1%. Southport had the largest percentage of people under financial stress from mortgage or rent with 40%, while Gold Coast Hinterland had the least (26.7%).

Figure 5. Percentage of low-income households under financial stress from mortgage or rent, Gold Coast SA3 regions, 2016



Source: Public Health Information Development Unit (PHIDU).

Unemployment

A 2012 study into behavioural risk factors found that unemployed individuals had poorer perceived mental health profiles, were more likely to delay healthcare services due to cost, and were less likely to have access to healthcare than employed participants [21].

As of September 2019, a total of 21,130 people in the GCPHN region were unemployed (5.8%), slightly below the Queensland rate (6.2%). Within the region, Gold Coast-North had the highest unemployment rate of 8.3% while Mudgeeraba-Tallebudgera had the lowest unemployment rate (4.2%).

[21] Pharr, J. R., Moonie, S., & Bungum, T. J. (2012). The Impact of Unemployment on Mental and Physical Health, Access to Health Care and Health Risk Behaviours. *ISRN Public Health*, *2012*, 1-7.

Table 8. Unemployment rate, Gold Coast SA3 regions, September quarter 2019

Region	Number	Percent
Queensland	165,414	6.2%
Gold Coast SA4	21,130	5.8%
Gold Coast-North	3,184	8.3%
Southport	2,954	8.1%
Nerang	2,652	6.3%
Coolangatta	1,973	6.1%
Gold Coast Hinterland	608	5.5%
Ormeau-Oxenford	4,183	5.0%
Surfers Paradise	1,397	4.9%
Robina	1,476	4.7%
Broadbeach-Burleigh	1,819	4.5%
Mudgeeraba-Tallebudgera	883	4.2%

Source Australian Government Department of Education, Skills and Employment, Small Area Labour Markets Australia, various editions. This data set is a component of the minimum data set.

Families with children with no parent employed

Children living in families lacking secure parental employment are vulnerable. Without at least one parent employed full time, children are more likely to fall into poverty which may effect the wellbeing of the child[22]. It has been identified children from families with no parent employed were at greater risk of socioemotional problem behaviour compared with those where a parent was continuously employed. The study further explained that parents' employment status was associated with a lower risk of problem behaviour for children in middle childhood, in part explained by sociodemographic characteristics of families and the apparent psychological and socioeconomic benefits of employment[23].

Analysing local data identified that the GCPHN region's rate of families with no parent employed was slightly below the Queensland rate in 2016. As can be seen in Table 9, three SA3s within the GCPHN region were above the Queensland rate of total families with no parent employed.

[22] Frasquilho, D., de Matos, M.G., Marques, A. et al. (2016). Unemployment, Parental Distress and Youth Emotional Well-Being: The Moderation Roles of Parent–Youth Relationship and Financial Deprivation. Child Psychiatry Hum Dev 47, 751–758.
[23] Hope, S., Pearce, A., Whitehead, M., & Law, C. (2014). Family employment and child socioemotional behaviour: longitudinal findings from the UK Millennium Cohort Study.

Table 9. Families with children with no parent employed, Gold Coast SA3 regions, 2016

Region	One-parent family with parent not employed	Couple family with both parents not employed	Total families with no parent employed	
			Number	%
Queensland	47,485	18,652	66,139	13.8%
Gold Coast SA4	4,868	1,766	6,636	11.7%
Broadbeach-Burleigh	384	130	516	9.9%
Coolangatta	402	124	526	10.8%
Gold Coast- North	623	251	870	16.0%
Gold Coast Hinterland	118	49	169	9.7%
Mudgeeraba-Tallebudgera	238	106	334	8.2%
Nerang	650	193	843	11.2%
Ormeau-Oxenford	1,220	429	1,649	10.9%
Robina	415	129	535	10.7%
Southport	572	231	805	16.2%
Surfers Paradise	254	131	384	14.6%

Source: ABS, Census of Population and Housing, 2016, unpublished data (families)

Southport and Gold Coast-North SA3 regions had the two highest rate of families with no parent employed and were also the two regions with the lowest socio-economic indexes. In 2011, the same report identified that Southport and Gold Coast-North were also SA3s within the GCPHN region with the lowest socio-economic indexes suggesting that cross generational impacts are cumulative.

Southport, Gold Coast-North and Surfers Paradise SA3 regions were all above the Queensland rate in 2016 for families with children with no parent employed. Analysing these three SA3 regions at a granular level, there is a large variance between the SA2 regions that have families with no parent employed.

Table 10. Families with children with no parent employed Queensland, Southport SA3 region, 2016

	One-parent family with parent not employed	Couple family with both parents not employed	Total families with no parent employed	
			Number	%
Queensland	47,485	18,652	66,139	13.8%
Gold Coast SA4	4,868	1,766	6,636	11.7%
Southport SA3	572	231	805	16.2%
Ashmore	100	31	128	11.1%
Molendinar	43	25	69	10.7%
Parkwood	70	33	103	12.1%
Southport-North	178	77	253	26.7%
Southport-South	182	69	249	18.0%

Table 11. Families with children with no parent employed Queensland, Gold Coast-North SA3 region, 2016

	One-parent family with parent not employed	Couple family with both parents not employed	Total families with no parent employed	
			Number	%
Queensland	47,485	18,652	66,139	13.8%
Gold Coast SA4	4,868	1,766	6,636	11.7%
Gold Coast-North SA3	384	130	516	9.9%
Arundel	94	43	133	13.1%
Biggera Waters	81	34	120	18.5%
Coombabah	111	35	146	15.2%
Labrador	233	85	319	22.5%
Paradise Point- Hollywell	50	22	74	9.8%
Runaway Bay	54	27	83	12.9%

Table 12. Families with children with no parent employed, Surfers Paradise SA3 region, 2016

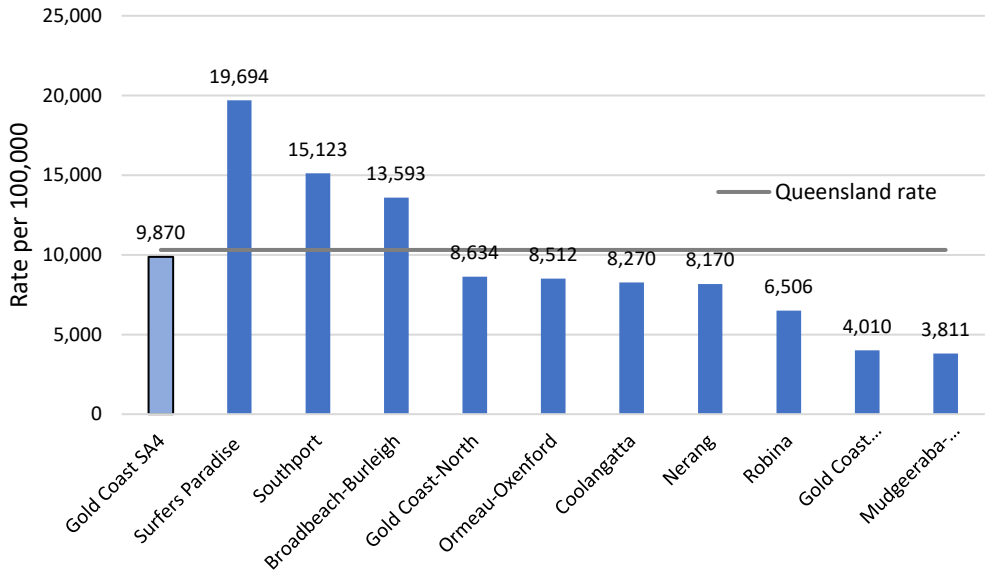
	One-parent family with parent not employed	Couple family with both parents not employed	Total families with no parent employed	
			Number	%
Queensland	47,485	18,652	66,139	13.8%
Gold Coast SA4	4,868	1,766	6,636	11.7%
Surfers Paradise SA3	254	131	384	14.6%
Benowa	65	36	104	11.4%
Bundall	31	12	38	8.2%
Main Beach	21	6	27	18.0%
Surfers Paradise	140	78	214	19.5%

Source: ABS, Census of Population and Housing, 2016, unpublished data (families)

Crime

Fear of crime is associated with poorer mental health and greater limitations in physical functioning[24]. In the GCPHN region during 2018-2019, there was 62,970 offences or 9,870 per 100,000 people, which was below the Queensland rate of 10,306 per 100,000 people.

Figure 6. Total number of reported offences per 100,000 people, Gold Coast SA3 regions, 2018-2019



Source: Queensland Police Service. Data is based on the location in which the offence occurred

[24] Mai Stafford, Tarani Chandola, Michael Marmot, "Association between Fear of Crime and Mental Health and Physical Functioning", *American Journal of Public Health* 97, no. 11 (November 1, 2007): pp. 2076-2081.

Volunteering

It has been observed that people who engage in voluntary work report better health and greater happiness than people who do not, a relationship that is not driven by socioeconomic differences between volunteers and non-volunteers[25].

During 2021 in the GCPHN region, 60,938 or 11.5% of people undertook voluntary work, which was lower compared to the Queensland rate of 14.4%. Within the GCPHN region, Gold Coast Hinterland had the largest percentage of persons who undertook voluntary work (17.1%) while Ormeau-Oxenford (10.1%) had the smallest percentage of volunteers.

Table 13. Voluntary work, Gold Coast SA3 regions, 2021

	Volunteer		Not a volunteer	
	Number	%	Number	%
Queensland	590,690	14.1%	3,304,685	78.8%
Gold Coast SA4	60,938	11.5%	430,859	81.6%
Broadbeach-Burleigh	6,974	12.3%	45,629	80.3%
Coolangatta	6,291	13.1%	38,602	80.2%
Gold Coast-North	6,129	10.2%	49,994	83.0%
Gold Coast Hinterland	2,840	17.1%	12,606	75.8%
Mudgeeraba-Tallebudgera	4,205	15.0%	22,477	80.1%
Nerang	6,672	11.9%	46,447	82.8%
Ormeau-Oxenford	12,264	10.1%	102,106	83.9%
Robina	5,200	11.6%	36,832	82.4%
Southport	6,121	11.0%	44,793	80.6%
Surfers Paradise	4,235	10.5%	31,372	78.0%

Source: ABS, Census of Population and Housing, 2021, General Community Profile – G23. Includes voluntary work not stated.

Health Services

Access to health services (primary, secondary, tertiary care) is an important determinant of health. Inequalities in access to healthcare include barriers faced by certain populations, such as the lack of cultural competence or the number of GPs that are available after-hours [26].

The GCPHN region is generally well serviced with 855 GPs across 212 general practices, as of 5 October 2022.

[25] Borgonovi, F. (2008). Doing well by doing good. The relationship between formal volunteering and self-reported health and happiness. Social Science & Medicine, 66(11), 2321-2334. doi: 10.1016/j.socscimed.2008.01.011

[26] Langheim, F. J. (2014). Poor Access to Health Care as a Social Determinant of Mental Health. *Psychiatric Annals*, *44*(1), 52-57. doi:10.3928/00485713-20140108-09

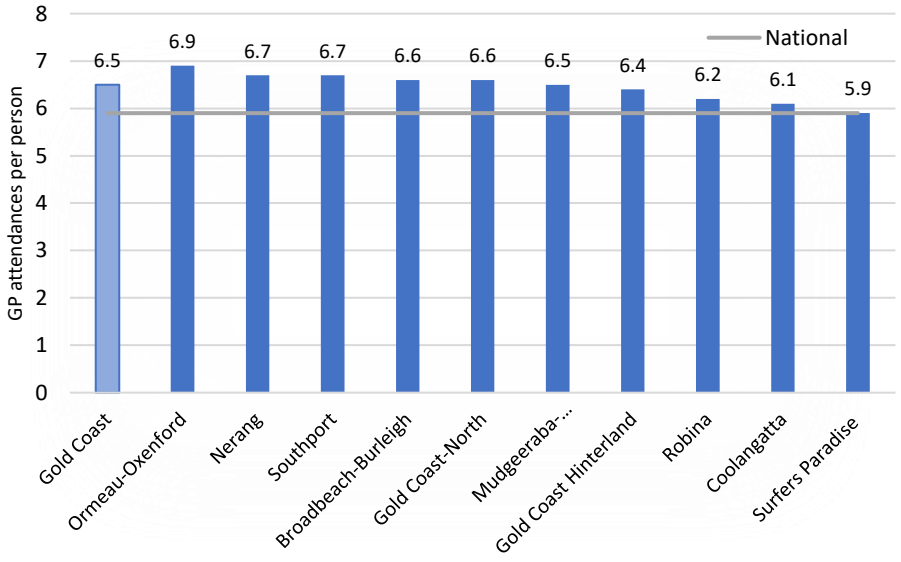
Table 14. Number of general practices within the Gold Coast PHN region with one or more GPs in each practice, as of 5 October 2022

Regions	Number of general practices	Number of GPs	Average number of GPs per practice
GCPHN region	212	855	4.0
Broadbeach-Burleigh	29	143	5.1
Coolangatta	19	84	4.5
Gold Coast-North	22	82	3.8
Gold Coast Hinterland	7	32	4.7
Mudgeeraba-Tallebudgera	7	24	3.1
Nerang	16	72	4.6
Ormeau-Oxenford	41	182	4.4
Robina	21	95	4.4
Southport	25	111	4.7
Surfers Paradise	20	66	3.4

Source: GCPHN CRM Tool

Figure 7 shows that the average number of GP attendances per person (6.5) in the GCPHN region was above the national rate (5.9) in 2016-2017.

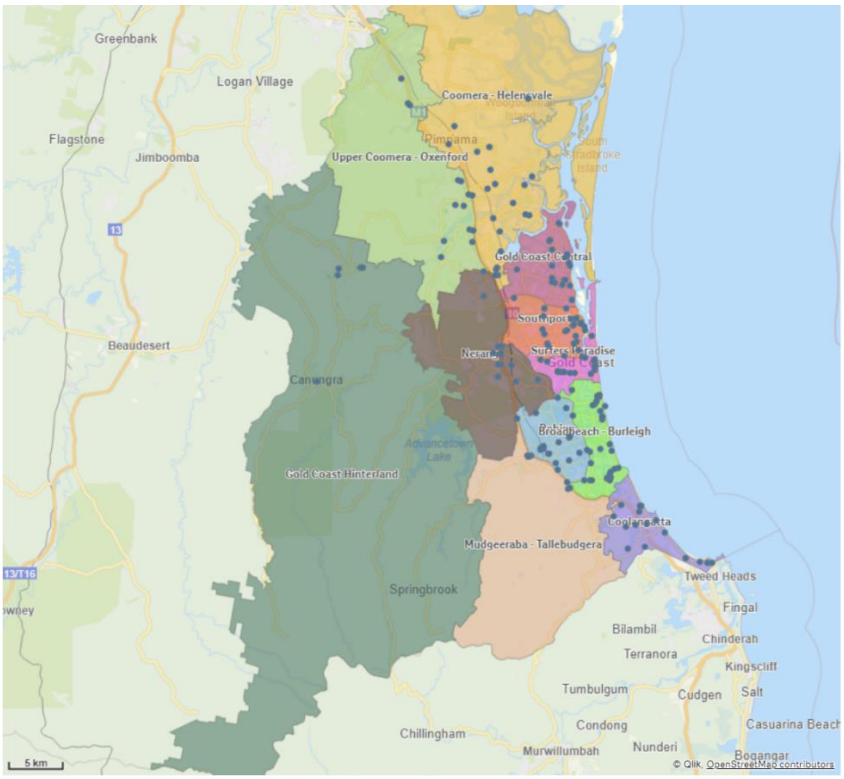
Figure 7. Average number of GP attendances per person, age-standardised, Gold Coast SA3 regions, 2016-2017



Source: Australian Institute of Health and Welfare analysis of Department of Human Services, Medicare Benefits claims data, and Australian Bureau of Statistics, Estimated Resident Population. This data set is a component of the minimum data set.

Figure 8 shows general practice locations in the GCPHN region. Most general practices are located on the coastline with many general practices also in the Ormeau-Oxenford SA3 region to meet the demand of population.

Figure 8. General practices on the Gold Coast, February 2021



Source: GCPHN CRM tool

Emergency Departments

The GCPHN region is well serviced with two public hospitals and three private hospitals. The two public hospitals are located at Southport and Robina. Gold Coast University Hospital Emergency Department (ED) is the busiest Emergency Department (ED) ED in Queensland.

Triage category four and five presentations (lower urgency presentations), which comprised 30% of all ED presentations in 2017-2018 in the GCPHN region, are often used an indicator of presentations that can be managed by general practice or primary health (i.e., non-urgent care). In 2017-18, public hospitals in the GCPHN region have one of the lowest rates of low urgency ED presentations among the 31 Primary Health Network regions in Australia (69 per 1,000 population, compared to national rate of 117.0 per 1,000)[27].

[27] Australian Institute of Health and Welfare analysis of the National Non-admitted Patient Emergency Department Care Database, 2015–16, 2016–17 and 2017–18

Proximal Determinants

Proximal determinants refer to any determinant of health that is readily and directly associated with the change in health status.

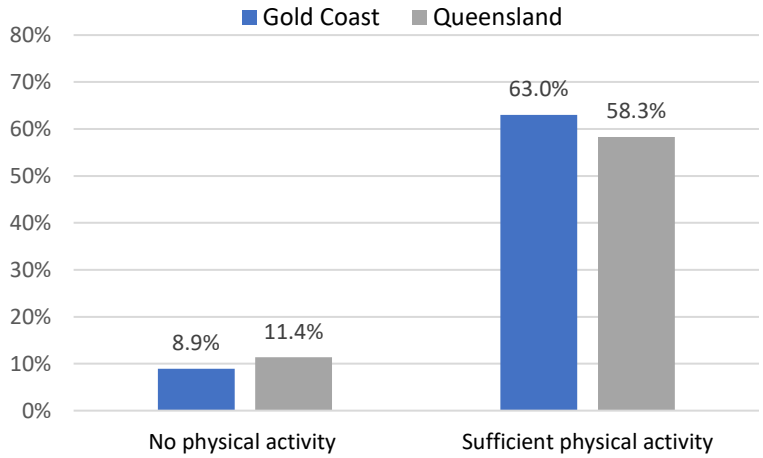
Physical activity

Physical activity includes structured activities such as sport or organised recreation, and unstructured activities such as incidental daily activities at work or home. Physical inactivity accounted for 6.6% of the burden of disease in Australia in 2003[28] . Being physically active:

- reduces the risk of all-cause mortality[29],
- improves self-esteem, self-image, and quality of life[30], and
- is an important factor in preventing and managing a range of chronic diseases, including type 2 diabetes, stroke, hypertension, and heart disease[31].

In 2018, 63% of residents in the GCPHN region aged 18 and over undertook sufficient physical activity while 8.9% were inactive. Sufficient physical activity for adults for the purpose of this report is based on physical activity guidelines 2014 requiring >150 minutes of physical activity or >75 minutes of vigorous activity) per week over five or more sessions.

Figure 9. Activity status among Gold Coast and Queensland residents, 2020



Source: Queensland Health. The health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020. This data set is a component of the minimum data set.

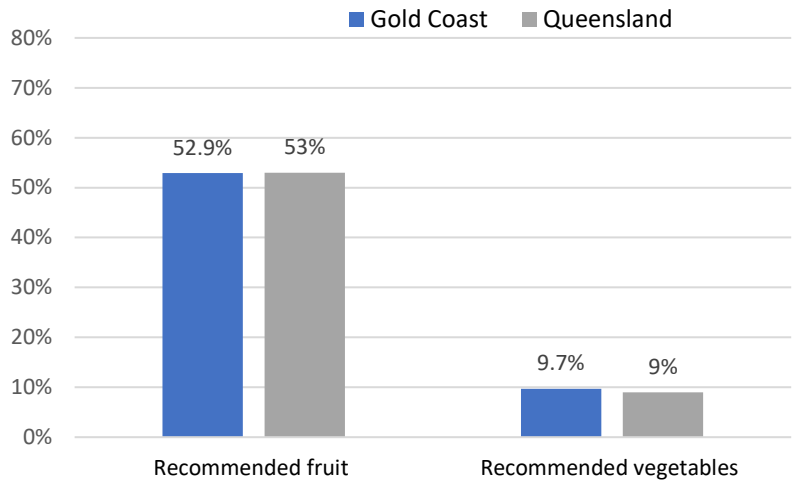
Dietary pattern

The health benefits of a dietary pattern consisting of a variety of nutritious foods in appropriate amounts leads to a reduced risk of chronic disease and improved health outcomes[32,33].

[28] *Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD. The burden of disease and injury in Australia 2003. Canberra: Australian Institute of Health and Welfare, 2007.*
[29] *Woodcock J, Franco OH, Orsini N, Roberts I. Non-vigorous physical activity and all-cause mortality: systematic review and meta-analysis of cohort studies. Int J Epidemiol 2011;40(1):121–38*
[30] *Warburton DE, Nicol CW, Bredin SS. Health benefits of physical activity: the evidence. Can Med Assoc J 2006;174(6):801–9*
[31] *Janssen I, Leblanc AG. Systematic review of the health benefits of physical activity and fitness in school-aged children and youth. Int J Behav Nutr Phys Act 2010; 7:40.*
[32] Wirt A, Collins CE. Diet quality--what is it and does it matter? Public Health Nutr 2009;12(12):2473–92.
[33] McCullough ML, Feskanich D, Stampfer MJ, Giovannucci EL, Rimm EB, Hu FB et al. Diet quality and major chronic disease risk in men and women: moving toward improved dietary guidance. Am J Clin Nutr 2002;76(6):1261–71.

In 2019, 52.9% of residents of the GCPHN region met the guidelines for recommended daily amount of fruit (two or more serves) and 9.7% of residents met the guidelines for vegetables (five to six or more serves for people aged 18 and over).

Figure 10. Daily intake of fruit and vegetables among Gold Coast and Queensland residents, 2019



Source: Queensland Health. The health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020. This data set is a component of the minimum data set. This data set is a component of the minimum data set.

Alcohol and Tobacco

Alcohol is the sixth highest risk factor contributing to the burden of disease in Australia. Alcohol use contributed to several diseases and injuries including:

- 100% of the burden due to alcohol use disorders,
- 40% of the burden due to liver cancer,
- 28% of the burden due to road traffic injuries,
- 14% of the burden due to suicide and self-inflicted injuries[34].

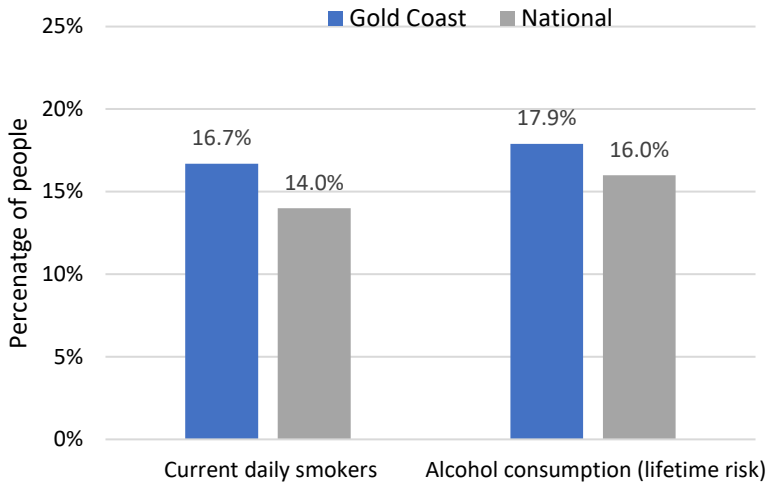
Lifetime risk of drinking alcohol is consumption of an average of > 2 standard drinks per day. During 2017-2018 in the GCPHN region, alcohol consumption for 17.9% of people was defined as lifetime risk, which was above the national rate of 16% for people aged 18 years and over[35].

Tobacco is the leading preventable cause of morbidity and mortality in Australia. In 2015, tobacco smoking was responsible for 9.3% of the total burden of disease and injury. Estimates for the burden of disease attributable to tobacco use showed that cancers accounted for 43% of this burden[36].

Data collected through the National Health Survey 2017-2018 suggested that 16.7% of the Gold Coast population aged over 18 were current daily smokers, which was above the national rate of 14% [37].

[34] AIHW 2019c. Australian burden of disease study: Impact and causes of illness and death in Australia 2015. Series no.19. BOD 22. Canberra: AIHW
[35] ABS 2019. Microdata: National Health Survey, 2017–18. ABS cat no. 4324.0.55.001. Canberra: ABS. Customised data report.
[36] AIHW 2019c. Australian burden of disease study: Impact and causes of illness and death in Australia 2015. Series no.19. BOD 22. Canberra: AIHW
[37] ABS 2019. Microdata: National Health Survey, 2017–18. ABS cat no. 4324.0.55.001. Canberra: ABS. Customised data report.

Figure 11. Rate of daily smokers and alcohol consumption (lifetime risk) for people aged 18 years and over, Gold Coast and national, 2017-18



Source: ABS 2019. Microdata: National Health Survey, 2017–18. ABS cat no. 4324.0.55.001. Canberra: ABS. Customised data report. This data set is a component of the minimum data set.

Healthy communities

Living an active, healthy lifestyle is part of the culture of the GCPHN region and individuals can make choices each day that can have a positive impact on their health. City of Gold Coast provides several services and facilities to improve the health and safety of residents and visitors through:

- **environmental health services** - City of Gold Coat continually works to identify, prevent, and remedy health and environment related hazards and health.
- **Immunisation -** Gold Coast Public Health Unit provides immunisation services for the city through immunisation clinics for children and annual school immunisation program.
- **active and healthy lifestyle -** City of Gold Coast aim to positively influence physical activity and healthy eating by offering many free and low-cost activities and activating a range of City facilities including parks, libraries, community centres and aquatic centres.

Fitness equipment

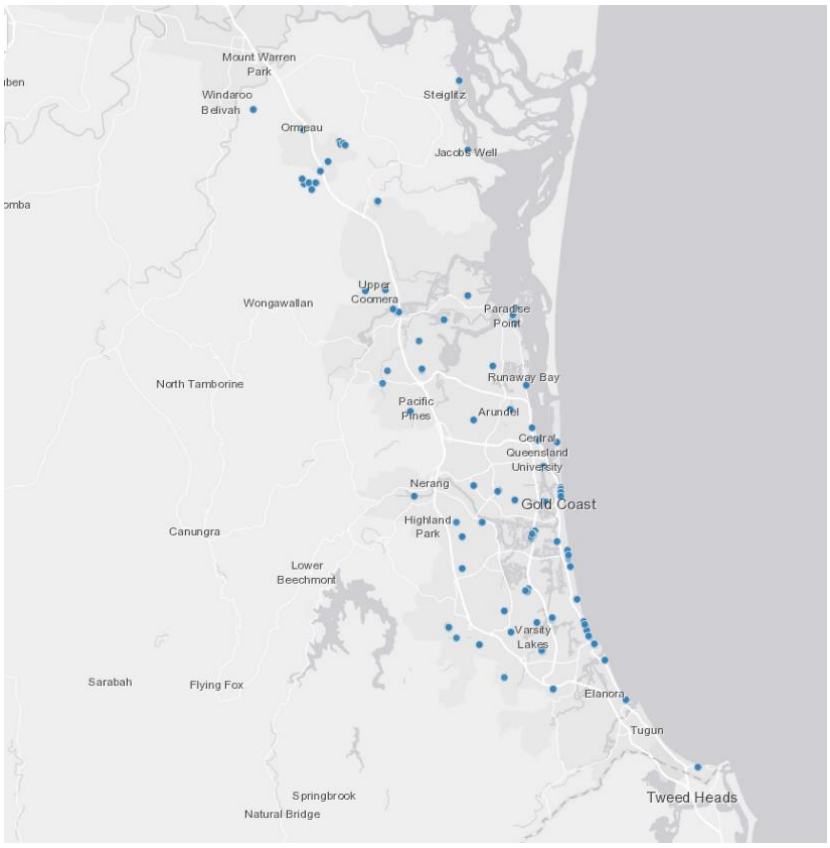
Access to places and equipment for physical activity plays an important role in influencing physical activity behaviour[38]. City of Gold Coast provides over 348 free fitness equipment facilities in parks in the region which aim to improve fitness levels and general coordination amongst the population. Equipment varies in different parks and can include cross trainer, stepper, ab-hip swinger, ezy rider, shoulder press, rowing machine, cycle seat, butterfly press, push up and sit up boards[39].

Fitness equipment is distributed throughout the GCPHN region with much of the equipment distributed across the coastline, however, Ormeau-Oxenford SA3 region had a limited number of fitness equipment considering its fast-growing population.

[38] KRUGER, J., CARLSON, S., & KOHLIII, H. (2007). Fitness Facilities for Adults Differences in Perceived Access and Usage. *American Journal of Preventive Medicine*, *32*(6), 500-505. doi: 10.1016/j.amepre.2007.02.003

[39] *Popular Parks for Fitness, Gold Coast City Council, 2019*

Figure 12. Fitness equipment on the Gold Coast, 2022

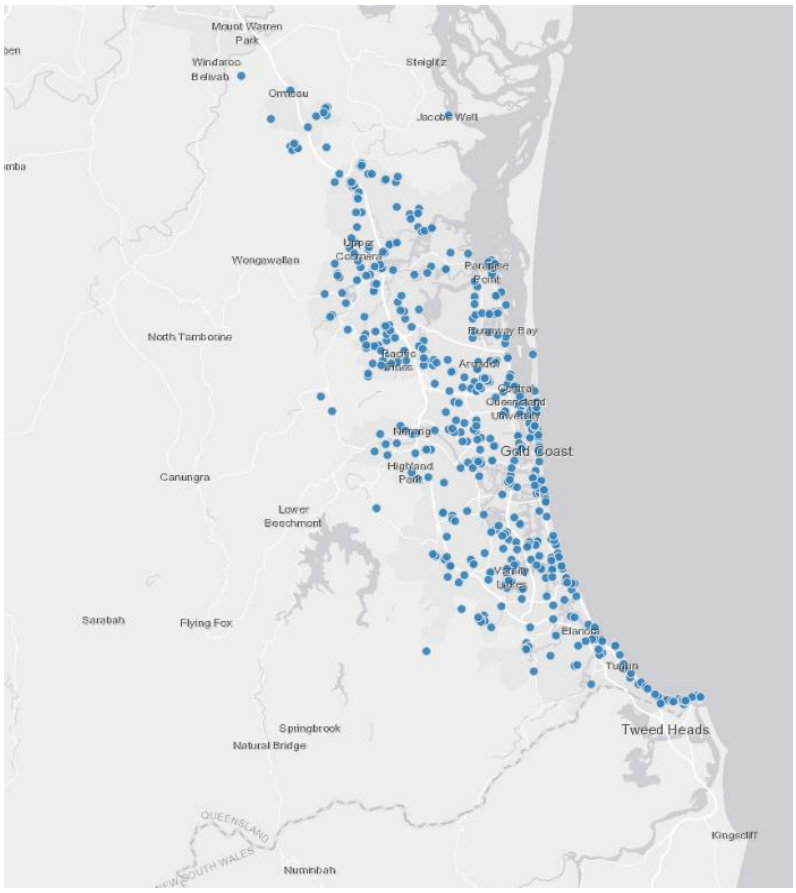


Source: City of Gold Coast Open Data, Fitness Stations, March 2022

Water fountains

Access to water fountains can promote the uptake of physical activity. The City of Gold Coast has supplied over 606 water fountains in the region as of February 2020. Water fountains are distributed throughout the GCPHN region with a large number of fountains distributed across the coastline which promotes physical activity and supports tourist demands. Ormeau-Oxenford SA3 has a smaller number of water fountains compared to other SA3s in the GCPHN region.

Figure 13. Water Fountains on the Gold Coast, 2022



Source: City of Gold Coast Open Data, Water Fountains, March 2022

Consultation

GCPHN Community Advisory Council (July 2020) provided the following feedback:

- lack of availability of public and social/community housing,
- homelessness has increased in recent years and will no doubt continue to with the impacts of COVID-19 still worsening for many,
- Ormeau-Oxenford region has the largest population on the Gold Coast yet have low number of water fountains and community fitness equipment for the community to utilise, and
- aged and disability continue to have access issues to health providers, a lot do not drive and if they do, cannot afford parking or unable to walk the distance required, Telehealth can only do so much in this space.

GCPHN Clinical Council (August 2020) provided the following feedback:

- language barrier can be a concern for patients who do not speak English, having a translator must be arranged prior to consultation,
- difficult to know of local GPs in the area who speak other languages other than English who a GP could refer a patient to,
- telehealth has improved access to care during COVID-19 which is often a determinant to health,
- less cancellations of patients using telehealth has been noted during COVID-19, and
- there is still a need for face-to-face consultations as some things can be missed on a telehealth consultation (skin checks etc) and digital divide (low social economic and literacy).

Community consultation

Health needs and service issues for people with a disability:

- access to adequate housing (leaving people with a disability inappropriately housed in aged care homes),
- accessibility,
- timely access to & effective health services,
- employment.

Older people

Please note this topic area incorporates information and findings from the Care Finders Needs Assessment undertaken in 2022.

Older Adults: local health needs and service issues

- Rate of potentially preventable hospitalisations in the Gold Coast Primary Health Network (GCPHN) region is above the national rate for people aged 65 and over.
- Top conditions of potentially preventable hospitalisations include urinary tract infections, iron deficiency anaemia, dental conditions, cellulitis, ear, nose and throat infections.
- For some providers there is limited capacity, and at times confidence and skills, to provide for palliative care needs at resident's place of choice as per Advance Care Plan.
- Referral pathways, including available capacity (to prevent navigation to nowhere).
- High prevalence of older people with frailty leads to many complex medical problems and is associated with an increased rate of future falls.
- Falls and wounds lead to increased Emergency Department (ED) presentations and hospitalisations.
- High estimated number of older people in GCPHN region are socially isolated.
- There are limited culturally appropriate services available for culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander older people.
- Transient workforce in the older people's sector and workforce shortages means some services do not have capacity and / or capability to manage the high complexity and care needs of older adults.
- The rate of people aged 65 and over is projected to grow steadily over the coming decades with limited capacity to meet demand.
- Some acute but low urgency needs such as minor infections are reportedly being admitted to hospital via ambulance as RACFs and home-based carers who are not aware of pathways to treat within the community.

Aged Care Services: local health needs and service issues (incorporating those from Care Finders Needs Assessment)

- There are many older people with one or more reasons they require intensive support without friends or family willing or able to help them to navigate the aged care system. This includes people who are socially isolated, have low literacy levels and those with cognitive impairment. Geographic areas identified where this is more of an issue include Gold Coast North, Oxenford-Ormeau and Southport SA3s.
- To support people needing intensive support to navigate the aged care system workforce considerations include:
    - Training of workforce to include aged-care or community service qualifications (e.g., Certificate IV), social work, trauma-informed care, MH First Aid.
    - Development of services and staff that are culturally appropriate for culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander people.

    - Professional development of staff to know the language of the system and to best navigate it (e.g. Centrelink, aged-care).
    - Professional development of workforce, and recruitment of workforce to ensure caring, empathetic, and key communication skills.
- Opportunities for integration in sector supporting people requiring intensive support to navigate the services system include:
    - interagency/consortia operation functions and coordinate meetings to enhance service and referral pathway knowledge.
    - Development of referral pathways, including available capacity (to prevent navigation to nowhere).
    - support the person to navigate the system via attending appointments and (physically) guiding them through the system.
    - a 'link' between service providers, and act as a central point.
    - Flexibility to facilitate integration and support a person-centred approach.
- There are significant workforce issues and a limited number of registered nurses working in aged care.
- Long wait times for appropriate support and/or aged care services at home lead to a higher level of care provided by a RACF service providers.
- Community services to support longer stays in community are not felt to be adequate and resulting in presentations to EDs as no other options exist or are known.
- At times RACFs on the Gold Coast do not have sufficient beds to meet permanent or respite care demands, which is resulting in unnecessary and lengthy hospital admissions when care needs cannot be met.
- Residents in RACFs are presenting to health services with increasing complexity of care including dementia.
- Some aged care staff lack understating of the language of the aged care system (e.g., Centrelink, My Aged Care).
- Transient workforce in the older people's sector and workforce shortages means some services do not have capacity and / or capability to manage the high complexity and care needs of older adults.
- Lack of role clarity and access to the relevant information to support early identification and management of palliative and end of life care in RACF.
- There is limited capacity to provide a coordinated and sustained coverage for palliative and end of life care within RACF without additional support.
- There is lack of a physical support to guide a person through the complex aged care system, and high dependency on a congested My Aged Care phone line.
- Challenges facing RACF's adoption of digital health include:
    - workforce shortages
    - clinical software is outdated in many RACFs
    - lack of access to and use of secure messaging to comply with Privacy Act when communicating with other healthcare providers for their residents
    - record keeping

Dementia: local health needs and service issues

- Care needs for older persons are getting more complex, and rates of dementia are on the rise.
- Dementia care extends across a continuum from diagnosis through to palliative care, and includes prevention, primary care and hospital care. Inexpert dementia care can cause unnecessary distress.
- Support for families and carers for people with dementia is needed.
- Clinical coordination tools and processes that result in fragmentation of the local health system in patient centered care particularly for patients with dementia are needed.
- There is currently limited understanding of the referral pathways, including available capacity (to prevent navigation to nowhere).

Older adults: key findings

- In 2021, over 114,000 residents of the Gold Coast were aged 65 or more, accounting for 17.8% of the total population.
- The distribution of the older adult population varies across GCPHN, with Gold Coast North, Ormeau – Oxenford and Southport being SA3 regions with highest number of residents aged 65 or more (together accounting for 43% of total the Gold Coast population of older people).
- Rates of utilising primary healthcare, particularly GP attendances (standard and after-hours) were higher for older adults on the Gold Coast, compared to the national rate.
- Most older adults present to the Emergency Departments via Ambulance. Once discharged from ED, they are more likely to be admitted to hospital or attend the short stay unit than be discharged home.
- GCPHN region's older residents report higher levels of health and wellbeing and lower levels of disability than other regions of Australia. Fewer older adults in the Gold Coast receive an age pension than the national average, which could indicate a smaller degree of socio-economic disadvantage.
- More older adults in the GCPHN region live alone than in other Southeast Queensland regions. This, combined with high levels of older adults moving to the Gold Coast who may lack informal care and support networks, raises concerns of social isolation and limited ability to access services without support.
- Multicultural communities, particularly Pasifika communities have a strong preference for keeping older people at home, however, may not be able to access care packages and supports to enable this.
- Increasing financial stress and housing affordability are expected to place increasing pressure on older persons including mental stress and increased rates of elder abuse.
- Dedicated projects within the GCPHN region appear to have had a significant increase in the completion of advance care planning

Aged Care Services: key findings

- The Royal Commission found that the workforce is understaffed, undertrained, and underpaid, particularly for in home and residential care. The number of staff employed and providing direct care are not sufficient to provide quality and safe care, and that the skills mix are not suited to the diversity of people needing care. It highlights the need for increased efforts in workforce planning and development, in addition to improving the working conditions in the sector and attracting more employees into roles
- Older adults are staying at home for much longer due to a desire to remain independent. However, there is a level of forced independence as waitlist times for aged care packages, particularly levels 2

to 4, are often longer than six months. This can result in older adults reaching a crisis point and being forced into care following a medical incident.

- Utilisation rates of publicly funded aged care services, both residential and home care, is high with a significant number of providers spread across the GCPHN region. However, there appears to be relatively low access to specialist palliative care services in the GCPHN region.
- There is higher utilisation of Level 3and 4 home care services by people from non-English speaking countries compared to total GCPHN population.
- Aboriginal and Torres Strait Islander older people more frequently use home care services than residential and transition care, when compared to the total GCPHN population using aged care services.
- There is a 50:50 split of admissions to Gold Coast RACF for respite and permanent services.
- Occupancy rate for residential care in South Coast Aged Care Planning region is 88.3%.
- Majority of people leave home care services for RACF.
- The primary reason for leaving a RACF for permanent residents is death.

Dementia: key findings

- In 2020, 9,044 people residing in the Gold Coast area reported having dementia, with 60% of those being women. It is estimated in 2050, 30,633 people will be living with dementia on the Gold Coast.
- Surfers Paradise and Robina SA2s have the highest prevalence of people living with dementia.
- Dementia related hospitalisations in the region have increased by over 24% between 2013 and 2016.
- 80% of dementia emergency department presentations were of higher urgency care.
- Queensland Police Service reports increased resourcing demands managing older persons with dementia in the community.

Older Adults

Demographics

According to the 2021 Census, the resident population of the Gold Coast aged 65 years and over (referred hereafter as 'older adults') was 114,349 people.

Table 1 provides a breakdown of the older adult population in the GCPHN region by age group based on 2021 Census data.

Table 1. Number and proportion of population of older adults by age group, Gold Coast SA3 regions

	65-74		75-84		85 or more		65 or more	
	Number	%	Number	%	Number	%	Number	%
Queensland	503,466	20.5%	274,997	20.0%	97,140	17.9%	875,603	20.0%
Gold Coast	64,273	12.8%	37,005	13.5%	13,071	13.5%	114,349	13.1%
Broadbeach - Burleigh	7,194	11.2%	4,215	11.4%	1,638	12.5%	13,047	11.4%
Coolangatta	6,506	10.1%	3,548	9.6%	1,599	12.2%	11,653	10.2%
Gold Coast - North	9,735	15.1%	6,398	17.3%	2,187	16.7%	18,320	16.0%
Gold Coast Hinterland	2,587	4.0%	1,273	3.4%	299	2.3%	4,159	3.6%
Mudgeeraba- Tallebudgera	3,182	5.0%	1,564	4.2%	494	3.8%	5,240	4.6%
Nerang	6,493	10.1%	3,737	10.1%	1,209	9.2%	11,439	10.0%
Ormeau - Oxenford	11,571	18.0%	5,603	15.1%	1,519	11.6%	18,693	16.3%
Robina	5,166	8.0%	3,287	8.9%	1,434	11.0%	9,887	8.6%
Southport	6,036	9.4%	4,042	10.9%	1,834	14.0%	11,912	10.4%
Surfers Paradise	5,804	9.0%	3,335	9.0%	849	6.5%	9,988	8.7%

Source: Australian Bureau of Statistics (ABS) community profiles G01

On the Gold Coast, 53.4% of the older adult population are female, compared to 46.6% of the all-age population, which is likely due to a higher life expectancy for females.

While the Gold Coast local government area (LGA) has slightly different geographical boundaries than the GCPHN region, data from the Gold Coast City Council forecasts the number of older adults aged 65 years and over residing in the Gold Coast LGA to double by 2030 which will account for over 20.2% of the total Gold Coast LGA population[1] .

Aboriginal and Torres Strait Islander population

There are 2,431 people aged 50 years and over identifying as Aboriginal and Torres Strait Islander who reside on the Gold Coast, which is the age of eligibility for Aboriginal and Torres Strait Islander people to enter the public-funded aged care system in GCPHN region. This accounts for 0.8% of all people aged 50 years, compared to a national rate of 1.4%.

One fifth (20.9%) of the Aboriginal and Torres Strait Islander population aged 50 years and over resides in Ormeau – Oxenford SA3 (Table 2).

[1] Gold Coast City Council, Social Planning and Research Reports, http://www.goldcoast.qld.gov.au/thegoldcoast/gold-coast-seniors-statistics-888.html

Table 2. Number and proportion of Aboriginal and Torres Strait Islander people aged 50 years+, Gold Coast SA3 regions 2021

	Aboriginal and Torres Strait Islander population aged 50 years and over	
	Number	%
Queensland	41,925	28.0%
Gold Coast SA4	2,431	5.8%
Broadbeach - Burleigh	204	8.4%
Coolangatta	323	13.3%
Gold Coast North	296	12.2%
Gold Coast Hinterland	79	3.2%
Mudgeeraba - Tallebudgera	118	4.9%
Nerang	321	13.2%
Ormeau - Oxenford	507	20.9%
Robina	157	6.5%
Southport	277	11.4%
Surfers Paradise	149	6.1%

Source: Australian Bureau of Statistics 2021 Census of Population and Housing (G07)

Culturally and linguistically diverse population

Culturally and linguistically diverse (CALD) is a term often used to describe people living in Australia who were born overseas, or people living in Australia who have parent(s) or grandparent(s) born overseas and are predominately from non-English speaking or non-Western countries.

CALD communities may experience disadvantages on several social and cultural determinants of health and mental health, such as language barriers, lower socio-economic status, lower education, and lower levels of mental health literacy, which are factors that relate to an increased risk of mental illness.

Table 3. People aged 65 years+ who were born overseas that do not speak English well or not at all, Gold Coast SA3 regions, 2021

Region	People aged 65+ born overseas that do not speak English well or not at all	
	Number	%
Queensland	19,036	2.1%
Gold Coast SA4	2,656	2.3%
Broadbeach - Burleigh	278	2.1%
Coolangatta	58	0.5%
Gold Coast North	440	2.4%
Gold Coast Hinterland	17	0.4%
Mudgeeraba - Tallebudgera	66	1.2%
Nerang	268	2.3%
Ormeau - Oxenford	417	2.2%
Robina	380	3.8%
Southport	477	4.0%
Surfers Paradise	257	2.5%

Source: Australian Bureau of Statistics 2021 Census of Population and Housing

When these results are further broken down to SA2 level, several geographical clusters of people aged 65 years and over from CALD communities who speak English not well or at all can be identified:

- Robina SA3: Varsity Lakes (3.8%) and Clear Island Waters / Merrimac (3.1%)
- Surfers Paradise SA3: Benowa / Bundall (3.7%)
- Nerang SA3: Pacific Pines – Gaven (3.6%)
- Southport SA3: Southport (3.4%)
- Gold Coast North SA3: Labrador (3.3%)
- Broadbeach/Burleigh SA3: Mermaid Waters / Miami (3.3%)

A total of 6,572 older adults aged 65 years and over who reside on the GCPHN region migrated from interstate or overseas within the last 5 years, which represents 7% of the older adult population. Over 30% of these people migrated within the last 12 months[2]. This may provide an indirect indication of the extent of older adults who may not have strong informal caring and support networks such as family and friends.

Age pension

The proportion of people aged 65 years and over in a region receiving a government age pension provides an indication of the socioeconomic status and financial vulnerability of older adults. As of June 2021, there were 66,893 Gold Coast residents receiving an age pension, which represents 60.5% of people aged 65 years and over, which is slightly lower than the national level of 61.8%. This finding aligns with the lower levels of

[2] Gold Coast City Council Community Profile, Gold Coast City migration by age (2016), https://profile.id.com.au/gold-coast/migration-by-age

socio-economic disadvantage observed within the wider Gold Coast population relative to other regions. Table 4 outlines the absolute number and relative proportion of age pensioners within the GCPHN region.

Table 4. Number and proportion of age pensioners, Gold Coast SA3 regions, 2021

Region	Number of age pensioners	Percentage of persons aged 65+ who are age pensioners
Australia	2,556,017	61.8%
Gold Coast SA4	66,893	60.5%
Broadbeach - Burleigh	7,171	53.1%
Coolangatta	6,840	58.1%
Gold Coast - North	11,452	65.4%
Gold Coast Hinterland	2,351	58.1%
Mudgeeraba - Tallebudgera	3,175	60.5%
Nerang	7,359	63.4%
Ormeau - Oxenford	10,757	63.1%
Robina	5,849	63.5%
Southport	7,398	66.6%
Surfers Paradise	4,541	48.0%

Source: Social Health Atlas of Australia, compiled by Public Health Information Development Unit (PHIDU) based on data from the Department of Social Services

Life expectancy and main causes of death

Between 2015 and 2019, the median age at death for Gold Coast residents was 81 years (78 years for males and 84 years for females)[3]. These figures are comparable to the total Australian population. The top five leading causes of mortality for Gold Coast residents are:

1. coronary heart disease (n=2,203 or 11.8%of all deaths)
2. dementia and Alzheimer disease (n=1,697 or 9.1%of all deaths)
3. cerebrovascular disease (n=1,208 or 6.5%of all deaths)
4. lung cancer (n=1,088 or 5.8%of all deaths)
5. chronic obstructive pulmonary disease (n=788 or 4.2% of all deaths)

Disease prevalence

Data on disease prevalence were sourced from Gold Coast PHN's Primary Sense tool which captures de-identified patient data submitted by registered general practices throughout the GCPHN region. As of August 2022, the most prevalent diseases among patients aged 65 and over was hypertension (n=58,086), osteoarthritis (n=39,194) and hyperlipidaemia (n=37,867). A total of 19,950 GP presentations was due to diabetes. Anxiety and/or depression accounted for 35,137 presentations. Prevalence of other diseases among GP-presenting older adults can be seen in Table 5.

[3] AIHW, Mortality Over Regions and Time (MORT) books 2015-2019

Table 5. Disease prevalence among GP presentations by patients aged 65 years+ Gold Coast, August 2022

Measure	Number
Total Population	141,537
Hypertension	58,086
Osteoarthritis	39,194
Hyperlipidaemia	37,867
Osteoporosis	28,000
Depression	20,521
CHD	16,021
Asthma	15,542
Anxiety	14,616
Diabetes Type II	13,920
Atrial Fibrillation	12,362
COPD	10,966
Chronic Kidney Disease (CKD)	5430
Undefined Diabetes	5,135
Heart Failure	4394
Stroke	3,956
Dementia	3,891
Bipolar	772
Schizophrenia	559
Diabetes Type I	535
ADHD	185
Postnatal Depression	18
Autism	9

Source: Primary Sense, n=159 Gold Coast general practices

Heart failure

Heart failure is a chronic health condition associated with impaired physical functioning, poorer quality of life, increased hospitalisation and co-morbidity. While only an estimated 1-2% of the Australian population lives with heart failure at a given time, the prevalence rises steeply with age. Two-thirds of people living with heart failure in Australia are aged over 65 years. This provides a forecast of the number of people with heart failure aged under 65 years who are likely to experience disability and have higher support needs in their older years. Table 6 outlines the number and rate of hospitalisations for heart failure in the GCPHN region in 2017-18.

Table 6. Hospitalisations for heart failure, Gold Coast SA3 regions, 2017-2018

Region	Hospitalisations (number)	Age-sex standardised rate per 100,000
Broadbeach - Burleigh	181	172
Coolangatta	174	187
Gold Coast - North	219	173
Gold Coast Hinterland	35	123
Mudgeeraba - Tallebudgera	49	162
Nerang	147	178
Ormeau - Oxenford	174	183
Robina	190	252
Southport	168	191
Surfers Paradise	66	100

Source: Australian Commission on Safety and Quality in Healthcare (ACSQHC), the Second Australian Atlas of Healthcare Variation, 2017

Falls

Another significant cause of morbidity and impaired quality of life among older adults is falls, which are often related to impaired balance, immobility, and frailty, as well as feeling dizzy and having poor vision. The report "Trends in hospitalised injury due to falls in older adults 2007-08 to 2016-17" identified that about 125,000 people aged 65 and over were seriously injured due to a fall. Injuries to the head (26.2%), hip and thigh (22.4%) were the most common.

Rate of injuries to the head nearly doubled over the 10-year period to 2016-17 for both men and women. In 2016-17, the rates of head injury among men and women were 832 and 865 cases per 100,000 population, respectively, compared with 469 and 477 cases per 100,000 in 2007-08.

While the availability of data relating to falls among older adults is limited, data on hospital admissions for hip fractures in people aged 65 years and over can provide an indication of incidence, as most hip fractures are associated with falls.

In the GCPHN region in 2012-13, there were a total of 530 hospitalisations for people aged 65 years and over for hip fractures at an age-standardised rate of 635 per 100,000 people. This is noticeably higher than the rates for Queensland (628 per 100,000) and Australia (610 per 100,000). Between July 2019 and June 2020, 15% of all ED presentations to Gold Coast Public Hospitals Emergency Department (ED) from RACFs were for falls, making it the leading reason for presentations.

Disability

The care needs of older adults are generally higher than for the rest of the population due to disability, illness, and injury. A person with profound or severe limitation is defined as someone that needs help or supervision always or sometimes to perform core activities of self-care, mobility and/or communication.

Table 7 outlines the absolute number and proportion of older adults aged 65 years and over within the GCPHN region with a profound or severe disability. The data includes figures for all older adults, and older adults living in the community (excluding those in Residential Aged Care Facilities (RACF), non-self-contained residences, and psychiatric hospitals). The figures indicate that there are higher proportions of older adults living with high care needs in Southport (both in the community and not) and Robina (not in the community), with high absolute numbers of older adults living with high care needs in Gold Coast-North (both in the community and not).

Table 7. People with a profound or severe disability aged 65 years and over, Gold Coast SA3 regions, 2016

SA3 Region	All persons aged 65+ with a disability		Living in the community (i.e., self-contained accommodation)	
	Number	% of all persons aged 65+	Number	% of all persons aged 65+
Gold Coast SA4	15,753	16.6%	12,282	13.0%
Broadbeach - Burleigh	1,815	13.8%	1,552	11.8%
Coolangatta	1,833	16.1%	1,467	12.9%
Gold Coast - North	2,519	17.3%	1,930	13.3%
Gold Coast Hinterland	393	11.8%	363	10.9%
Mudgeeraba - Tallebudgera	647	15.8%	550	13.4%
Nerang	1,570	17.0%	1,384	15.0%
Ormeau - Oxenford	2,123	17.5%	1,625	13.4%
Robina	1,670	20.7%	1,001	12.4%
Southport	2,191	22.6%	1,516	15.6%
Surfers Paradise	992	10.9%	894	9.9%

Source: Public Health Information Development Unit (PHIDU) www.phidu.torrens.edu.au, based on the ABS Census of Population and Housing data, 2016

The greatest proportion of GCPHN residents aged 65 years and over that need assistance with core activities live in Southport, Robina and Gold Coast North (combined, accounting for 57.6% of total Gold Coast population aged 65 and more needing assistance). As a population size, Ormeau – Oxenford and Gold Coast North have the largest number of people aged 65 years and over need assistance with core activities.

Table 8. People aged 65 years and over needing assistance for core activities, Gold Coast SA3 regions, 2021

Region	Number of people aged 65+ who need assistance	Proportion of population aged 65+ needing assistance
Queensland	156,209	17.8%
Gold Coast SA4	19,113	16.7%
Broadbeach to Burleigh	1,917	14.7%
Coolangatta	1,866	16.0%
Gold Coast North	3,294	18.0%
Gold Coast Hinterland	510	12.3%
Mudgeeraba - Tallebudgera	851	16.2%
Nerang	1,936	16.9%
Ormeau - Oxenford	3,243	17.3%
Robina	1,870	18.9%
Southport	2,467	20.7%
Surfers Paradise	1,153	11.5%

Source: Australian Bureau of Statistics 2021, Census of population and housing

Wound management

Wound care is a significant issue in Australia, with chronic wounds presenting a large health and economic burden to Australians, the healthcare system, and providers of health services. The Government established the Taskforce as an advisory body to review all the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. In 2018, a wound management working group was established to make recommendations to the taskforce on the review of MBS items within its concern, based on rapid evidence review and clinical expertise on wound management.

The taskforce noted that stakeholders strongly supported the work of the Wound Management Working Group towards improving the management of wounds in Australia, including the suggested chronic wound cycle of care and the development of a national wound consumables scheme.

Wounds can be broadly classified as acute or chronic based on the duration of the wound and the cause underpinning its development. Most chronic wounds in Australian hospitals and RACF consist of pressure injuries (84%), venous leg ulcers (12%), diabetic foot ulcers (3%) and arterial insufficiency ulcers (1%)[4,5].

Approximately 450,000 Australians currently live with a chronic wound, directly costing the Australian healthcare system around AU$3 billion per year[6]. In hospital and RACF settings in Australia in 2010-11, the direct healthcare costs of pressure ulcer, diabetic ulcer, venous ulcer, and artery insufficiency ulcer was found to be approximately US$2.85 billion[7].

[4] Graves, N and Zheng, H. The prevalence and incidence of chronic wounds: a literature review. Wound practice & research: Journal of the Wound Management Association. 2014. Vol. 22, 1. 4.
[5] Graves, N and Zheng, H. Modelling the direct healthcare costs of chronic wounds in Australia. Wound Practice & Research: Journal of the Australian Wound Management Association. 2014. Vol. 22, 1. 20-4, 6-33.
[6] Pacella R, and the AusHSI chronic wounds team. Issues Paper: Chronic Wounds in Australia. Brisbane: Australian Centre for Health Service Innovation (Aus. HSI), 2017. Available from: https://www.aushsi.org.au/news/chronic-wounds-solutions-forum/]
[7] Graves, N and Zheng, H. Modelling the direct healthcare costs of chronic wounds in Australia. Wound Practice & Research: Journal of the Australian Wound Management Association. 2014. Vol. 22, 1. 20-4, 6-33.

According to the Bettering the Evaluation and Care of Health (BEACH) program, in 2010-11, the application of wound dressings was the second most frequently recorded procedure in general practice and the second most common procedure performed by general practice nurses[8].

In 2021-22, 4,083 individuals presented to Gold Coast EDs for diseases of the skin and subcutaneous tissue. In total, 4,083 or 1.8% of all ED presentations were for diseases of the skin and subcutaneous tissue[9]. For those, the departure status was:

- emergency service episode completed and discharge: n= 2,177 (53.3%)
- admitted to short stay unit: n=929 (22.8%)
- admitted to hospital: n=919 (22.5%)
- left at own risk after treatment commenced: n=35 (0.9%)
- transferred to another hospital: n=21 (0.5%)
- admitted to hospital in the Home service: n<=10 (<0.2%)

Gold Coast Health Local area health needs assessment consultation with over 120 stakeholders in 2022 identified with community identified some acute but low urgency needs such as minor infections, which are reportedly being admitted to hospital via ambulance as RACFs and home-based carers do not know of pathways to treat within the community. QAS reports long times on stretchers to manage health needs of older adults and QPS reports increased resourcing demands managing older persons with dementia and missing persons in the community.

Frailty

Frailty is commonly associated with aging and includes characteristics such as low physical activity, muscle weakness, slowed performance, fatigue or poor endurance, and unintentional weight loss. Frail older adults often have many complex medical problems and a lower ability for independent living, may have impaired mental abilities, and often require assistance for daily activities (dressing, eating, toileting, mobility). A growing body of literature has also documented a positive association between frailty and future falls[10,11,12].

Most frail older adults are women (partly because women live longer than men), are more than 80 years old, and often receive care from an adult child[13]. Because of the rapid rate of growth in the population aged 65 years and older, the number of frail elderly persons is increasing every year.

The data presented in Table 9 has been extracted from Primary Sense for 155 (of a total of 208) general practices in the GCPHN region. The table outlines the number of active patients with a frailty flag as determined by Adjusted Clinical Groups (ACG). The ACG frailty flag for older adults is assigned based on age, sex, diagnostic codes, and pharmacy data if available. It does not, however, account for other factors such as socio-economic status.

Postcode 4215 (Gold Coast North SA3) has the highest number of active patients with a frailty flag (N=595), followed by 4212 (Ormeau – Oxenford SA3) with N = 545. When aligning each postcode with SA3s the Ormeau

[8] Britt, H, et al. General practice activity in Australia 2010-2011. General practice series no. 29. Sydney: Sydney University Press, 2011.
[9] Gold Coast Health, Emergency Department presentations, 2021-22.
[10] Kojima G. Frailty as a predictor of future falls among community-dwelling older people: a systematic review and meta-analysis. J Am Med Dir Assoc. 2015;16(12):1027–33.
[11] Tom SE, Adachi JD, Anderson FA Jr, Boonen S, Chapurlat RD, Compston JE, Cooper C, Gehlbach SH, Greenspan SL, Hooven FH, et al. Frailty and fracture, disability, and falls: a multiple country study from the global longitudinal study of osteoporosis in women. J Am Geriatr Soc. 2013;61(3):327–34.
[12] De Vries OJ, Peeters GM, Lips P, Deeg DJ. Does frailty predict increased risk of falls and fractures? A prospective population-based study. Osteoporos Int. 2013;24(9):2397–403.
[13] Torpy JM, Lynm C, Glass RM. Frailty in Older Adults. JAMA. 2006;296(18):2280. doi:10.1001/jama.296.18.2280

– Oxenford SA3 has the highest overall number of patients with a frailty flag N= 1321 (note: some postcodes extend beyond more than one SA3 and some SA3s have more than one postcode).

Please note that patients are attributed to the postcode of the general practice, not their residence, when reviewing data in Primary Sense.

Table 9. Patients aged 65 years and over with a frailty flag, Gold Coast region, July 2022

Postcode	SA3 of the post codes	Number of active patients aged 65+	Number of patients aged 65+ with a frailty flag	Proportion of patients aged 65+ with frailty flag
4215	Gold Coast North	14,972	595	3.9%
4212	Ormeau - Oxenford	11,120	545	4.9%
4220	Broadbeach - Burleigh	13,867	474	3.4%
4216	Ormeau - Oxenford/Gold Coast North	9,903	472	4.8%
4211	Gold Coast Hinterland	10,842	420	3.9%
4221	Coolangatta	4,862	412	8.5%
4217	Surfers Paradise	9,288	365	3.9%
4218	Broadbeach - Burleigh	8,975	266	3.0%
4214	Southport	6,095	245	4.0%
4209	Ormeau - Oxenford	6,268	228	3.6%
4226	Robina	6,144	184	3.0%
4225	Coolangatta	4,547	178	3.9%
4227	Robina	3,684	168	4.6%
4210	Gold Coast Hinterland	4,279	140	3.3%
4272	Gold Coast Hinterland	1,862	137	7.4%
4223	Coolangatta/Mudgeeraba - Tallebudgera	2,667	128	4.8%
4224	Coolangatta	1,811	84	4.6%
4208	Ormeau - Oxenford	2,540	76	3.0%
4271	Gold Coast Hinterland	1,033	72	7.0%
4213	Gold Coast Hinterland	2,021	54	2.7%
4230	Robina	1,391	51	3.7%
4270	Gold Coast Hinterland	634	31	4.9%
4275	Gold Coast Hinterland	769	15	2.0%

*Source: Primary Sense. Note: *active patients are those that are currently in the general practices data base and have had an MBS item billed three times in the last two years. Mapping postcode to SA3 was done with the Queensland treasury and concordance file, some postcodes contain multiple SA3s the corresponding SA3 is one that forms the majority of the postcode.*

Social isolation and loneliness

Social isolation (having minimal contact with others) and loneliness (subjective state of negative feeling about having a lower level of social contact than desired[14]) can be damaging to people's mental and physical health, particularly in older persons. Loneliness and social isolation have been linked to mental illness, emotional distress, suicide, and development of dementia[15].

[14] Peplau L & Perlman D 1982. Perspectives on loneliness. In: Peplau L & Perlman D (eds). Loneliness: A sourcebook of current theory, research, and therapy. New York: Wiley.

[16] Beer A, Faulkner D, Law J, Lewin G, Tinker A, Buys L et al. 2016. Regional variation in social isolation amongst older Australians. Regional Studies, Regional Science.

It is estimated that around one in five (19%) older Australians are socially isolated, with the highest rates occurring in the largest urban regions and in sparsely populated states and territories[16]. In absence of local social isolation data, applying the national estimate to the Gold Coast region suggest that over 21,700 Gold Coast residents aged 65 years and over are socially isolated.

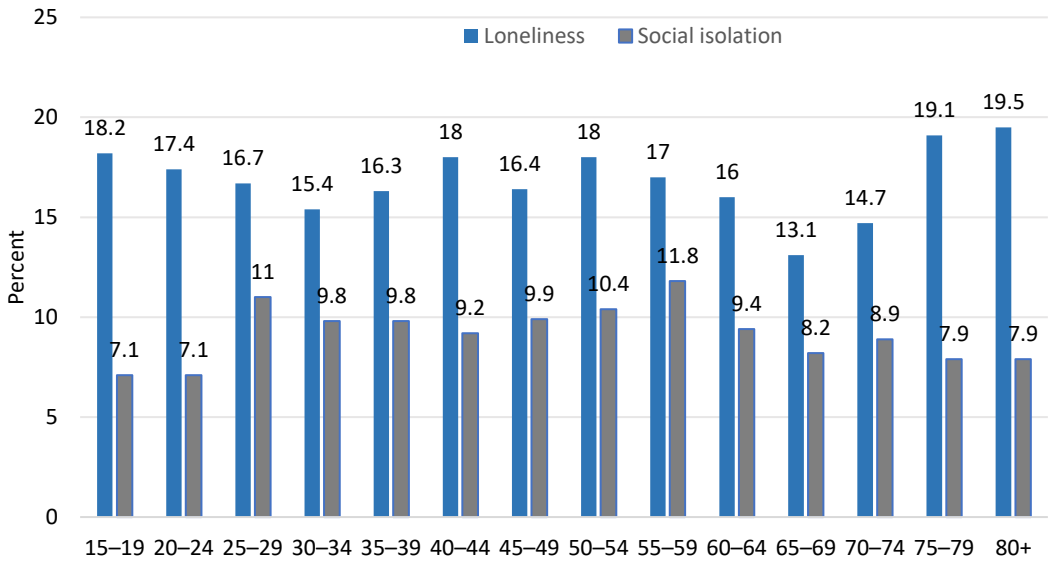
In 2016, the number of older adult lone person households in the GCPHN region was 19,519. This represents around 9.1% of all household types, which is slightly higher when compared to the rate for South-East Queensland (8.5%).

Further analysis of 2016 Census data shows there are areas in the Gold Coast with significant proportions of the population aged 65 years and over are living alone. Around one third of the persons aged 65 years and over living alone were in the following regions:

- Gold Coast North SA3: Labrador (34.9%)
- Southport SA3: Southport (32.8%)
- Gold Coast North SA3: Biggera Waters / Coombabah (32.0%)

Figure 1 shows the distribution of social isolation and loneliness across age groups. Significantly more people across all age groups reported experiencing loneliness than social isolation; the former was most prevalent in among people aged 75 and more, while highest rates of social isolations were reported among the 25-29- and 55–59-year-olds.

Figure 1. Australia proportion of people experiencing social isolation and loneliness by age, 2018



Source: Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labor Dynamics of Australia Survey. Canberra: Relationships Australia.

Elder abuse

Elder abuse takes a myriad of forms, including psychological abuse, financial abuse, physical abuse, and sexual abuse, and often a combination of these. Like family violence, elder abuse is about one person having power and control over another person.

In Australia, the available evidence suggest that prevalence varies across abuse types, with psychological and financial abuse being the most common. The Australian Longitudinal Study of Women's Health 2014[17], a population-based study into the prevalence of elder abuse among women found that in 2011, 8% of women aged 85-90 had experienced being exposed to abuse, with name calling and put-downs being the most common forms. A similar level of prevalence was evident for this cohort in a preceding wave, conducted in 2008, and slightly lower prevalence levels were found at younger ages (70-81 years). Data showed a relatively stable prevalence rate of neglect, experienced by about 20% of women across waves, from ages 70-75 to 85-90 years.

In Queensland, calls to the Elder Abuse Prevention Unit (EAPU) have increased from just over 200 in 2000-01 to nearly 1,300 in 2014-15[18]. The calls were mostly in relation to female victims (68% female, 31% male and 1% unknown). Perpetrators were male in 50% of calls and female in 45% (unknown 5%). Children were the largest groups of perpetrators reported (31% sons, 29% daughters), and 10% were other relatives.

In 2014-15, the most reported type of abuse to the EAPU helpline was financial abuse, accounting for 40% of reports, compared to 35% for psychological abuse which was the most common type in 2012-13.

Increasing financial stress and housing affordability are expected to place increasing pressure on older persons, which may result in mental stress and increased rates of elder abuse[19].

Mental health

There is increasing recognition that good mental health is one of the key factors associated with healthy ageing[20]. According to the World Health Organization, mental health is "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"[21] – as well as timely access to appropriate and effective clinical and non-clinical services.

The mental health of older adults can also be affected by losing the ability to live independently, experiencing bereavement (particularly with death of a life partner), and a drop in income following retirement from the labor force[22,23]. These factors may lead to social isolation and/or loneliness, loss of independence and increased psychological distress.

It is thought that between 10 to 15% of older adults experience depression and about 10% experience anxiety[24]. Rates of depression among people living in RACF are believed to be much higher, at around 35%[24]. Applying these rates to the Gold Coast population aged 65 years and over, almost 16,000 suffer from depression and over 10,000 are experiencing anxiety. With the annual growth rate on the Gold Coast being above the Queensland rate (2.4% vs 1.5%), and the proportion of Gold Coast residents aged 65 and over exceeding that of the total Queensland (16.6% vs 15.7%), it is reasonable to expect that the number of older adults on the Gold Coast experiencing mental illness will continue to increase in the future[25].

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[17] *Australian Longitudinal Study on Women's Health. (2014). 1921-26 cohort: Summary 1996-2013. Callaghan, NSW & Herston, Qld: University of Newcastle and the University of Queensland.*

[18] *Spike, C. (2015). The EAPU helpline: Results of an investigation* of five years of call data. Report for the International Association of Gerontology and Geriatrics Asia & Oceania Regional Congress 2015.

[19] Robinson, E., & Adams, R. (2008). Housing stress and the mental health and wellbeing of families.

[20] Kane RL 2005. What's so good about aging? Research in Human Development 2(3):115–32.

[21] World Health Organization. Promoting mental health: concepts, emerging evidence, practice (Summary Report) Geneva: World Health Organization; 2004

[22] Rickwood D 2005. Pathways of recovery: preventing further episodes of mental illness. Canberra:
National Mental Health Promotion and Prevention Working Party

[23] WHO (World Health Organization) 2013. Mental health and older adults. Factsheet no. 381. Geneva: WHO.

[24] National Ageing Research Institute. (2009). beyondblue depression in older age: a scoping study. Final Report. Melbourne: National Ageing Research Institute.

[25] ABS 3218.0, Regional Population Growth, Australia, various editions

Low literacy levels

Health literacy relates to how people access, understand and use health information in ways that benefit their health[26]. People with low health literacy are more likely to have worse health outcomes overall, such as:

- lower engagement with health services, including preventive services such as cancer screening[27],
- higher hospital re-admission rates[28], and
- lower ability to self-manage care[29].

Data is not regularly collected in the Gold Coast on the prevalence of people with low literacy levels, however national estimates suggest low literacy is highly prevalent among Australian communities. The Australian Bureau of Statistics found 65% of people aged 60-74 years had low literacy levels (levels 1 and 2 out of 5)[30]. Applying this prevalence to the local Gold Coast older adult population, over 74,000 people are estimated to have low literacy skills.

Cognitive impairment

Mild cognitive impairment is typically defined as significant memory loss without the loss of other cognitive impairment. There are limited data available on the prevalence of mild cognitive impairment, however the AIHW has estimated a national prevalence to be 13.7%[31] . On the Gold Coast, this translates to over 15,600 people aged 65 years and over with mild cognitive impairment. Furthermore, it is estimated that people with mild cognitive impairment are 3-5 times more likely to develop dementia, particularly Alzheimer's Disease[32].

Service Access

Hospitalisations

Reducing the number of avoidable hospital admissions is a performance priority for PHNs across the country. The analysis of potentially preventable hospitalisations (PPHs) for people aged 65 years and over shows that there were 9,278 PPHs recorded in Gold Coast public hospitals between 2019 and 2020 (Table 11).

The five leading causes of PPH in this age group are:

1. Urinary tract infections, including kidney infections
2. Chronic obstructive pulmonary disease (COPD)
3. Congestive cardiac failure
4. Iron deficiencies
5. Cellulitis

Table 11. Potentially preventable hospitalisations (PPHs) per 100,000 people aged 65 and over, national and Gold Coast, 2019-20

	Gold Coast	National

[26] Australian Institute of Health and Welfare (AIHW) 2022, Health literacy, https://www.aihw.gov.au/reports/australias-health/health-literacy
[27] Kobayashi LC, Wardle J and von Wagner C (2014) 'Limited health literacy is a barrier to colorectal cancer screening in England: evidence from the English Longitudinal Study of Ageing', Preventive Medicine, 61:100–105.
[28] Mitchell SE, Sadikova E, Jack BW and Paasche-Orlow MK (2012) 'Health literacy and 30-day postdischarge hospital utilization', *Journal of Health Communication*, 17(Supplement 3):S325–338.
[29] Geboers B, de Winter AF, Spoorenberg SLW, Wynia K and Reijneveld SA (2016) 'The association between health literacy and self-management abilities in adults aged 75 and older, and its moderators', *Quality of Life Research*, 25(11):2869–2877.
[30]Australian Bureau of Statistics (2013), Older Australians have lower levels of literacy and numeracy media release
[31] AIHW Dementia in Australia: National data analysis and development
[32] Dementia Australia, Mild Cognitive Impairment, 2022

Total acute	3,117	2,471
Total chronic	5,522	5,014
Total vaccine preventable	721	710
Total potentially preventable	9,278	8,098

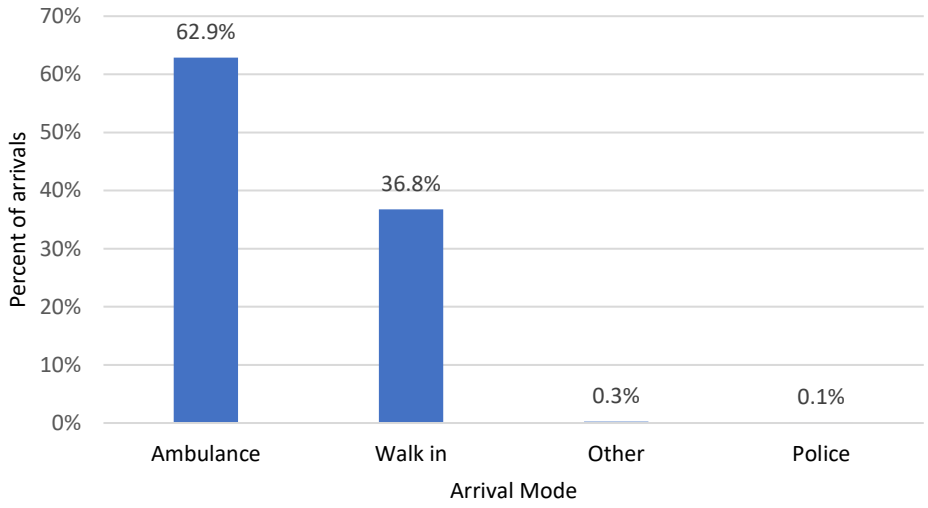
Source: AIHW 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20.

Consultation identified older adults are discharged from hospitals on the assumption that medication and wound management will be funded, but often the older person or their family may not have financial means for it.

Emergency Departments

People who do not have appropriate supports or aged care services in place may utilise Queensland Ambulance Service (QAS) and hospital services more frequently. While there is no direct data available for this group, general usage patterns align with this idea. Figure 2 demonstrates that the primary mode of arrival for older adults to ED is via ambulance (62.9%). The ambulance service is a valuable, yet expensive service to operate compared to other primary and community services.

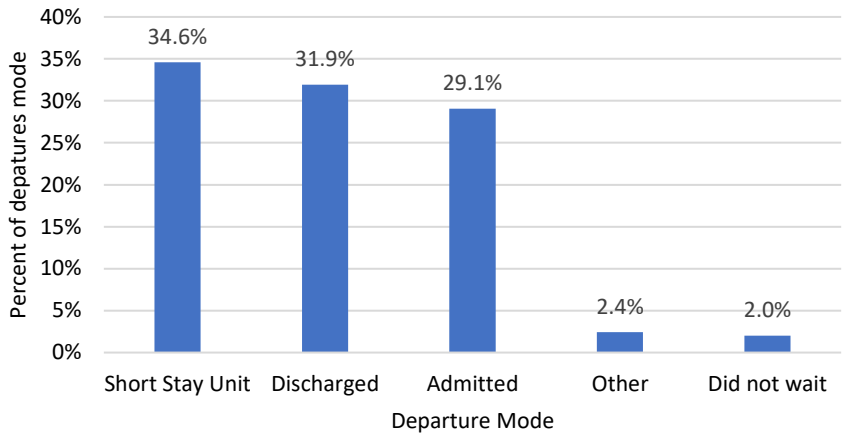
Figure 2. Proportion of ED presentations for older adults 65+ in the GCPHN region, by arrival mode, 2021-22



Source: Gold Coast Health, Emergency Department presentations

Figure 3 shows that around one third (32%) of older adults who presented to ED were discharged directly from the ED. Most older adults were transferred to a short stay unit (35%) or admitted to hospital stay (29%). This highlights the opportunities in the local health system if we are able to manage older adults' health care prior to them presenting to ED.

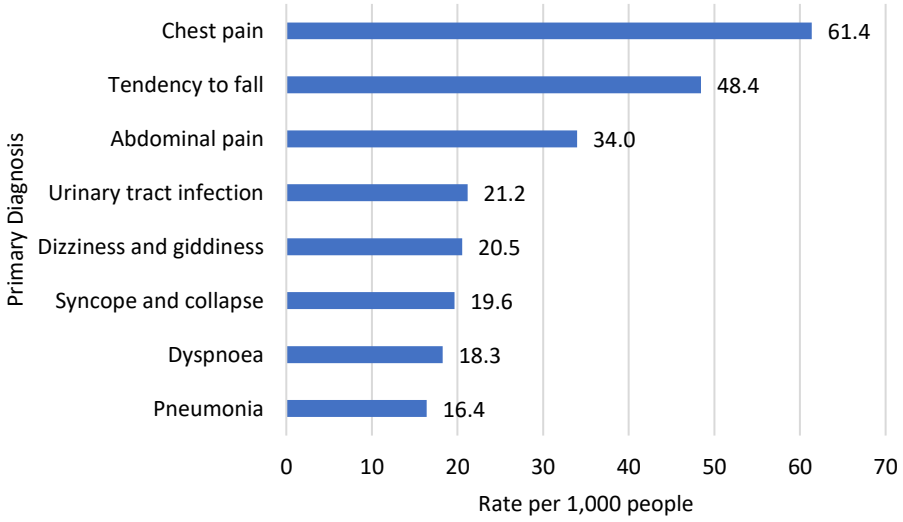
Figure 3. Proportion of ED presentations for older adults 65+ in the GCPHN region, by departure mode, 2021-22



Source: Gold Coast Health, Emergency Department presentations

The three most common reasons for people aged 65 years and over presenting to ED in GCPHN were chest pain, tendency to fall, and abdominal pain (Figure 4).

Figure 4. Top primary diagnoses of ED presentations for older adults 65+, Gold Coast, 2021-22



Source: Gold Coast Health, Emergency Department presentations

People who present to ED are triaged based on the level of urgency of the care needed. The Australian Triage Scale has five triage categories:

- Category 1: Immediately life-threatening. Patient should be seen by a treating doctor or nurse within two minutes of arriving.
- Category 2: Imminently life-threatening. Patient should be seen by a treating doctor or nurse within 10 minutes of arriving.
- Category 3: Potentially life-threatening. Patient should be seen by a treating doctor or nurse within 30 minutes of arriving.
- Category 4: Potentially serious. Patient should be seen by a treating doctor or nurse within 60 minutes of arriving.

- Category 5: Less urgent. Patient should be seen by a treating doctor or nurse within 120 minutes of arriving.

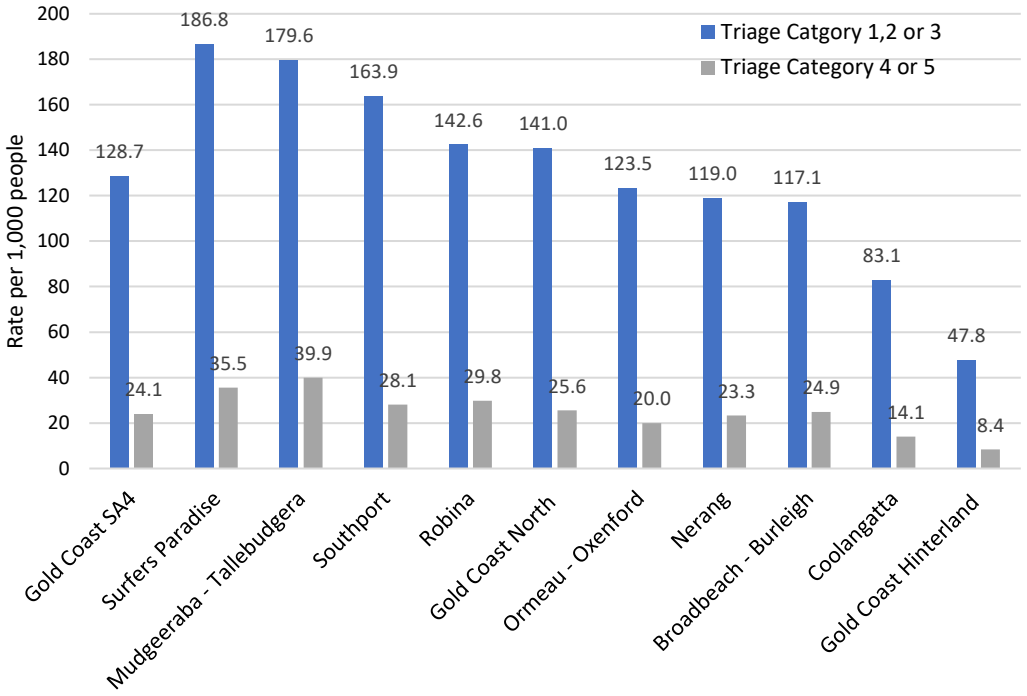
As seen in Figure 5, in 2021-22, the highest rates for more urgent presentations (category 1, 2 or 3) by older adults are in the following SA3 regions:

- Surfers Paradise: 186.8 per 1,000 people
- Mudgeeraba – Tallebudgera: 179.6 per 1,000 people
- Southport: 163.9 per 1,000 people

The highest rates of less urgent ED presentations (category 4 or 5) for older adults were in:

- Mudgeeraba – Tallebudgera: 39.9 per 1,000 people
- Surfers Paradise: 35.5 per 1,000 people
- Robina: 29.8 per 1,000 people

Figure 5. Rate of ED presentations by older persons by triage category, Gold Coast, 2021-22



Source: Gold Coast Health, Emergency Department presentations, 2021-22

Primary care providers

The capacity of the primary healthcare system to manage the ongoing health needs of older adults, particularly those living in RACFs, is critical in preventing unnecessary transfers to hospital facilities.

The Royal Commission into Aged Care Quality and Safety heard from many people that the level of service provision by GPs is not adequate to meet the needs of people receiving aged care. Primary healthcare

practitioners are either not visiting people receiving aged care at their residences, not visiting frequently enough, or not spending enough time with them to provide the care required[33].

GPs are primarily funded via fee-for-service. The Royal Commission heard evidence about the problems with the fee-for-service funding model, particularly that it creates an incentive for care that responds to an episode of care of ill health, rather than encouraging care that proactively attempts to reduce the risk of ill health. The fee-for-service model is considered by some to be "in conflict with the proactive, coordinated and ongoing team-based approaches that are needed to support the prevention and optimal management of chronic and complex conditions"[34]. The Royal Commission into aged care identified that part of the access problem is the amount of funding available for GPs providing care to people receiving aged care.

The number of GP and specialist attendances per person for the GCPHN region based on Medical Benefits Schedule (MBS) claims data is outlined in Table 12. Unsurprisingly, older adults on the Gold Coast had higher claim rates than the all-age population in the region. GP attendances (standard and after hours) were higher for older adults on the Gold Coast when compared to the older adult population nationally, but specialist attendances were lower.

Table 12. Rate of GP and specialist services per 100 people, Gold Coast PHN region, 2020-2021

	GP attendances		After-hours GP attendances		Specialist attendances	
	65-79	All ages	65-79	All ages	65-79	All ages
Gold Coast	1321	666	49	47	218	93
Nationally	1166	762	33	34	241	102
	GP attendances		After-hours GP attendances		Specialist attendances	
	80+ years	All ages	80+ years	All ages	80+ years	All ages
Gold Coast	2009	666	137	47	267	93
Nationally	1782	762	90	34	281	102

Source Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits claims data, 2020 -2021

Prescribed medications

Dispensing rates under the Pharmaceutical Benefits Scheme (PBS) provide an indication of the utilisation of medications as well as an insight into the health needs of older adults within the GCPHN region. Table 13 provides dispensing rates for medications listed on the PBS under several relevant categories for older adults including antidepressants, anxiolytics (for treating anxiety), anti-psychotic and anticholinesterase (for treating conditions such as Alzheimer's) medications. The rates of dispensing for anxiolytic and anticholinesterase medicines are higher than the state and national rates in almost all GCPHN SA3 regions. Southport has particularly high rates of dispensing across all four selected medicine types.

[33] Royal Commission into Aged Care Quality and Framework
[34] Report for the Primary Healthcare Advisory Group, Better Outcomes for People with Chronic and Complex Health Conditions, December 2015

Table 13. Rate of prescriptions dispensed for selected medications for people aged 65 years and over, Gold Coast SA3 regions, 2013-14

Region	Age-standardised rate of prescriptions dispensed per 100,000 people aged 65 years and over		
	Anti-depressants	Anti-psychotics	Anxiolytics
Australia	196,574	27,043	37,695
Queensland	221,409	31,763	42,664
Broadbeach - Burleigh	182,793	18,533	45,666
Coolangatta	196,998	19,341	54,714
Gold Coast - North	201,933	22,025	53,587
Gold Coast Hinterland	183,492	18,967	39,013
Mudgeeraba - Tallebudgera	220,915	21,381	52,490
Nerang	192,221	17,161	43,510
Ormeau - Oxenford	216,858	18,259	43,619
Robina	176,026	13,888	40,708
Southport	230,803	34,386	62,901
Surfers Paradise	176,153	17,442	49,921

Source: Australian Commission on Safety and Quality in Healthcare (ACSQHC), the First Australian Atlas of Healthcare Variation, 2015

Advance care planning

Advance care planning is the process of planning for future health and personal care whereby a person's values, beliefs and preferences are made known so they can guide clinical decision-making at a future time when that person cannot make or communicate their decisions. Advance care planning is a priority for quality person centered or end of life care and promotes an individual's choice and control over healthcare decisions.

An advance care directive is a type of written structured advance care plan recognised by common law or specific legislation that is completed and signed by a competent adult[35]. An advance care directive will typically document the persons values, beliefs, and specific preferences for future care and/or include the appointment of a substitute decision maker. A substitute decision maker may be required to make medical treatment decisions on behalf of a persons whose decision-making capacity is impaired[36].

In Queensland, there are three ways individuals can record their choices for future healthcare:

- Enduring Power of Attorney - this process allows the individual to choose a trusted relative or friend to manage your personal matters (including healthcare) and financial matters.
- Advance Health Directive - this is a formal way to give instructions about the individuals future healthcare. It is sometimes called a living will. It will only take effect if the individual does not have capacity to make decisions.

[35] Rhee JJ, Zwar NA, Kemp LA. Why are advance care planning decisions not implemented? Insights from interviews with Australian general practitioners. Journal of Palliative Medicine. 2013;16(10):1197-204.
[36] Australian Health Ministers' Advisory Council. National Framework for Advance Care Directives. Canberra, Australia: Commonwealth Government of Australia; 2011.

- Statement of Choices - this allows the individual to record their personal values and preferences for healthcare.

Despite the recognised benefits of formally documenting one's advance care planning preferences, available estimates suggest less than 30% of Australians have completed an advance care directive[37].

There are no dedicated MBS item numbers for advance care planning; instead, advance care planning it is undertaken as part of standard GP consultations, health assessments, chronic disease management plans, or case conferencing items.

Gold Coast PHN is involved in several projects with RACFs, GPs, practice nurses and practice managers and the community to increase the uptake of Advance Care Plans (ACP) to enable people to make decisions about their future healthcare. In 2019-20, Gold Coast PHN secured funding to trial The Advance Project, initiating advance care planning and palliative care through training and resources for six general practices on the Gold Coast to assist local GPs in delivering palliative care for their patients.

Through the ongoing promotion of ACPs, by February 2020, the Office of Advanced Care Planning had received 1,645 ACP documents. In addition, the five RACFs that worked with Gold Coast PHN on the Enhanced Primary Care Project had 369 ACPs completed by March2020. Work that supported this included:

- Three Advance Care Planning introductory education workshops were delivered at the Gold Coast Justices Association's education symposium where 183 Justice of the Peace volunteers participated.
- In collaboration with Kalwun and PEPA, a "Dying to Yarn" Expo was organised that aimed to empower Aboriginal and Torres Strait Islander people about when and where they need palliative care within the community.
- Six general practices participated in a trial to determine barriers to implementing advance care planning in RACFs, which will assist in improving mechanisms to increase uptake.
- The Palliative Care Health Literacy project team has explored options for consumer resources to increase awareness and understanding about palliative care and the options available to them including the uptake of advance care planning.

Analysing data uploaded by Gold Coast residents to Queensland Health electronic hospital record (The Viewer), a large increase was seen across all document types (statement of choice, advanced health directive and enduring power of attorney) from 2017-18 to 2019-20. There was a total of 1,006 Gold Coast residents who had completed Statement of Choices in 2019-20[38].

[37] Deterring KM, Buck K, Ruseckaite R, Kelly H, Sellars M, Sinclair C, et al. Prevalence and correlates of advance care directives among older Australians accessing health and residential aged care services: multicentre audit study. BMJ Open. 2019;9(1): e025255

[38] Office of Advance care Planning – Queensland Health

Table 14. Number of advance care planning documents uploaded to the Queensland Health electronic hospital record, Gold Coast residents, 2017-18 to 2019-20

Document type	2017-18	2018-19	2019-20
Statement of Choices	483	467	1,006
Advance Health Directive	16	129	311
Enduring Power of Attorney	23	167	810

Source. Office of Advance care Planning – Queensland Health

Aged Care Services

Aged care services – Government subsidised Residential and Home Care Packages

Australia's changing demographic profile significantly influences the demand for and provision of aged care. Australians are living longer than ever before. It is projected that the number of Gold Coast residents aged 85 years and over will increase from 11,991 in 2016 (2% of the Gold Coast population) to 34,360 in 2041 (3.6% of the Gold Coast population)[39].

The Australian aged care system provides subsidised care and support to older adults. It is a large and complex system that includes a range of programs and services. The care ranges from low-level support to more intensive services, including:

- assistance with everyday living activities,
- respite,
- equipment and home modifications (e.g., handrails),
- personal care, such as help getting dressed, eating, and going to the toilet,
- health care, including nursing and allied healthcare, and
- accommodation.

Aged care is provided in people's homes, in the community, and in residential aged care settings. People commonly think of nursing homes, or residential care, when they think about aged care. However, while most of the aged care budget is spent on residential aged care, more than two-thirds of people using aged care services do so from home.

Government-funded aged care services include in-home care (care in your home), residential care in aged care homes, and short-term care such as respite care.

The aged care system offers care under three main types of service:

- **Care in your home**: In-home aged care provides support to help older persons stay independent for as long as possible. It can help with things like personal care, transport, food, shopping, housework, physio, social activities, and modifications to your home. The Australian Government subsidises:
    - entry-level support through the Commonwealth Home Support Program, and
    - support for more complex needs through Home Care Packages.

39 Queensland Government population projections, 2018 edition; Australian Bureau of Statistics, Population by age and sex, regions of Australia, 2016 (Cat no. 3235.0).

- **Short-term care**: Short-term care can help an older person to improve their wellbeing and independence or get back on their feet after a hospital stay. It can also give their carer a break. The Australian Government subsidises:
    - after-hospital or transition care – support for up to 12 weeks to help recover after a stay in hospital,
    - short-term restorative care – support for up to eight weeks to help improve your wellbeing and independence, and
    - respite care – support for a few hours, days or longer to give the older person or their carer a break.
- **Residential care in aged care homes:** Residential care in aged care homes is for older adults who can no longer live at home or need ongoing help with everyday tasks or health care. The Australian Government subsidises aged care homes to provide care that is available 24 hours a day. Residential care can be short-term (respite care) or permanent.

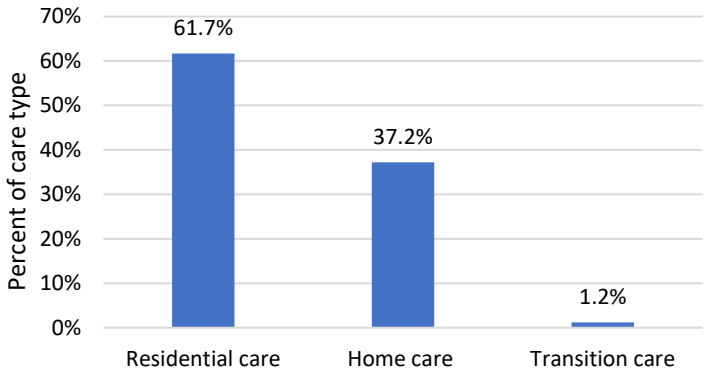
Table 15. Number of users and allocated places for South Coast region by care type and provider type, 2020

Care type	Number of allocated places
Residential	5,578
Home care	3,044
Transition care	99

Source: AIHW, GEN Aged Care data portal, extracted from www.gen-agedcaredata.gov.au and home care packages program report, Department of Health

The majority of people accessing aged care services in the South Coast Aged Care Planning Region access residential aged care rather than home care (Figure 6). This may indicate a limited ability for some older people to access the home care services they need. If people are unable to access appropriate supports and or aged care services at home, they may require the higher level of care a residential aged care service provides sooner.

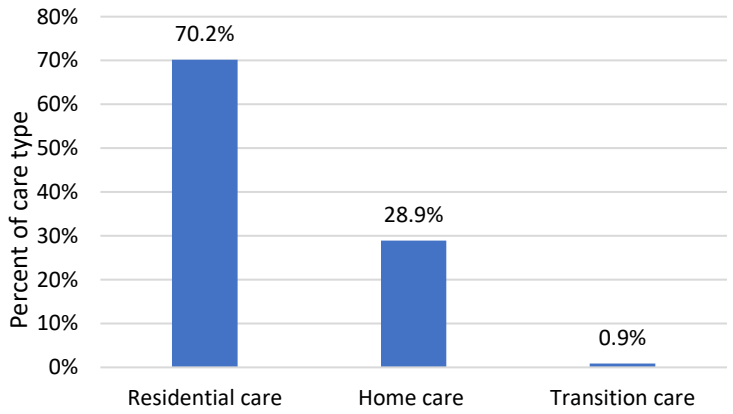
Figure 6. Proportion of people using aged care services in South Coast Aged Care Planning Region, by care type, 2020-21



Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

70% of non-Indigenous people born in Australia who are engaged with aged care services use residential aged care (Figure 7). As the largest population group, this skews the overall service utilisation of the Gold Coast population.

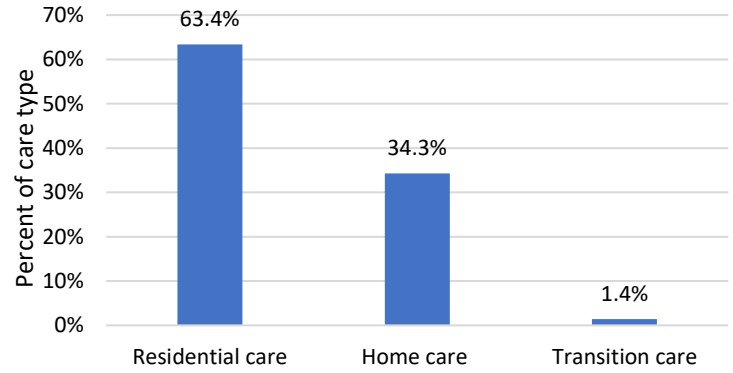
Figure 7. Proportion of non-Indigenous people born in Australia using aged care services in South Coast Aged Care Planning Region, by care type, 2020-21



Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

There is a higher utilisation of home care services and a lower utilisation of residential care services by Aboriginal and Torres Strait Islander people, compared to the distribution of types of care accessed across the total Gold Coast population (Figure 8).

Figure 8. Proportion of Aboriginal and Torres Strait Islander people using aged care services in South Coast Aged Care Planning Region, by care type, 2020-21



Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

Targeted Care Finder Stakeholder Survey, distributed to Gold Coast service providers and community representatives in July 2022, found the following to be the most common challenges experienced by people navigating and accessing the aged care system:

- Fear of not being able to stay in own home if engaged with aged care services,
- Lack of insight that aged care supports are required,
- Computer literacy and access to the internet,

- Lack of family support to access the aged care system, and
- Trust issues with engaging with the aged care system.

Home care

Home care packages are one of the ways older Australians with more complex care needs can access care services to get help at home. Older person can choose a service provider while the government then pays the provider a subsidy to arrange a package of care services to meet their needs.

There are four levels of Home Care packages, spanning basic support needs through to high care needs with different funding amounts:

- Level 1: Basic care needs – $9,179.75 / year
- Level 2: Low care needs – $16,147.60 / year
- Level 3: Intermediate care needs – $35,138.55 / year
- Level 4: High care needs – $53,268.10 / year

In 2020-21, 3,044 older people in the South Coast region were using home care packages. Of those:

- 13.8% had a carer
- 34.8% were born outside of Australia
- 22.0% had a disability
- 0.9% identified as Aboriginal or Torres Strait Islander
- 45.0% lived alone
- 3.9% had a preferred language other than English

Current waiting lists to access home care packages are extensive both within the GCPHN region and nationally, which is likely to impact the utilisation of other aged, community and health services. As of 31 December 2021, there were 746 people on the National Prioritisation Queue for a home care package residing in the South Coast Aged Care Planning Region (ACPR) who were not accessing or had not been assigned a care package[40]. These people are approved for:

- Level 1: 22
- Level 2: 245
- Level 3: 341
- Level 4: 138

Estimated wait times for people entering the National Prioritisation Queue are outlined in Table 16. The first package assignment is often offered at lower level of what the applicant has applied for, as this enables the applicant to receive care and services as soon as possible whilst waiting until the requested level is made available.

[40] Department of Health, Home care packages data report, 1 October -31 December 2021, Home Care Packages Program Data Report

Table 16. Estimated waiting time for home care package on National Prioritisation Queue, December 2021

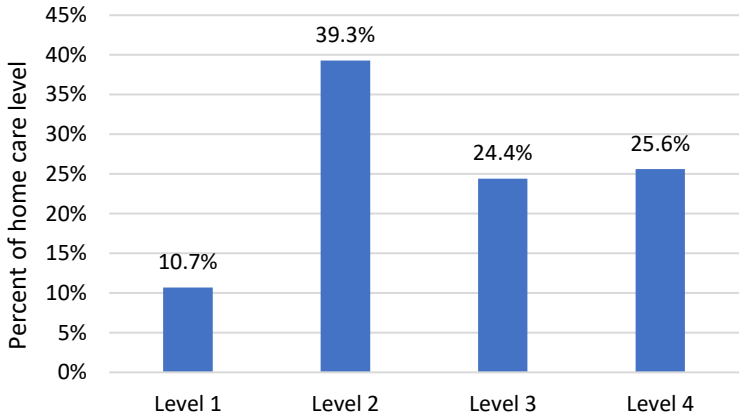
Package level	First package assignment	Time to first package	Time to approved package
Level 1	Level 1	3-6 months	3-6 months
Level 2	Level 1	3-6 months	6-9 months
Level 3	Level 1	3-6 months	6-9 months
Level 4	Level 2	6-9 months	6-9 months

Source: Department of Health, Home Care Packages Data Report 2 October to 31 December 2021.

The Australian Government has announced an additional 80,000 home care packages nationally (40,000 in 2021-22 and 40,000 in 2022-23)[41]. The time to approve packages has decreased for levels 3 and 4 from 12+ months in March 2018 to 6-9 months in December 2021. However, the first package assignment across all four package levels is being provided at a lower level of care than what is required, potentially increasing risk of hospitalisation or early admission to RACF.

Figure 9 shows there is a higher utilisation of Home Care Services for Levels 2, 3 and 4 in the South Coast aged care planning region, with the highest usage at Level 2 (39.*2%)*

Figure 9. Proportion of all people using Home Care Services in South Coast aged care planning region, by level of Care, 2020-21

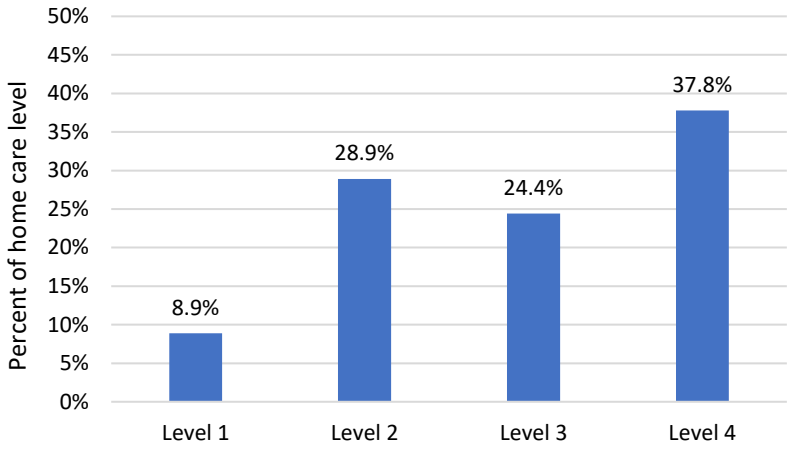


Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

Of Aboriginal and Torres Strait Islander people using home care services in the South Coast aged care planning region, 37.8% use level 4 support, compared to 25.6% for the rest of the Gold Coast population. It needs to be noted that for 28.9% of home care users, Indigenous status was not stated or adequately described.

[41] Department of Health, Home care packages data report, 1 October -31 December 2021, Home Care Packages Program Data Report (gen-agedcaredata.gov.au)

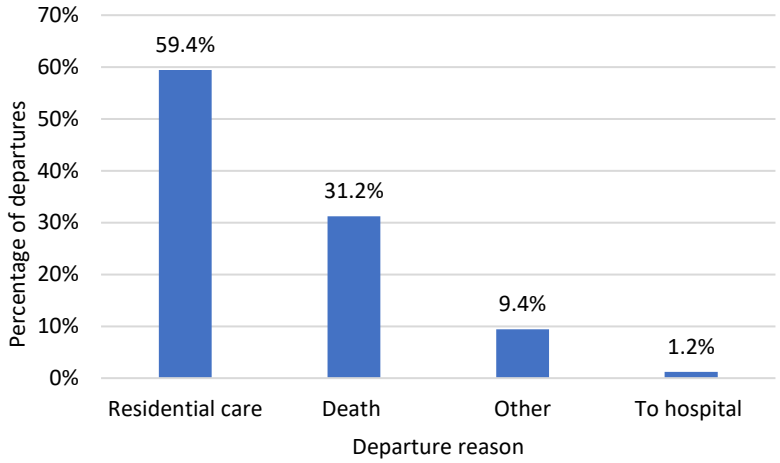
Figure 10. Proportion of Aboriginal and Torres Strait Islander People in South Coast aged care planning region using Home Care Services by Level of Care, 2020-21



Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

Figure 11 shows almost 60% of people leaving home care services are moving into residential care facilities. However, it is unknown what proportion of people enter residential care from home care for respite or permanent services.

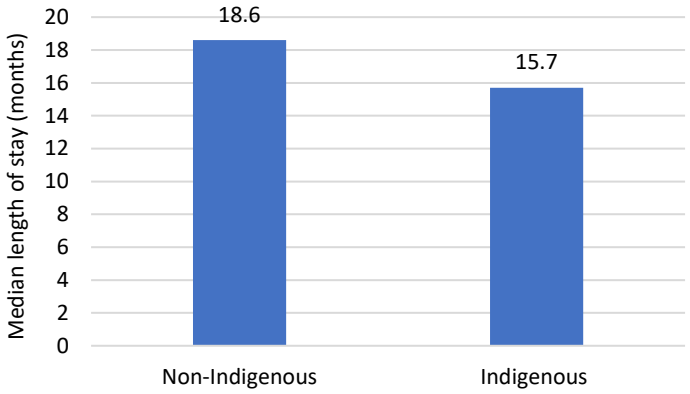
Figure 11. Proportion of exits from Home Care services in South Coast Aged Care Planning Region, by departure reason, 2020-21



Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

In 2020-21, the median length of stay in home care was 18 months. As Figure 12 suggests, Aboriginal and Torres Strait Islander people stayed in home care services for less time. However, this data should be interpreted with caution due to the small number of Aboriginal and Torres Strait Islander people exiting home aged care services in the reporting period.

***Figure 12. Length of stay** for people using home care services in South Coast aged care planning region, by Indigenous status, 2020-21*



Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

Residential aged care facility

A Residential Aged Care Facility (RACF) is for older adults who can no longer live at home and need ongoing help with everyday task or health care.

Utilisation trends for permanent residential aged care services in the GCPHN region, including number of admissions, and people using aged care services during the year 2020-21 is outlined in Table 13. It includes a breakdown for various demographic characteristics (age, sex, Indigenous status, and preferred language*).*

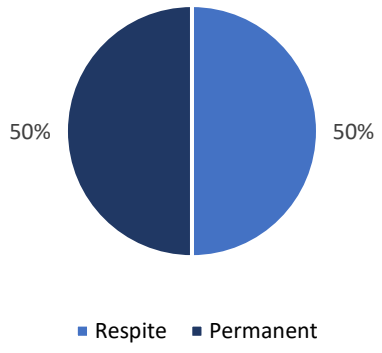
Table 17. Admissions, and number of people using aged care, GCPHN region, 2020-21

		Number of admissions	Number of people using aged care
Total		3,485	4,984
Age group	0-49	0	6
	50-54	0	13
	55-59	10	18
	60-64	20	53
	65-69	127	173
	70-74	300	376
	75-79	522	615
	80-84	677	919
	85-89	893	1152
	90-94	692	1,070
	95-99	215	506
	100+	29	83
Sex	Male	1,491	1,791
	Female	1,994	3,193
Indigenous status	Yes	15	24
	No	3,470	4,957
Preferred language	English	3,324	4,793
	Other	103	158

Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

There is a 50:50 split of admissions to residential aged care for respite and permanent services. However, due to the short-term nature of respite there are more permanent residents in a facility at any given point.

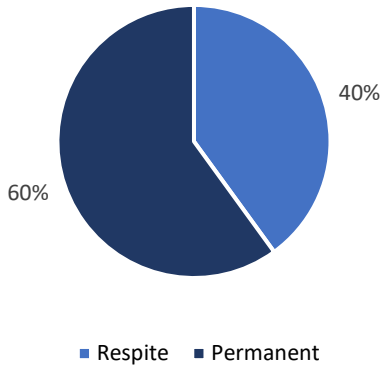
Figure 13. Proportion of residential aged care admissions in South Coast Aged Care Planning Region, by admission type, 2020-21



Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

There is no significant variation of admission type between countries of birth, however there is a 60:40 split for Aboriginal and Torres Strait Islander people towards permanent residency (Figure 14).

Figure 14. Proportion of Aboriginal and Torres Strait Islander people residential aged care admissions in South Coast Aged Care Planning Region, by admission type, 2020-21



Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

Table 18 shows that over 82% of people who exited permanent residential aged care in 2020-21 did so due to death.

Table 18. Length of stay and exits from permanent residential care in South Coast, by discharge reason, 2020-21

	Death	Return to community	To hospital	Other	To other residential care
Mean length of stay (months)	32.6	12.9	16.1	16.7	20
Median length of stay (months)	22.3	6.1	3.4	6.6	12.3
Range length of stay (months)	0 -281.5	0- 80.2	0 - 92.6	0 - 125.3	0.2 - 97.3
Total exits	1,349	106	28	38	107

Source: GEN Aged Care Data, People Using Aged Care (2020-2021)

Nurses in aged care

Table 19 shows the numbers and Full Time Equivalent (FTE) of nurses working in hospitals, primary and community care, and residential aged care. Hospitals employ more than five-times the number of nurses in primary and community care, and aged care.

Table 19. Number and FTE of nurses working in hospitals, primary and community care, and aged care, Gold Coast, 2021-22

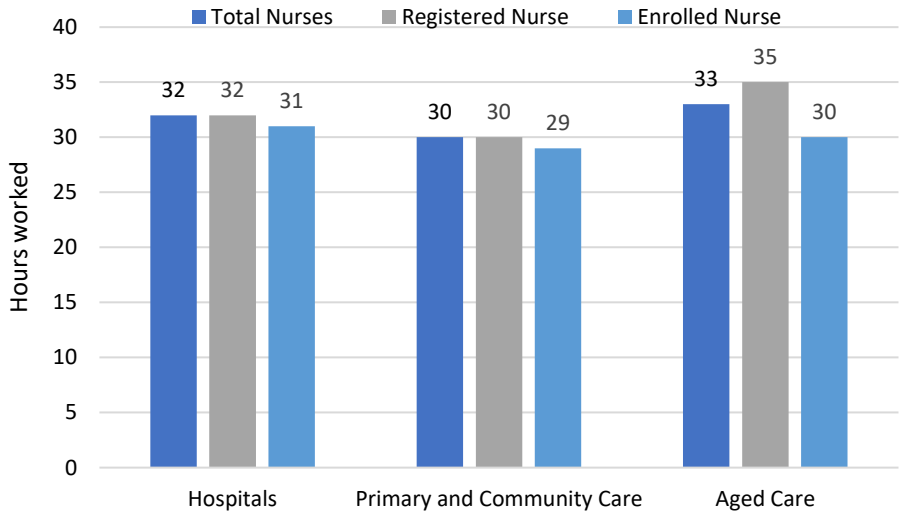
	Hospitals		Primary and Community Care		Aged Care	
	Number	FTE	Number	FTE	Number	FTE
Total	6,401	5,451.9	1,383	1,096.8	1,186	1,051.5
Registered Nurse	5,389	4,618.8	1,168	931.4	763	708.4
Enrolled Nurse	1,012	833.1	215	165.4	423	343.1

Source: HeaDS UPP, 2021-2022

Registered nurses make up 64% of the nursing workforce in aged care, whereas registered nurses account for 84% of nurses in hospitals and primary and community care.

The high demand for registered nurses working in aged care is further demonstrated in Figure 15, which shows that on average, registered nurses in aged care work five hours more each week than registered nurses in primary and community care, and 3 hours more than registered nurses in hospitals.

Figure 15. Average weekly hours worked of nurses in hospitals, primary and community care and aged care, Gold Coast, 2021-22



Source: HeaDS UPP, 2021-2022

Wound management in RACF

Chronic wounds represent a major health burden in RACFs, with residents often entering RACFs with one or more chronic conditions and complex wounds[42]. The elderly in general are at an increased risk of impaired skin integrity due to age related changes to the skin, frailty, malnutrition, incontinence, immobility, and impaired cognition[43].

[42] Jaul, E, et al. An overview of co-morbidities and the development of pressure ulcers among older adults. BMC Geriatrics. 2018. 18, 305.
[43] Pagan, M, et al. Wound programmes in residential aged care: a systematic review. Wound Practice and Research. 2015. 23, 2. 52-60.

In 2021-22, 140 Gold Coast RACF residents presented to Gold Coast public hospitals ED for diseases of the skin and subcutaneous tissue. In total, 140 of 6,243 RACF ED presentations (2.2%) of were for diseases of the skin and subcutaneous tissue[44]. Their departure status was:

- 50.0% (n=70) admitted (excluding ED bed),
- 32.8% (n=46) short stay unit,
- 17.1% (n=24) discharged ED service completed.

GCPHN piloted a wound management service in 55 RACFs during 2021-22 which saw 111 unique people accessing the service. The pilot wound management in RACF service aimed to meet the gap in service delivery for older people with chronic and complex wounds who are living in RACFs. This is achieved through a nurse led, in reach program that provides access to specialist wound advice and mentoring to support the effective assessment, care plan development and management for these patients in their usual place of residence, thus reducing the requirement to transfer resident to hospital for additional clinical interventions. Benefits of the pilot include:

- Reduce potentially preventable hospitalisations,
- Improve access to specialist wound care services,
- Build capacity of RACF staff when caring for residents with wounds,
- Improve knowledge, skills and confidence of RACF staff, and
- Enhance intersectional collaboration and coordination.

Most common wound types indicated by the provider in the 55 RACFs include pressure injuries, skin tears, lower limb ulcers, cancerous wounds. Of the 111 individuals who accessed the service, 97% were aged 70 years and their mobility status were the following:

- Non -ambulatory: 43%
- Uses mobility aid: 37%
- Unknown: 14%
- Ambulatory: 5%

GP attendances in RACF

General Practitioners (GPs) are key providers of medical care to people living in RACF, with the type of care differing significantly from that provided in the consultation room. It is well recognised that specific education and training is required to work effectively in the RACF setting, including knowledge and skill development in managing common clinical syndromes, multimorbidity and deprescribing, multidisciplinary care, palliative care and medicolegal issues.

Table 20 highlights the number of GP attendances per RACF patient on the Gold Coast and nationally. As can be seen, Gold Coast has a higher number of GP attendances per RACF patient compared to the national rate. The number of GP RACF attendances increased from 122,830 in 2016-17 to 144,574 in 2020-21 (17.7% increase).

[44] Gold Coast Health, Emergency Department presentations, 2021-22.

Table 20. GP attendances in residential aged care facilities, national AND Gold Coast, 2020–21

Region	GP attendances per residential aged care patient	Number of GP residential aged care attendances	Number of GP residential aged care patients
National	17.8	4,767,988	268,520
Gold Coast	21.6	144,574	6,698

Source: Medicare-subsidised GP, allied health, and specialist health care across local areas: 2016-17 to 2020–21, Australian Institute of Health and Welfare

Mental health services in RACF

RACF residents have very high rates of mental illness, with estimates that approximately 39% of all permanent aged care residents are living with mild to moderate depression[45].

One of the biggest issues facing residents is difficulty adjusting to the changes that a move into aged care can bring. Many people experience a great sense of loss because of this. If untreated, this can lead to more serious mental health issues.

GCPHN has commissioned a service to provide the psychological services in RACFs. The service objective is to build capacity of RACF and their staff through education, training, and liaison to enable:

- early identification, response, and referral,
- support to attend therapy, undertake self-help and follow interventions, and
- provide an environment and lifestyle options to support mental wellbeing.

For this initiative, the definition of mental illness is consistent with that applied to MBS Better Access items. This means that dementia and delirium are not regarded as mental illness. This is because these conditions require medical and/or other specialised support which is not within scope of this initiative. People with dementia are not excluded from treatment if they also have a comorbid mental illness such as anxiety or depression.

From July 2020 to March 2021, over 400 unique residents had been referred to or were accessing psychological services on the Gold Coast, accounting for over 1,500 service contacts. There has been an increase in referrals for social isolation and loneliness to the psychological services program in RACFs in 2020-21. There have been recent cases where residents have been referred for hopelessness and depression, with main causes for hopelessness identified as being related to:

- enduring power of attorney issues,
- public guardians being unresponsive,
- family members misappropriating finances,
- slow response from advocacy groups,

[45] Australian Institute of Health and Welfare 2015. Australia's welfare 2015. Australia's welfare series no. 12. Cat. no. AUS 189. Canberra: AIHW

Dementia

What is dementia?

Dementia is a term used to describe a group of conditions characterised by the gradual impairment of brain function. It is commonly associated with memory loss, but can affect speech, cognition, behavior, and mobility.

Dementia presents in many ways with its most common form being Alzheimer's, a degenerative brain disease, caused by nerve cell death and resulting in the shrinking of the brain. Multiple forms of dementia can also be present at once, known as 'mixed dementia'[46].

Who is impacted?

The likelihood of the onset of dementia increases with age, however it can also develop in those under the age of 65. This is known as younger or early onset dementia. Children can also develop childhood dementia. Dementia and each of its forms, although common, should not be described as a normal part of ageing. As dementia progresses, cognitive function declines and thus dependency on carers and care providers increases dramatically. Currently, there is no cure for dementia, however there are strategies in use to aid individuals and their families to improve independence and quality of life for as long as possible.

What factors increase the risk of dementia?

Many factors have been found which contribute to the development of dementia and may affect symptoms and their progression. Risk factors such as age, genetics and family history cannot be changed, however there are many modifiable lifestyle factors which can prevent or delay dementia, such as education, physical and social activity, smoking status, obesity, high blood pressure, hearing loss, depression, high blood plasma glucose, impaired kidney function and diabetes[47].

What is the impact on the Gold Coast?

Dementia has become a significant health and aged care issue in Australia, causing a multitude of burdens on the individual, their family, and support systems. It is now the second leading cause of death of Australians and the leading cause of death for Australian women[48].

The AIHW recorded that a total of 9,044 people residing in the Gold Coast area reported having dementia, with more women (60%) than men (40%). It is estimated in 2050, 30,633 people will be living with dementia on the Gold Coast[49]. This will be a 195%% increase from the number of people living with dementia in 2020.

Table 21 shows the number of people living in the GCPHN region living with dementia grouped into Statistical Area Level three regions (SA3).

[46] Australian Institute of Health and Welfare 2022. Dementia in Australia.
47 Livingston G, Sommerlad A, Orgeta V, Costafreda SG, Huntley J, Ames D et al. (2017) 'Dementia prevention, intervention, and care'. *The Lancet*, 390:2673–2734.
48 Australian Institute of Health and Welfare 2021. Dementia in Australia Cat no. DEM 2 Canberra: AIHW.
49 Projections of dementia prevalence and incidence in Queensland 2011-2050, Alzheimer's Australia Qld

Table 21. Gold Coast population living with dementia, Gold Coast SA3 regions, 2020

SA3 Region	Males	Females	Persons	Proportion
Broadbeach Burleigh	452	834	1287	13.9%
Coolangatta	420	741	1161	12.6%
Gold Coast-North	573	1008	1582	17.1%
Gold Coast Hinterland	135	175	309	3.3%
Mudgeeraba-Tallebudgera	171	236	406	4.4%
Nerang	394	650	1043	11.3%
Ormeau-Oxenford	327	459	785	8.5%
Robina	306	555	859	9.3%
Southport	360	724	1083	11.7%
Surfers Paradise	283	431	714	7.7%

Source: Australian Institute of Health and Welfare 2022. Dementia in Australia.

Hospitalisations due to dementia

In 2015-16, there were 436 overnight hospitalisations relating to dementia in the Gold Coast region, with an average length of hospital stay of 12 days. Combined, this accounted for a total of 5,232 hospital bed days. The age-standardised rate for the Gold Coast region is 6 per 10,000 people, ranking as 13th highest out of all 31 regions. The number of dementia related hospitalisations in the region has increased by over 24% in the last three available reporting years (Table 23).

Table 22. Overnight hospitalisations for dementia, Gold Coast SA3 region, 2013-14 to 2015-16

Region	Number of hospitalisations			Rate of hospitalisations per 10,000 people, 2015-16	Rate of bed days per 10,000 people, 2015-16
	2013-14	2014-15	2015–16		
Australia	-	-	-	6	93
Gold Coast SA4	351	373	436	6	74
Broadbeach - Burleigh	45	37	49	5	65
Coolangatta	24	47	51	6	64
Gold Coast - North	68	56	84	7	96
Gold Coast Hinterland	9	13	8	NP	NP
Mudgeeraba - Tallebudgera	17	19	12	NP	NP
Nerang	27	26	48	7	64
Ormeau - Oxenford	38	45	50	6	63
Robina	41	58	47	7	74
Southport	55	46	72	10	134
Surfers Paradise	27	26	15	NP	NP

Source: www.myhealthycommunities.gov.au (Note – NP: not publishable)

ED presentations due to dementia

Dementia is highly prevalent among older patients presenting to ED, recorded in between 26% and 40% of all ED presentations in this age group[50].

In 2019-20, there were 438 dementia presentations to Gold Coast and Robina Hospital. Of these presentations, 20%were lower urgency care (triage category 4 and 5).

There is evidence that older ED patients with cognitive impairment are at increased risk of negative events and health outcomes, including ED re-presentation and hospitalisation[51]. When caring for older persons in ED it is important to understand neurological presentations and to be able to differentiate between delirium and chronic cognitive impairment such as dementia. Older persons with dementia are also at high risk of undertreatment of pain, and frequently receive fewer analgesics than others of similar age and pathology[52].

Deaths due to dementia

Dementia was the second leading cause of death on the Gold Coast in 2015-19, accounting for 1,697[53] deaths. In females, dementia was leading cause of death in 2019 (1,065 deaths), and for males, it was the second leading cause (632 deaths).

Dementia in the community

Based on the AIHW estimates, in 2021, there were an estimated 246,200 people (93,000 men and 153,200 women) with dementia living in the community, rather than in a cared accommodation. This equates to 65% of all people with dementia living in the community.

Applying the above proportion to the Gold Coast population indicates that 5,878 people are living with dementia in the community.

As people with dementia age, they are more likely to move into residential aged care homes and so the proportion living in the community decreases with increasing age. Most people with younger onset dementia (aged less than 65) are living in the community (20,300 people or 91%). Among the older age groups, just under half of people with dementia live in the community (32,100 people or 48% of people with dementia aged 85–89, and 41,600 people or 46% of people aged 90 and over). This decrease is more substantial among women than men.

According to the 2018 Survey of Disability, Ageing and Carers (SDAC), of the people with dementia who lived in the community, 86% lived in private dwellings with other people, while 14% lived alone. Men were more likely to have been living with other people (91%) than women (81%).

Dementia-specific medications

Although there is no cure for dementia, there are four medicines that may alleviate symptoms: Donepezil, Galantamine and Rivastigmine are approved in Australia for the treatment of mild to moderate Alzheimer's disease, and Memantine is approved in Australia for the treatment of moderately severe to severe Alzheimer's disease. These medications are subsidised through the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme.

[50] Hustey, F.M. and S.W. Meldon, The prevalence and documentation of impaired mental status in elderly emergency department patients. Annals of emergency medicine, 2002. 39(3): p. 248-253.
[51] Meldon, S.W., et al., A brief risk-stratification tool to predict repeat emergency department visits and hospitalizations in older patients discharged from the emergency department. Acad Emerg Med, 2003. 10(3): p. 224-32
[52] https://clinicalexcellence.qld.gov.au/sites/default/files/docs/priority-area/service-improvement/care-of-older-person-emergency.pdf
[53] Mortality over Regions and Time books. Statistical Area Level 4, 2014-18, Australian Institute of Health and Welfare

In 2019–20, there were over 623,000 prescriptions dispensed for dementia-specific medications to just under 64,600 Australians with dementia aged 30 and over. There was a 43% increase in scripts dispensed for dementia-specific medications between 2012–13 and 2019–20. In 2019–20, antipsychotic medications were dispensed to about one-fifth (21%) of the 64,600 people who had scripts dispensed for dementia-specific medication[54].

Of the 159 Gold Coast practices who submit data through Primary Sense, 3,965 patients aged 65 years and over were diagnosed with dementia. Of these, 1,015 (25.6%) had been prescribed dementia medication in the last 24 months[55].

Residential Aged Care Facilities (RACF)

RACF are an important resource for people with dementia and their carers. Services include those provided in the community for people living at home (home support and home care), and residential aged care services for those requiring permanent care or short-term respite stays. In the GCPHN region, 53.3% of people using permanent residential care in 2020 had a diagnosis of dementia[56].

People with dementia typically have longer median lengths of stay at RACF. In 2020–21, the median length of stay in permanent residential care was over eight months longer for people with dementia than for people without a record of dementia. The difference in length of stay between people with dementia and without dementia was 10 months for women and over 6 months for men[57].

Among people with dementia in Australia, one in three people live in cared accommodation. In 2019–20, there were over 244,000 people living in permanent residential aged care, and more than half (54% or about 132,000) of these people had dementia. In Queensland, there were 25, 377 people with dementia who were living in permanent residential aged care in 2019–20[58].

MBS services by people with dementia

GPs and other medical specialists play a crucial role in the diagnosis of dementia. It is not diagnosable by one single test, as it requires a combination of comprehensive cognitive and medical assessments. If dementia is suspected by a GP, the patient is then referred to specialist services such as geriatrics or memory clinics.

Service usage differ for those people with dementia who live in permanent residential aged care compared with those living in the community, but only at older ages. As seen in Table 24, for people with dementia aged under 80, the number of services used by people who were living in residential aged care was similar to the number of services used by people who were living in the community. From age 80 onwards, the number of services used by people with dementia living in residential aged care was greater than the number used by similarly aged people with dementia living in the community.

[54] Dementia in Australia, Prescriptions dispensed for dementia-specific medications—data tables, 2021, Australian Institute of Health and Welfare.
[55] Primary Sense is a clinical decision support, population health management and data extraction tool, developed by GCPHN.
[56] Gen Aged Care Data, 2021
[57] Australian Institute of Health and Welfare 2022. GEN fact sheet 2020–21: People leaving aged care. Canberra: AIHW
[58] Dementia in Australia – aged care services, 2021, Australian Institute of Health and Welfare

Table 23. MBS services used by people with dementia, by age and place of residence, 2016-17

Age (years)	Living in residential aged care		Living in the community	
	MBS services - number	MBS services – rate per 1,000 people	MBS services - number	MBS services – rate per 1,000 people
30–64	90,086	1	120,919	1
65–69	111,167	4	124,360	5
70–74	236,844	9	257,917	10
75–79	426,877	20	440,610	20
80–84	719,495	45	523,212	32
85–89	926,581	91	402,169	40
90–94	554,297	162	119,642	35
95+	168,288	241	17,817	26
Total	3,233,635	13	2,006,646	8

Source: AIHW analysis of National Integrated Health Services Analysis Asset version 0.5.

The rate of services used by people with dementia living in residential aged care increases with age — from 45 services per 1,000 people among those ages 80–84 to 241 services per 1,000 people among those aged 95 or over[59]. This is likely due to the increasing number of co-existing health conditions and more complex health needs as people age.

Carers

The level of care required for people with dementia depends upon individual circumstances, but likely increases as dementia progresses. Carers are often family members or friends of people with dementia who provide ongoing, informal assistance with daily activities.

The AIHW estimates that in 2021, there were between 134,900 and 337,200 informal primary carers of people with dementia. Among primary carers of people with dementia, three in four were female and one in two were caring for their partner with dementia.

Caring can be physically, mentally, emotionally, and economically demanding. Caring full-time can leave family members feeling socially isolated and having to meet hidden costs. The negative psychological and physical health consequences of looking after a loved one with dementia are well documented[60].

According to the Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) 2018, among carers of people with dementia:

- One in two provided an average of 60 or more hours of care per week.
- Three in four reported one or more physical or emotional impacts of the role.
- One in four reported that they needed more respite care to support them.

[59] Dementia in Australia, GP, specialist and other healthcare services—data tables, 2021, Australian Institute of Health and Welfare

[60] Sara Tookey, Caroline V. Greaves, Jonathan D. Rohrer, Roopal Desai, Joshua Stott, 2022: Exploring experiences and needs of spousal carers of people with behavioural variant frontotemporal dementia (bvFTD) including those with familial FTD (fFTD): a qualitative study, 22, 1

- One in two experienced financial impacts since taking on the role[61].

In 2017, there were an estimated 94,672 paid carers looking after people with dementia in the residential aged care setting, and 196,491 carers of people with dementia in the community, the majority of whom are informal carers.

The projections suggest that by 2036, some 362,930 carers will be needed in the community and 173,225 carers working in the paid cared accommodation sector. The need for carers for people with dementia is expected to double by 2056 to around 525,540 carers in the community and 250,420 paid carers in residential aged care if current levels of care are to be maintained[62].

[61] Dementia in Australia – Carers, 2021, Australian Institute of Health and Welfare

[62] Laurie Brown, Erick Hansnata and Hai Anh La, Economic Cost of Dementia in Australia 2016-2056, NATSEM at the Institute for Governance and Policy Analysis, University of Canberra.

Service system

Services	Number in the GCPHN region	Distribution	Capacity discussion
General practices	212	Clinics are generally well spread across Gold Coast; majority in coastal and central areas	• GP services include preparation of chronic disease management plans, team care arrangements, medication prescribing and management, health checks and plan review.
General practitioners	855 GPs supported by 619 non-GP staff working in general practice (e.g., nurses and allied health staff)	Clinics are generally well spread across Gold Coast; majority in coastal and central areas	• GPs deliver continuity of care for older adults and use their clinical judgements to make decisions about the most appropriate care for the individual. Roles carried out by GPs generally include: ○ recognition and management of health conditions, ○ assessment of functional capacity of the individual, ○ recognition of their accommodation and care needs, ○ identification of the impacts on family and carers and associated needs for respite care. • GPs' role in the requirement for and facilitation of ACP is critical due to their ongoing and trusted relationships with patients. In the GCPHN region, GPs provide services for older adults in general practices, at an individual's private residence and into RACFs.
Residential aged care facilities	56	Residential Aged Care Facilities are spread from Ormeau to Coolangatta	• The RACFs range from capacity of 36 to 167 bed facilities, providing differing levels of care and services across general aged care, palliative, respite, and dementia care.
Aged care services	Residential Care: 56 Home Care: 46 Home Support: 56		• Eligibility is based on factors like individual's health, how they are managing at home, and any support they currently receive. Individuals may be eligible for aged care services if they have: • noticed a change in what they can do or remember, • been diagnosed with a medical condition or reduced mobility,

			• experienced a change in family care arrangements, • experienced a recent fall or hospital admission, or are • 65 years or older (50 years for Aboriginal or Torres Strait Islander people)
Medical deputising services	4	Service GCPHN region	• The National Association for Medical Deputising includes several services that offer after-hours care in in the GCPHN region.

Allied health services	419 services with 1,230 workers	Services are generally well spread across Gold Coast; majority in coastal and central areas	• Many different allied health groups contribute to the care of older adults on the Gold Coast, both individually and as part of multidisciplinary care teams.
			• Allied health can be provided in a community or hospital setting and range from dieticians, physiotherapists, occupational therapists, pharmacists, podiatrists, psychologists, and social workers.
			• Allied health plays a key role in care for older adults by providing:
			  ○ Interventions to promote healthy ageing and reduce the impact of chronic conditions and disabilities,
			  ○ Rehabilitative care to support people to regain function and strength after serious injury or an illness such as a stroke,
			  ○ Strategies to support people to live independently in their own home,
			  ○ Care co-ordination to assist people navigate the aged care system and make choices that are best for them.
			• In addition to allied health, counsellors and pastoral care workers can provide a range of support to RACF residents.

Specialist practices	236 services with 664 workers	Services are generally well spread across Gold Coast; majority in coastal and central areas	• Many different specialists contribute to the care of older adults on the Gold Coast. • Specialist can range from cardiology, psychiatry, and oncology etc.

Hospital and Health Service (Gold Coast Health)	2 public Hospitals at Southport and Robina and Helensvale Community Health Centre and Palm Beach Community Health Centre 3 private Hospitals at Southport, Tugun and Benowa		• Aged Care Assessment Teams at Gold Coast University Hospital (GCUH) at Southport, Robina Hospital, Helensvale Community Health Centre, and Palm Beach Community Health Centre. • Specialist palliative care in an inpatient and community setting. • Older Persons Mental Health Unit at Robina Hospital: 16 inpatient beds and community outreach. • Complex Needs Assessment Panel (CNAP) 65+ providing coordination of care and services to support older adults with complex mental health needs. • Geriatric Evaluation and Management in the Home located at GCUH. • Bereavement services at Robina Hospital and GCUH.
Residential Aged Care Facility (RACF) Acute Support Service (RaSS)	Available seven days a week from 7.30am until 6pm to support RACF residents, staff, and GPs		• Clinical advice is also available via phone and by virtual options including Microsoft Teams, Skype, Telehealth and FaceTime. • The RaSS team provides support for residents who present to ED or are admitted to hospital. • The RaSS team liaise with treating hospital teams, GPs, RACF staff and will support coordination around discharge with an individualised plan for continuity of care including follow up phone calls post discharge to identify and address any concerns. • This service does not aim to replace or duplicate existing GP cover, but is a supplementary service providing a single point of contact for RACFs and GPs on behalf of Gold Coast Hospital and Health Service.
Non-Government organisations			• There are a range of not-for-profit providers who deliver after hours and in-home care. Services can include: • Home modification and maintenance • Cleaning • Personal care • Shopping

			• Social outings • Transportation to respite care • Palliative care and dementia care. • The cost of the individual's community care can often be supported through Commonwealth Home Support Program (CHSP) and Home Care Package (HCP), depending on the eligibility. Co-contributions are an expectation for individuals accessing CHSP and HCP, except in cases of hardship.
Queensland Advocacy Incorporated (QAI)	Office in South Brisbane, can be contacted through phone, fax, email, and post	South Brisbane	• QAI is an independent not-for-profit advocacy organisation and specialist community legal centre for people with disability. We are first and foremost a systems advocacy organisation focused on changing attitudes and policy to improve the lives of the most vulnerable people with disability. • Queensland Advocacy's mission is to promote, protect and defend, through advocacy, the fundamental needs and rights and lives of the most vulnerable people with disability in Queensland.
Aged and Disability Advocacy Australia (ADA Australia)	Office in Geebung, can be contacted through telephone, email, email, post and fax	Geebung	• Aged and Disability Advocacy Australia (ADA Australia) is a not-for-profit, independent, community-based advocacy and education service. • They support and improve the wellbeing of older adults and people with disability. • Services are free, confidential and client focused.

Consultation

Care Finder Stakeholder Survey (August 2022)

- GCPHN formulated an online structured interview survey with questions formulated to identify potential solutions to best address local needs, priorities for care finder supports, and identifying opportunities to enhance integration between health, aged care, and other systems relevant to the care finder program.
- The care finder program aims to provide specialist and intensive assistance to help people in the care finder target population to understand and access aged care and connect with other relevant supports in the community.
- This survey was distributed to 124 stakeholders. Organisations ranged from aged care and community care providers, local and state government bodies, peak bodies and local groups and networks including, religious, crisis support, LGBTIQ+, CALD, Forgotten Australians, and Aboriginal and Torres Strait Islander groups.
- 39 stakeholders completed the survey, identifying two main priorities:
    - people who are socially isolated and people who are, or at risk of homelessness were identified as the highest priority for the 'care finder program'.
    - Gold Coast North SA3, Southport SA3 and Ormeau-Oxenford SA3 identified as region with the highest priority for the 'care finder program'.
- Main challenges people experience in accessing and navigating the aged care system included:
    - computer literacy and access to internet,
    - fear of not being able to stay in own home if engaged with aged care services,
    - trust issues with engaging with the aged care system,
    - low literacy levels, and
    - mental health issues.
- Biggest frustration with interaction with aged care system in the last 12 months included:
    - My Aged Care is not an experience that many older people enjoy,
    - lack of consistent information and knowledge,
    - lack of residential aged care places on the Gold Coast for permanent and respite care,
    - lack of timely access to funding to support elderly patients to remain at home, and
    - low aged care staffing numbers.
- Areas of the aged care service system identified to be in the greatest need for improved integration included:
    - admission to aged care,
    - older people living at home with no family or support and limited knowledge on what they are entitled to,
    - a single assessment gateway for Commonwealth Home Support Program and Home Care and Residential Care is urgently needed.

Joint Regional Plan Mental Health, Suicide Prevention, Alcohol and Other Drug Services

- Gold Coast Primary Health Network (GCPHN) and Gold Coast Health jointly led the development of the Joint Regional Plan.
- This Joint Regional Plan is a foundational plan for the GCPHN region. As such, it aims to set out the agreed way forward for improved collaboration and integration between mental health, suicide prevention, alcohol, and other drugs services in the GCPHN region.
- The process brought together cross-sectoral and community stakeholders to develop, agree and document a shared understanding of the issues our region faces, a shared vision for the future, and a roadmap for change.
- The Joint Regional Plan took a person-centred approach to consultation because we understand that whilst there are unique elements to mental health, suicide prevention, alcohol, and other drugs, and Aboriginal and Torres Strait Islander social and emotional wellbeing, many of the issues people face are interrelated and multifactorial.
- Current state and identified gaps:
    - mental health and aged care related issues (e.g., dementia) are often treated in isolation of each other or as separate disciplines,
    - limited access to assessment and treatment by public sector geriatricians to patients in the community,
    - gaps in clinical resources, knowledge and supports in the community result in people referring to Older Person's Mental Health unit (tertiary service) as a default option or last resort,
    - isolation and loneliness can have a significant impact on people's mental and physical health. The growing and changing population of the Gold Coast has resulted in loss of connection and sense of community that can be natural or informal support systems. The Gold Coast has more older adults living alone than in other Southeast Queensland regions. This combined with high levels of older adults moving to the Gold Coast in their later years, who may lack informal care and support networks, raises concerns of social isolation among older adults and potentially limited ability to access services without support. Proactive engagement can prevent further social isolation and loneliness, however activities in the community that support inclusion/connection may not be targeted or inclusive of older adults and their needs.

Dementia survey (September 2022)

During September 2022, GCPHN conducted a community facing survey for Gold Coast residents. Key issues and themes that were raised included:

- There is lack of confidence in general practitioners to be able to provide a dementia diagnosis.
- A need for more capability in ongoing management and follow up post dementia diagnosis.
- There needs to be better access to resources for those diagnosed with dementia and their carers would be beneficial to make the current services more visible.
- Not enough supports for dementia patients and their carers unless they have access to private healthcare funds.

Primary Care Partnership Council (July 2021)

Gold Coast PHN utilised the Primary Care Partnership Council as an engagement mechanism (face to face) to discuss emerging issues relating to unplanned hospital care in the GCPHN region. Key issues and themes raised included:

- Can't get GPs to service RACF after hours.
- Demand increased and after-hours GP are less available, fully booked because all community are now utilising.
- RACFs need clarity around when GP will arrive because if calling at night it is urgent.
- Not having timely access to GP after hours in RACF has led to increase in hospitalisation.
- Social isolation due to covid and language issues.

GCPHN Clinical Council (June and August 2018)

GCPHN undertook engagement with their Clinical Council to explore inefficiencies and opportunities within the aged care sector. The qualitative data is summarised under two main domains:

- Medications
    - access to some medications can be problematic if stocks are low
    - medication dispensed days ahead, problematic if GP recently changed medication
        - this causes issues with wastage of medications
    - some corporate pharmacies request backdated scripts, which is illegal for a GP
    - medication can often be prescribed on admission, however reviews can be overlooked
- Staffing
    - high staff turnover and limited expertise in palliative care
    - number and experience of staff – high likelihood of transfer of resident to hospital
    - some RACFs can be 'unwelcoming' to visiting GPs
    - residents are often described in quote 'rosy terms' when in fact, their behaviour is worse
    - limited time to engage or upskill staff. Unsupported by facility when staff are required to deliver front line services

While these issues are not representative of all RACFs, this information identifies inconsistencies across the sector. The importance of understanding the size and scope of the private fee-for-service aged care environment was noted, acknowledging the challenges in sourcing data.

Anecdotally, it was reported that the Gold Coast has pockets of high socio-economic status with people willing to self-fund care to avoid wait lists and maintain choice. It was noted that the local context can change quickly, for example with financial crises leading to a greater number of older adults accessing publicly funded services who may have previously been self-funded. Alongside issues presented, there was a range of opportunities identified by the Clinical Council, including:

- Case conferencing between GPs and Hospital and Health Service (HHS) staff to work together on more complex cases such as dementia to avoid unnecessary hospital transfers.
- Networking across RACFs and GPs to ensure backup outside of the individual facility.
- Trialing new models of care in which a GP services RACFs in an area.

Community Advisory Council (March 2022)

Members of GCPHN Community Advisory Council (CAC) were asked to rate the clarity of the steps to take if they observed changes in a loved one and wanted to investigate and confirm if they had dementia. The scale was from 1-5 (1 = not clear at all, 5 = very clear). The average rating of clarity by CAC members was 3.

Information and resources to support people living with dementia and their families/carers were identified including talking with a GP and receiving an ACAT assessment, Dementia Australia's online resources, joining the Alzheimer's Association or a similar group, My Aged Care, and the NDIS. Asking for help and being proactive was a recurring theme in CAC discussions.

Suggested places to look to find information related to dementia, including resources and available support were discussed. Dementia Australia, particularly The Dementia Guide was mentioned as a helpful resource. Google searching for dementia and carer support groups such as the Alzheimer's Association was a recurring theme, however issues with older persons accessing online resources was argued. In response, the Dementia Australia National Hotline, and the Dementia Australia telephone book, which includes questions, where to access physical resources and contacts was deemed a helpful resource. Consequently, the request to have more physical dementia support resources in GPs, community centres, RACFs and pharmacies was raised.

Education and information which was considered helpful included a reference section or community display of resources for older people wanting current information on planning ahead e.g., enduring Power of Attorney documents, statements of choice. ACAT assessments being used as an opportunity to provide the right education was also discussed.

Additional information

- The Australian Medical Association (AMA) Aged Care Survey Report sought feedback on members' impressions and experiences of providing medical care to older adults. The survey presented some insights which need to be taken into consideration for the future planning of primary care services for older adults, particularly in RACFs and after-hours periods including:
    - Over a third of survey respondents reported an intention to decrease or stop attending RACFs in the coming two years, attributed to the considerable amount of paperwork involved, responding to faxes and phone calls, and discussing issues with RACF staff or relatives of residents. This was despite a reported increase in demand for RACF-visiting medical practitioners.
    - Respondents reported that in almost half of instances of GPs reducing the frequency of visits to RACFs in the last five years it was due to unpaid non-contact time, while a further 40% was due to practitioners being too busy in their general practices.

Palliative Care

Local health needs and service issues

- There is limited uptake of Advanced Care Plans.
- Limited systems to support care coordination and support to general practice to be the centre of care where possible.
- Current systems are not always supportive to ensure planning, commissioning, and delivery of integrated and coordinated service matrix.
- Limited access to integrated palliative care system across the health and social sector.
- Limited access to good quality end of life care 24/7.
- Limited access to clear communication, and accessible information for patients, families, and healthcare professionals.
- General practitioners understanding of the clinical triggers for commencing palliative care can vary.
- Over half of GPs on the Gold Coast were trained overseas which may affect their understanding of palliative care services.

Key findings

- National research shows that most Australians would prefer to die at home, but many don't, with over half of deaths occurring in a hospital. While the accessibility and use of palliative care services is increasing, the proportion of people who receive palliative care services is still relatively low, particularly for non-cancer related diagnoses.
- At a national level, patient outcomes show that the effectiveness of palliative care services has increased significantly over the last 10 years in relation to symptoms such as pain, fatigue, breathing problems and family or carer problems.
- Data on patient outcomes for palliative care services in the Gold Coast Primary Health Network (GCPHN) region is still emerging. Early indicators show that the effectiveness of inpatient treatment exceeds national benchmarks, however treatment delivered in a community setting did not meet benchmarks due to the limited availability of these services to provide treatment on demand at all times of the day.
- The demand on palliative care and specialist palliative care services is projected to increase in the GCPHN region, with its ageing population and higher proportion of older people. Currently, the majority of the specialist palliative care service demand falls to the specialist public inpatient and community facilities at Robina Hospital and Gold Coast University Hospital.
- Consultation highlighted a range of issues that may be impacting the effectiveness of generalist palliative care services to meet the needs of people, which would enable specialist services to focus their limited resources more appropriately on more complex cases.
- These issues include clinical handover and discharge planning to support transitions between the hospital and home (including RACFs). Continued integration and coordination of specialist and generalist palliative care services could lead to more positive patient outcomes. A desire for GPs to play a central role throughout a person's palliative care journey was reported from multiple perspectives. More broadly, community and sector consultation confirmed issues on the Gold Coast with:

- Service access and navigation,
- Limited health and death literacy,
- Workforce capacity and capability for generalist services,
- Service availability and resourcing,
- Professionals feeling supported and able to learn and to care,
- People want to receive care in their homes and local communities as much as possible,
- People want information that supports them to be partners in decisions about their care,
- People need end of life and palliative care that responds to an ageing population,
- People are sicker and require palliative care that can be provided alongside other treatments that respond to their complex care needs,
- Many people with chronic or life-limiting illnesses (including some cancers) are living for much longer, requiring a different response from end of life and healthcare services,
- Some groups in our community do not access services for end-of-life care or get the care they need,
- The healthcare, human services and community workforce needs to adapt with new skills to better identify and support the end of life needs of people, their families, and carers,
- All services need to operate more efficiently to deliver care that is sustainable, and
- Community expectations have increased, with growing interest in discussing death and dying and planning for end of life with a method such as advance care planning.

Palliative Care

The Australian Commission on Safety and Quality in Healthcare (ACSQHC) defines palliative care as care specifically tailored to assist with the effects of life-limiting illnesses[1]. It positions palliative care as different from the broader concept of end-of-life care which generally refers to the period of the 12 months prior to death, whereas palliative care may be episodic over an extended period.

Palliative care is an approach to treatment that improves the quality of life for patients and their families facing life-limiting illness, through the prevention and relief of suffering. It involves early identification, impeccable assessment and treatment of pain and other problems (physical, psychosocial, and spiritual).

Palliative care is now provided in almost all settings where healthcare is provided, including neonatal units, paediatric services, general practices, acute hospitals and residential and community aged care services.

Specialist palliative care services are comprised of multidisciplinary teams with specialised skills, competencies, experience, and training to deliver care to people where the palliative needs are complex and persistent. Specialist palliative care services operate from a variety of settings, including specialist inpatient consulting services, specialist inpatient settings, hospices, and community-based specialist services[2].

The Australian Government established the Royal Commission into Aged Care Quality and Safety in October 2018, which received various submissions on palliative care within the aged care sector. The Commission's final report was released on 26 February 2021. Key recommendations for palliative care included:

- Compulsory palliative care training for aged care workers,

[1] Australian Commission on Safety and Quality in Health Care (2015). National Consensus Statement: essential elements for safe and high-quality end-of-life care

[2] DoH (Department of Health) 2019. National Palliative Care Strategy 2018. Canberra: Department of Health. Viewed 9 July 2020. This data set is a component of the minimum data set.

- Comprehensive sector funding specifically including palliative care and end-of-life care,
- A review of the Aged Care Quality Standards to regulate high quality palliative care in residential aged care,
- Access to multidisciplinary outreach service, and
- A new Aged Care Act that includes the right to access palliative care and end-of-life care

Service demand

On the Gold Coast and more broadly in Australia, the demand for palliative care services is increasing due to the ageing of the population and the increases in the prevalence of cancer and other chronic disease that accompany aging.

There were 4,038 deaths recorded for the GCPHN region in 2021. The number of deaths recorded in the GCPHN region has increased from 3,558 in 2015, an increase of 12% in the 7-year period.

The ten leading causes of death for the GCPHN region over the period 2015-2019 which accounted for 50% of all deaths are outlined in Table 1.

Table 1. Ten leading causes of death for Gold Coast PHN region by number and proportion of all-cause mortality, 2015-2019

Cause of death (ICD classification)	Number of deaths	Proportion of all causes
Coronary heart disease (I20–I25)	2,203	11.8%
Dementia including Alzheimer disease (F01, F03, G30)	1,697	9.1%
Cerebrovascular disease (I60–I69)	1,208	6.5%
Lung cancer (C33, C34)	1,088	5.8%
Chronic obstructive pulmonary disease (COPD) (J40–J44)	788	4.2%
Colorectal cancer (C18–C20, C26.0)	663	3.6%
Prostate cancer (C61)	481	2.6%
Suicide (X60–X84, Y87.0)	447	2.4%
Diabetes (E10–E14)	419	2.2%
Pancreatic cancer (C25)	387	2.1%

Source: AIHW (Australian Institute of Health and Welfare) 2021. MORT (Mortality Over Regions and Time) books: Primary Health Network (PHN), 2015–2019.

Service utilisation

Accessibility and appropriate utilisation of high-quality palliative care services can enable a person and their family to receive the care and support they need at the end-of-life, supporting them to die at home with dignity and in comfort and prevent unnecessary hospitalisations. Previous estimates indicate that 70% of Australians wish to die at home[3] , however around half of all deaths occur in hospital.

Palliative care services in Australia are provided in a range of settings including:

- public and private hospital facilities,
- residential aged care facilities, and

[3] Swerissen, H and Duckett, S., (2014). Dying Well. Grattan Institute: Melbourne

- in patients homes through primary care providers.

The availability of data relating to palliative care services is limited, particularly comprehensive data relating to palliative care services delivered in the community by GPs, non-palliative medicine specialists and allied health and ancillary practitioners. The AIHW has reported it is exploring the development of a mechanism to collect national data on palliative care activity in general practice.

Admitted patient palliative care and other end-of-life care and hospital-based facilities

This section presents information on episodes of admitted patient (patients who undergo a hospital's formal admission process to receive treatment and/or care) palliative care and other end-of-life care occurring in Australian hospitals.

In this section, palliative care-related hospitalisations are separated into two groups:

- Palliative care hospitalisations: hospitalisations that involved specialist palliative care. This was evidenced by a code of Palliative care for the 'Care type'.
- Other end-of-life care hospitalisations: hospitalisations where a diagnosis of palliative care was provided but the palliative care was not necessarily delivered by a palliative care specialist. This was evidenced by an additional diagnosis of palliative care, but where the 'Care type' was not Palliative care.

Key points identified nationally from the admitted patient palliative care and other end-of-life care and hospital-based facilities:

- 83,430 palliative care-related hospitalisations were reported from public acute and private hospitals in Australia in 2018–19; 57.3% were for palliative care, and 42.7% were for other end-of-life care.
- 53.6% of palliative care hospitalisations and 54.2% of other end-of-life care hospitalisations were for people aged 75 and over.
- 17.7% increase in palliative care hospitalisations and 47.5% increase in other end-of-life care hospitalisations between 2014–15 and 2018–19, compared to a 13.7% increase in hospitalisations for all reasons over the same period.
- 38.4% of all hospitalisations in which the patient died, the patient had received palliative care in 2018–19; 18.6% had received other end-of-life care.
- 53.6% of palliative care and 33.9% of other end-of-life care hospitalisations involved cancer as the principal diagnosis in 2018–19.
- 110 public acute hospitals reported that they had a hospice care unit in 2018–19, with just over a quarter located in both New South Wales (27.3%) and Western Australia (27.3%).
- 1 in 6 (16.4%) public acute hospitals (excluding public psychiatric hospitals) in Australia had a hospice care unit in 2018–19. Hospices don't exist in publicly funded hospitals any more in 95% of Australian hospitals'

Diagnosis

About half of all palliative care (53.6%) and one third of other end-of-life care (33.9%) hospitalisations recorded a principal diagnosis of cancer in 2018-19. The most frequently reported principal diagnoses other than cancer for palliative care hospitalisations were cerebrovascular disease and heart failure and complications (4.3% and 3.1%, respectively). For other end-of-life care, the most frequently reported

principal diagnoses other than cancer were septicaemia and other ill-defined causes (4.9% and 4.8%, respectively).

Table 2 shows the change in Gold Coast Health palliative care-related hospital separations and associated bed days over the period 2014-15 to 2020-21.

Table 2. Number of palliative care-related separations and occupied bed days in Gold Coast Health facilities, 2014-15 to 2020-21

Age group (years)	Financial year						
	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Separations							
0-14	0	<5	0	0	<5	0	0
15-44	41	43	57	27	30	34	22
45-69	334	298	299	320	322	352	283
70-84	420	342	336	322	476	506	457
85+	157	160	163	150	231	269	260
Bed days							
0-14	0	6	0	82	65	0	0
15-44	313	395	476	228	269	249	157
45-69	2,536	2,516	2,166	2,542	2,335	2,576	2,130
70-84	3,184	2,627	2,406	2,544	2,868	3,068	3,101
85+	1,060	1,086	938	866	912	1322	1,308

Source: Gold Coast Hospital and Health Service, Strategy and Health Service Planning Branch

A total of 1,002 palliative care-related separations occurred in 2020-21, which represented a total of 6,696 occupied bed days. The most separations were recorded for the 70-84 year age group. There is a lack of funding for people under 65 years of age as they not eligible for palliative care packages. The only option is to self-fund at the moment. While Gold Coast Health have been able to fund a small number, this is reducing their budget for service delivery.

Hospital-based facilities

A specialist palliative care inpatient unit is a specialist unit delivering palliative care services and can include both free-standing facilities and wards within a hospital. In 2018-19, a total of 110 public acute hospitals nationally reported having a hospice care specialist palliative care inpatient unit. In Australia, just over a quarter (27.3%) of hospitals with a specialist palliative care inpatient unit were in each of New South Wales and Western Australia, with 11 in Queensland as of 2018-19.

Palliative care delivered in primary care and community settings

There is currently no nationally consistent, routinely collected primary healthcare data collection that enables reporting on the provision of palliative care by GPs. Additionally, while the Medicare Benefits Schedule includes specific items for palliative medicine specialist services (delivered by palliative medicine specialists) for which a proportion of the MBS fee is reimbursed, there are no palliative care-specific item that can be used by GPs or other medical specialist who may be providing palliative care. It is likely that GPs

use other MBS items, for example, those for chronic disease management and home visit items, when providing patients with palliative care. Therefore, the number of palliative care-related services delivered by GPs cannot be established from existing Medicare data.

BEACH survey data

Palliative care related encounters provided by GPs using data from the Bettering the Evaluation and care of health (BEACH) survey of general practice activity which was conducted for the last time in 2015-16. The national findings included:

- About 1 in 1,000 GP encounters were palliative care-related.
- About 9 in 10 palliative care encounters were with people aged 65 and over, and 4.8% were with those aged under 55.
- Females accounted for a greater proportion of GP palliative care-related encounters (53%) than males (47%), but there was no difference between the sexes in palliative care encounter rates (about 1 per 1,000 of GP encounters for both males and females).
- 1.3% of palliative care-related encounters were with Indigenous Australians[4].

Medicare subsidised palliative medicine services

This section discusses the number and type of Medicare Benefits Schedule (MBS) subsidies for palliative care-related services provided by palliative medicine specialists. The Royal Australian College of Physicians (RACP) describes palliative medicine as the specialist care of people with terminal illnesses and chronic health conditions in community, hospital, and hospice settings. Palliative Medicine Physicians work collaboratively with a multidisciplinary team of health professionals to provide end of life care, provide relief from pain and symptoms of illness, and optimise the quality of life for a patient. Palliative medicine treats the physical aspects of illness, but also integrates psychological and spiritual facets of patient care[5].

A palliative medicine specialist is a medical specialist who is a Fellow of the RACP and has completed the College's training program in palliative medicine, a Fellow of the Australian Chapter of Palliative Medicine, or both[6].

Broadly, the MBS-subsidised palliative medicine specialist services can be categorised as follows:

- palliative medicine attendances (specialist consultation with patient)
    - attendances at hospital or surgery
    - home visits
- palliative medicine case conferences (multidisciplinary team meetings)
    - community case conference—organisation and coordination
    - community case conference—participation
    - discharge case conference—organisation and coordination
    - discharge case conference—participation

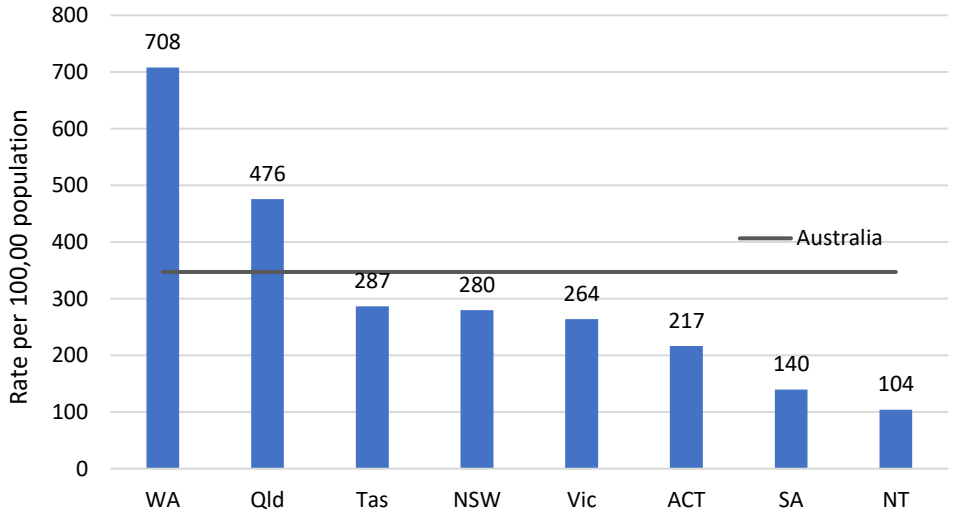
In 2019–20 there were 88,605 MBS-subsidised services provided by palliative medicine specialists. This is an increase of 4.4% per year over the last five years, from 74,555 in 2016-17. Palliative medicine attendances in hospital or surgery made up the majority 80.2% (71,077 services) of all MBS-subsidised palliative medicine

[4] Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L et al. 2016. General practice activity in Australia 2015–16. General practice series no. 40. Sydney: Sydney University Press.
[5] RACP (Royal Australian College of Physicians) 2020. Australasian Chapter of Palliative Medicine. Sydney: RACP. Viewed 18 March 2021
[6] ANZSPM (Australian and New Zealand Society of Palliative Medicine) 2008. Defining the meaning of the terms: Consultant Physician in Palliative Medicine and Palliative Medicine.

specialist services in 2019–20 with a further 9.4% (8,369) of all services being consultations in the patient's home.

The rate of MBS-subsidised palliative medicine specialist services in 2019-20 varied among states and territories. Western Australia recorded the highest rate (707.7 per 100,000 population) and Queensland had the second highest rate (475.6 per 1,000 population) or a total of 24,397 services which was the highest total number of services claimed among all Australian states.

Figure 1. MBS-subsidised palliative medicine specialist services, by states and territories, 2019-20



Source: Medicare Benefits Schedule data (AIHW analyses)

General practice palliative care-related attitudes and awareness

A study commissioned by the Australian Government Department of Health researching the awareness, attitudes and provision of best practice advance care planning, palliative care, and end of life care within general practice. The study identified that GPs' understanding of what constitutes palliative care and end of life care varies widely and that differing palliative care settings have very different requirements in terms of best practice.

The study also provided a variety of recommendations including:

- better defining the role of GPs in palliative care,
- promoting a better understanding of the clinical triggers for commencing palliative care,
- the development of local directories to enable GPs to access palliative care resources and better communication,
- integration with other parts of the health system including encouraging referrals to specialist palliative care teams or GP experts[7].

Palliative care for people living in residential aged care

The Australian Government subsidies residential aged care services for older Australians whose care needs are such that they can no longer remain living in their own homes. Providing palliative care in residential aged

[7] DOH (Department of Health) 2017. Final report: research into awareness, attitudes and provision of best practice advance care planning, palliative care, and end of life care within general practice. Canberra: Department of Health.

care is complex. In 2019-20, there were 244,327 people living in residential aged care in Australia, of whom 3,178 (1.3%) had an indicated need for palliative care.

Workforce

The palliative care workforce is made up of a number of health professional groups including specialist palliative medicine physicians, nurses, GPs, pharmacists, other medical specialists (such as oncologists and geriatricians), as well as other health workers, support staff and volunteers. Reliable data relating to the size and breakdown of the palliative care workforce is not currently available for the GCPHN region.

There were 292 palliative medicine physicians employed in Australia in 2019, accounting for 0.8% of all employed medical specialists. On the Gold Coast there were six medical practitioners with a primary speciality of palliative medicine.

Table 3 shows the employed palliative medicine physicians for each state in 2018.

Table 3. Employed palliative medicine physicians, by states and territories, 2018

	Palliative medicine physicians	Average hours worked / week	Average clinical hours worked / week	FTE	Clinical FTE	FTE / 100,000 population	Clinical FTE / 100,000 population
New South Wales	104	38.3	30.2	99.5	78.6	1.2	1.0
Victoria	72	34.3	23.9	61.8	43.1	0.9	0.7
Queensland	51	41.0	34.7	52.3	44.3	1.0	0.9
Western Australia	32	36.2	29.2	28.9	23.4	1.1	0.9
South Australia	19	35.1	26.5	16.6	12.6	0.9	0.7
Tasmania	6	39.5	31.3	5.9	4.7	1.1	0.9
Australian Capital Territory	6	37.3	26.7	5.6	4.0	1.3	0.9
Northern Territory	3	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.
National	292	37.4	29.1	272.8	212.6	1.1	0.8

Source: National Health Workforce Data Set 2019

Prescribed medications

Prescribed medication is an important component of palliative care. These medications are defined as clinically relevant for patients with 'active, progressive and far advanced diseases for whom the prognosis is limited and the focus of care is quality of life'. These medications typically involve:

- analgesics for pain relief
- anti-epileptics to treat seizures
- anti-inflammatory and anti-rheumatic products to treat inflammation
- drugs for gastrointestinal disorders
- laxatives

While no regional data is available, national data on palliative care-related prescribing in 2019-20 indicate that:

- 17,000 patients received an MBS-subsidised palliative medicine specialist service.
- 88,605 MBS-subsidised services were provided by palliative medicine specialist.
- $7 million was paid in benefits for MBS-subsidised palliative medicine specialist services in 2019-20, at an average of $416 per patient.
- Nationally, the rate of subsidised palliative medicine specialist services provided in 2019-20 was 347 per 100,000 population.

Performance of palliative care services

The Australian Palliative Care Outcomes Collaboration (PCOC) is a national program that utilises standardised clinical assessment tools to measure and benchmark patient outcomes in palliative care[8]. Participation in PCOC is voluntary and can assist palliative care service providers to improve patient outcomes. It is administered by the Australian Health Services Research Institute based at the University of Wollongong. PCOC's data collection covers more than 250,000 people who have received palliative care over the last decade. National data for 2017 shows that[9] :

- Just over half of all episodes completed were in an inpatient setting (53.4%), with the remainder completed in the community (46.6%).
- Palliative care episodes were disproportionately accessed by socioeconomic status, with those people in higher socio-economic status categories reporting higher episodes of palliative care in both inpatient and community settings.
- The average age of people undertaking a palliative care episode was 72.8 years.
- There was a total of 228 episodes reported for patients under 25 years of age, which represented 0.4% of all episodes.
- A higher proportion of males (53.2%) underwent palliative care episodes compared to females (46.8%).
- Over three quarters of episodes of palliative care (77.6%) were for patients with a cancer diagnosis, despite patients suffering from other chronic life-limiting conditions such as heart failure, COPD or dementia have symptoms as severe and distressing as those of cancer patients.
- Over three quarters of episodes of palliative care (77.6%) were for patients with a cancer diagnosis.

Analysis of the patterns of national outcome data collected through PCOC from 2009 to 2016 shows:

- More patients are having palliative care commence within two days of when they are ready.
- The time patients spend in the unstable phase has been getting shorter.
- The proportion of patients reporting absent or mild distress at the end of a phase has been improving, with slightly better outcomes in the inpatient setting.
- The number of family members and carers experiencing moderate or severe problems at the end of a phase of care has been decreasing over time.

[8] Palliative Care Outcomes Collaboration (PCOC), Australian Health Services Research Institute, University of Wollongong https://ahsri.uow.edu.au/pcoc/index.html

[9] Palliative Care Outcomes Collaboration (2018) Palliative care services at a glance, 2017 data tables Australian Health Services Research Institute, University of Wollongong

Advance care planning

Advance care planning is the process of planning for future health and personal care whereby a person's values, beliefs and preferences are made known so they can guide clinical decision-making at a future time when that person cannot make or communicate their decisions. Advance care planning is a priority for quality person centered or end of life care and promotes an individual's choice and control over healthcare decisions.

An advance care directive is a type of written structured advance care plan recognised by common law or specific legislation that is completed and signed by a competent adult[10].An advance care directive will typically document the persons values, beliefs, and specific preferences for future care and/or include the appointment of a substitute decision maker. A substitute decision maker may be required to make medical treatment decisions on behalf of a persons whose decision-making capacity is impaired[11].

In Queensland, there are three ways individuals can record their choices for future healthcare:

- Enduring Power of Attorney - An Enduring Power of Attorney process allows the individual to choose a trusted relative or friend to manage your personal matters (including healthcare) and financial matters.
- Advance Health Directive - An Advance Health Directive is a formal way to give instructions about the individuals future healthcare. It is sometimes called a living will. It will only take effect if the individual does not have capacity to make decisions.
- Statement of Choices - A Statement of Choices allows the individual to record their personal values and preferences for healthcare.

Despite the recognised benefits of formally documenting, one's advance care planning preferences, available estimates suggest less than 30% of Australians have completed an advance care directive[12].

There are no dedicated MBS item numbers for Advance Care Planning, instead it is undertaken as part of standard GP consultations, health assessments, chronic disease management plans or case conferencing items.

As such, there is no regional data to indicate the number of Advance Care Plan (ACP) services being undertaken by GPs. A study to investigate the prevalence, characteristics, and accessibility of statutory and non-statutory advance care directives for older people at the point of care in Australian health and residential aged care services was completed. This study conducted an audit of 4,187 health records of individuals aged 65 years or over in participating general practice, hospitals, and residential aged care facilities.

The study had the following outcomes:

- 25% of participants had least one advance care directive in their health record. Of those:
    - 6% had a statutory advance care directive outlining their preferences for care.
    - 12% had a statutory advance care directive appointing a substitute decision-maker.
    - 12% had a non-statutory advance care directive.
- Prevalence rates were highest in residential aged care facilities, with 38% of residents having one or more advance care directives (compared to 11% of people in hospitals)

[10] Rhee JJ, Zwar NA, Kemp LA. Why are advance care planning decisions not implemented? Insights from interviews with Australian general practitioners. Journal of Palliative Medicine. 2013;16(10):1197-204.
[11] Australian Health Ministers' Advisory Council. National Framework for Advance Care Directives. Canberra, Australia: Commonwealth Government of Australia; 2011.
[12] Deterring KM, Buck K, Ruseckaite R, Kelly H, Sellars M, Sinclair C, et al. Prevalence and correlates of advance care directives among older Australians accessing health and residential aged care services: multicentre audit study. BMJ Open. 2019;9(1): e025255

- 6% of people of attending general practices had an advance care directive in their health record.

Analysing data uploaded by Gold Coast residents to Queensland Health electronic hospital record (The Viewer), a large increase was seen across all document types (statement of choice, advanced health directive and enduring power of attorney) from 2017-18 to 2019-20. There was a total of 1,006 Gold Coast residents who had completed Statement of Choices in 2019-20[13].

Table 4. Advance care planning documents uploaded to the Queensland Health electronic hospital record (The Viewer), Gold Coast residents, 2017-18 to 2019-20

Document type	2017-18	2018-19	2019-20
Statement of Choices	483	467	1,006
Advance Health Directive	16	129	311
Enduring Power of Attorney	23	167	810

Source: Office of Advance care Planning – Queensland Health

Gold Coast has implemented a number of programs that have focused on palliative care and increasing advanced care planning in RACFs over recent years these have included:

- Advance Care Planning in RACFs Project (June 2017 – December 2018)
- The Advance Project (1 Jan 2019 – 30 March 2020)
- Enhanced Primary Care (Clinical Educator- Palliative) (1 June 2019 – 30 June 2020)
- Greater Choices for at Home Palliative Care (June 2017 – October 2021)
- Specialist Palliative Care in Aged Care (SPACE) (1 Nov 2020 – 30 June 2024)

[13] Office of Advance care Planning – Queensland Health

Service system

Services	Number in the GCPHN region	Distribution	Capacity discussion
Gold Coast Health, Inpatient Facility (Specialist Palliative Care)	1	Robina Hospital	• One public purpose-built 16 bed palliative care unit is available at Robina Hospital. • The Palliative care unit is not a long-term facility, and some patients may be discharged to more appropriate care including the generalist services and RACFs or the private hospice.
Gold Coast Hospital and Health Service Specialist Palliative Care in Aged Care	1	Robina Hospital	• Project providing in reach support to upskill RACF staff to improve ability. • Funded from 2020 to 2024.
Hopewell Hospice	1	Arundel	Seven beds located a few km from GCUH, it's often used for terminal care (one non-private bed available).
Gold Coast Health Community Service	1	Gold Coast wide	The Community Service team provide a consultative service in patients' homes and provide support to the GP and other teams when necessary. There are no services currently to RACF (nursing homes or hostels).
Gold Coast Health Bereavement Services	1	Gold Coast wide	When a palliative care patient passes away, the family and significant others receive follow up consultations by a Social Worker, Chaplain, Community Nurse or Medical Officer. Their bereavement needs are continuously assessed from the first meeting, and their immediate needs are assessed in the week following the passing of the patient. Ongoing support is arranged as needed through other community services.

Gold Coast Health, Consultation and Liaison Service (Specialist Palliative Care)	1	Gold Coast University Hospital	Symptom assessment, support and management advice, family support, case/ family conference, care planning, triage admissions and discharge advice.
Gold Coast Health, Outpatient/Community Facility (Specialist Palliative Care)	2	Robina and Gold Coast University Hospital	• Assessment and ongoing management via outpatient clinics and home visits. • Liaison with GPs and community nurses.
Gold Coast Health, Inpatient Facility (Children's Palliative Care Service)	1	Gold Coast University Hospital	• Works closely with Children's Health Queensland. • Not a standalone service, staff are shared across multiple services.
BlueCare, Ozcare and Anglicare (funded by Gold Coast Heath)		Gold Coast wide	• Complex nursing and personal care, and support to help patient stay at home, including post-death support. • Other NGOs including Aquamarine Care, RSL Life Care at Home Kalwun Home and Community Care provide limited services.
Aged care service providers	Numerous	Gold Coast wide	• Numerous aged care providers across the GCPHN region report providing generalist palliative services, but do not provide specialist palliative care support. • This can include domestic and personal care, home maintenance and modifications, equipment, social support, clinical services, respite, and counselling.
General Practitioners	855	Gold Coast wide	Critical role in coordinating care and making referrals, identifying and assessing palliative care needs pain management, medication management, bereavement

			support and advance care planning.

Consultations

Gold Coast Aged and Palliative Care Steering Group (2020/21)

- SPACE Project – working in RACF is challenging due to the competing needs for the education and training of RACF staff, particularly with the increase in training required in relation of COVID and meeting the new quality standards.
- Workforce – Local hospice has found it challenging to engage GPs to provide clinical governance due to fact that the model does not provide adequate income for GPs. Hospice reviewing the model to determine ongoing sustainability options.
- With over 900 GPs on the Gold Coast, they are unlikely to see many palliative patients per year (10 to 20) and as such, may not prioritise the area for extra training or professional development.
- GPs may only have one to two that require specialist palliative care.
- Many GPs do Program of Experience in the Palliative Approach (PEPA) programs each year, there has been a decrease since the PEPA program stop paying GPs to complete the program.
- Palliative Care Health Pathway – availability on the GCPHN website has provide GP with access to information when required.
- 1,127 unique page views for the Palliative care health pathways whilst hosted on GCPHN website (January to June 2021).
- Two main challenges Supportive and Specialist Community Palliative Care Service Delivery teams face are:
- Lack of funding for people under 65 years of age as not eligible for packages (only option is to self-fund at the moment. Gold Coast Health have been able to fund a small number but this is reducing their budget for service delivery).
- GPs not providing home visits. Medicare Covid phone payments have increased GPs engagement.

Clinical Council (2021)

In August 2021, Gold Coast PHN utilised the Clinical Council as an engagement mechanism to discuss emerging issues relating to palliative care in the GCPHN region. Key issues and themes raised include:

- As RACFs largely undertaking palliative care – important to note Royal Commission – notes issues of adequate staffing, particularly in the afterhours.
- GPs don't do much in home palliative care as not remunerated appropriately to do so, it is not viable. Most will do some for longer term existing patients but would be unlikely to deliver home support for someone they did not already know.
- Increasing personal care responsibilities and part time nature of work in general practice makes it difficult to service in home palliative care, particularly in the afterhours.
- In home palliative care needs family support. In the GCPHN region, some elderly patients had moved to the region from interstate so they do not have the supports at home required.
- Limited private options – most people with specialist palliative care needs end up in in the public systems.

- Patients make choices about GP services. They may attend a mixed billing practice for longer term, complex issues but visit bulk billing for quick fix things like prescriptions.
- Home nursing services are very important in delivering at home palliative care, they have great expertise but need to link in / be networked better with the specialist services
- Details of pharmacies stocking palliative care medication are being added to health pathway.
- GCPHN has previously explored supporting palliative care volunteers but there was little interest from relevant NGOs and initiative did not progress.
- Despite increase in promotions of ACP and some increase in number of ACP being completed, the broader understanding of consumers understanding of ACPs remains limited.

Primary Care Partnership Council (2021)

In July 2021, Gold Coast PHN utilised the Primary Care Partnership Council as an engagement mechanism to discuss emerging issues relating to palliative care services in the GCPHN region. Key issues and themes raised include:

- Underfunding in this sector leads to issues regarding continuity and access – some get access to funding some don't. Access is restricted to people in very late stage of illness. Should be support for journey with psychologists, emotional as well as physical. Access is fragmented and comes too late.
- When a person comes back from hospital with new diagnosis – palliative, this is not well understood, the implications and next steps are unclear. Limited support is available to travel that journey, people become anxious. Language used in form from hospital - "palliative" what does that mean in terms of ongoing care.
- Capacity building for carers - what is available and the services they can access.

Gold Coast Primary Health Network Clinical Council (2018)

In June 2018, Gold Coast PHN utilised it's Clinical Council as an engagement mechanism to discuss emerging issues relating to palliative care services in the GCPHN region. Key issues and themes raised include:

- Cost across several domains, the cost of non-PBS listed palliative medications and their lack of availability at some pharmacies across the GCPHN region. With RACFs not serviced under state funded palliative care services, their residents have little options but hospital admission to access palliative care services.
- Clinical handover in both public and private settings can be challenging. Case conferencing and discharge planning can help to ensure the GP remains the centre of a person's care, however telehealth services are rarely utilised due to a lack of MBS subsidies in metropolitan locations such as the Gold Coast. Both specialist services and GPs have raised the desire to ensure GPs are in position as a central and ongoing part of a patient's care, but some instances reported this was not the experience.
- Resourcing is often an issue with timely access to palliative beds and other potential resources when the case is often urgent. With the Gold Coast Hospice resourced with generally only one public bed (and seven private), a lot of the demand for acute service falls to the public inpatient facilities.
- An opportunity for education to take place through peer-to-peer learning or shared learning with GPs and allied health providers was identified in the GCPHN region relating to the continuing holistic care (e.g., allied health treatment) of a person once they begin accessing palliative care services.

Gold Coast Primary Health Network Community Advisory Council (2018)

In June 2018, GCPHN undertook engagement with their Community Advisory Council (CAC) to review and evaluate the Older Persons Needs Assessment Summary developed in 2017, which included a component on palliative care. 93% percent of CAC members either agreed or strongly agreed on the needs identified in the document.

Additional engagement with the group identified a range of areas where improvement is needed:

- Service Access and Navigation
    - Navigate the right level of care and provider of home support for a loved one is challenging, and there is minimal support for this.
    - Significant modification costs are often borne by families.
    - After hours GPs (at their discretion) can decline home visits for palliative patients leaving emergency presentation the only option.
    - Members of the CAC identified the importance of their own GP remaining actively involved in their care.

Several opportunities were raised including:

- The utilisation of volunteers in palliative care to support the individual and their families with housework, physical activity, or social support.
- Positive feedback was received regarding palliative care nurse services in the GCPHN region and a call made for more palliative providers in community and RACFs.
- Opportunities for more consumer directed care are on the horizon with the upcoming aged care funding changes.

Gold Coast Primary Health Network stakeholder consultation (2017)

In September 2017, Gold Coast PHN carried out stakeholder consultation with the intention to identify gaps and explore opportunities to improve coordination and integration of palliative care services across the GCPHN region. Visions were created to support a more efficient and effective local palliative care system. Some of the emerging visions include:

- Access to flexible 24/7 carer and nursing support.
- Upskilling of general practice / community service / ED / RACFs in identifying patients who are at risk of dying within 12 months and aided through Advance Health Directives and Advance Care Planning (ACP).
- Palliative care embedded as a part of normal patient care and inclusive of family and caregiver.
- Better connected infrastructure/networks and system navigation.

In addition, there were a range or barriers identified to achieving these visions, which included but were not limited to stigma, lack of access to knowledge, discharge summaries and handover, and lack of carer support.

Palliative care services co-design workshop (2018)

In September 2018, a co design workshop with 41 sector representatives was held with the aim of informing the design and delivery of a regionalised approach to Gold Coast PHN's investment in primary and community-based palliative care services. The outcomes of the co-design workshop along with the findings

of the need's assessment will directly inform the development of Gold Coast PHN's 3-year strategic service planning report for palliative care.

The co-design workshop was designed to maximise participation, incorporating a variety of feedback mechanisms including small group sessions, whole-of-room sessions, or individual opinion in an anonymous format. Informal breaks were included for networking and further discussion and integration amongst the group.

Key themes emerged from the co design workshop included:

- **Workforce capacity building** – The need for meaningful, appropriate, accessible workforce capacity building across primary care and palliative care sectors was a prominent theme. It was reported that confident, skilled, and connected staff would lead to a reduction in potentially preventable hospitalisations.
- **Community awareness and education** - While some difficulties were reported in measuring community awareness and education outcomes, it was still a leading theme throughout the workshop. Some recurring areas for education and awareness identified were Advance Care Planning, service awareness, and health and death literacy.
- **Advance Care Planning** – Advance Care Planning continues to carry significant importance across palliative care sector on the Gold Coast. It has been reported that uptake remains low, which can be attributed to the difficulty and complexity of the paperwork involved. However, it is reported that having an Advance Care Plans in place results in a more informed, seamless, coordinated, and appropriate journey for the individual in line with their values, beliefs and wishes at the end of life.
- **Service navigation and coordination** – While activities around service navigation and coordination were strongly supported by attending representatives, measures to improve this can often be challenging in a constantly evolving and time-poor sector. Activities proposed to improve service navigation and coordination on the Gold Coast were dependent on having a key a navigator role to support individuals through their palliative care journey.
- **Sector collaboration** - A key focus area explored at the workshop was sector collaboration, which is particularly important in the palliative care sector due to frequent transitions between emergency department, hospital inpatient wards, residential aged care facilities, community care and GPs. Some of the key activities explored to support sector collaboration included leadership groups, compassionate communities style programs and increased support for case conferencing.
- **Volunteer programs** – The invaluable support of the volunteer workforce in palliative care was widely cited across the palliative care workshop. Volunteer programs are perceived as cost-effective and can prevent or reduce social isolation and loneliness of individuals. The importance of appropriately skilled palliative care volunteers was raised due to the highly emotional and challenging environment they will be exposed to.

Evaluation and Learning

The Advance Project

- The findings from this project suggest that successful implementation of the Advance Project model of initiating Advanced Care Planning and palliative care needs assessment in general practice is dependent on several factors. These factors include the preparedness of general practice, general practice staff attitudes to support behaviour change, and ongoing support and incentives available for general practice.

- The project identified that implementing new routines/changes takes time and ongoing practical support for general practices is essential for sustainability in the short and long term.

Enhanced Primary Care (Clinical Educator- Palliative)

- A large portion of the staff who provide direct care for residents are unregistered staff with minimal healthcare education. A Certificate III in Aged Care is the preferred qualification but is not required. Therefore, education provided needed to be adaptable across a wide range of skills, knowledge, and scopes of practice appropriate to various staff.
- Formal education sessions were reportedly well-received. However, experience and published evidence suggest that the best learning outcomes for nurses are achieved with real-time, hands-on clinical education. The PC-CNE role had limited scope for hands-on clinical teaching. Instead, it was based on formal "classroom-style" education methods.
- GPs expressed interest and support for the education program and the upskilling of staff working in RACFs but were difficult to engage. Electronic correspondence (email and telephone) had a poor response, with better engagement achieved via face-to-face interactions.

Palliative Shared Care

- Several structural and systemic barriers were identified for the development of Palliative Shared Care arrangements. These were:
    - The absence of a real-time detailed shared information management system across all parts of the health system.
    - Adequate remuneration for general practice to cover things like after-hours call outs to people in their home.
- The development of Palliative Shared Care arrangements for the Gold Coast health system did not progress due to the COVID-19 pandemic and lack of sector capacity, systems, and resources.

2018 Palliative Care Regional Plan

The Gold Coast Primary Care Network Palliative Care Regional Plan identified five strategic priorities in response to the local health needs, service issues and opportunities determined through needs assessment and co-design processes. These key priorities areas were:

- workforce capacity building
- volunteer availability
- sector collaboration
- community awareness and education
- service navigation and coordination.

The below projects initiatives align with the Regional Plan key priorities areas.

Workforce capacity building

The Advance Project

The Advance Project aimed to increase GPs, nurses and practice managers' ability to initiate conversations about advance care planning (ACP) and screening for palliative care needs. The project achieved this outcome by providing face-to-face training to 127 general practice staff (56 GPs, 48 general practice nurses and 23 practice managers), and by providing intensive support to six general practices to implement ACP processes in their practice and support the evaluation of project resources.

There was strong evidence that those workshops increased the confidence of attendees to discuss ACP and start the conversation with patients. Additionally, the workshops increased the understanding of QLD ACP processes and online project resources to start the conversation and screen the palliative care needs of patients. The GCPHN had a positive role in supporting general practice change. General practices that engaged with the PHN for advice during and before implementing the project and took up the offer of mentoring appeared to be more successful in implementing clinical practice changes.

Enhanced Primary Care (Clinical Educator- Palliative)

The Enhanced Primary Care (Clinical Educator-Palliative) pilot project aimed to deliver palliative and end of life (EOL) education and development training to RACFs. The project utilised a Specialist Palliative Care (PC) – Clinical Nurse Educator (CNE) model. Five sites were selected for participation in the project. Two full-day education sessions were delivered with a total of 37 participants; 100% of participants self-reported increased knowledge and skills to impact their practice positively. The PC-CNE supported trial sites to implement/review palliative, EOL and ACP policies and procedures.

In March 2020, in response to the COVID-19 pandemic, the Australian Government implemented restrictions whereby the PC-CNE could not access trial sites. This led to the planned service delivery being suspended. As a result, the PC-CNE position was diverted to a clinical COVID-19 response team provided by Gold Coast Health (GCH).

Program of Experience in the Palliative Approach (PEPA Program)

GCPHN collaborated with GCH and Program of Experience in the Palliative Approach (PEPA) to design and implement ***'Live well. Die well: a multidisciplinary approach to palliative care'*** conference targeting allied health and nursing professionals. The conference was initially planned for June 2020 (with 126 registrations within the first two weeks of with 15 trade display requests). However, due to the COVID-19 pandemic, the conference was postponed twice (2020 and 2021). A new proposed date is planned in 2022 for medical professionals and 2023 for allied health professionals, including nursing.

Specialist Palliative Care in Aged Care (SPACE) project

The SPACE project aims to improve access to specialist palliative and end-of-life care for older people living in residential aged care facilities (RACFs). A key aim of the project is to increase the capacity and capability of general practice and aged care staff to deliver care at the end of life.

The project has been well received by GPs and RACF staff, with GPs actively contacting RACFs to ensure they were part of the program. RNs within RACFs reported that their increased knowledge gained through the project assisted them in managing symptoms better, and RACF staff reported feeling generally better supported.

Volunteer Availability

Explored Volunteer Availability Initiative across the Gold Coast

A deliverable of the Greater Choices for at Home Palliative Care funding included a co-design workshop to identify ideas and concepts for regional home-based palliative care volunteer services, including Justice of the Peace volunteers. The workshop, held in May 2019, had limited attendance and response from community organisations and service providers.

Service navigation and coordination

Palliative Care Shared Care and Health Pathways

The Palliative Care Shared Care and Health Pathways were a deliverable of the Greater Choices for at Home Palliative Care funding. Palliative Care Health Pathways were developed in partnership with Gold Coast Health (GCH) and localised to include Gold Coast community service providers. It was initially hosted on the GCPHN website and transitioned to Gold Coast Community Health Pathways in June 2021.

The development of a Shared Care Framework for the Gold Coast health system was put on hold due to the COVID-19 pandemic and lack of sector capacity, systems, and resources in place.

Community awareness and education

Development of health literacy tools

The development of health literacy tools was a deliverable of the Greater Choices for at Home Palliative Care funding. An online resource called *Planning your Future Care Today* has been developed to provide simple information to adults about Advance Care Planning. The online resource, aimed at all ages but with greater emphasis on middle age and older persons, encourages readers to start the conversation and complete documents at any age, regardless of their health status. Delays in the development of this resource arose due to COVID-19. The online booklet is to be published and promoted in July 2021.

Programs implemented on the Gold Coast

Gold Coast has implemented several programs that have focused on increasing advanced care planning in RACFs over recent years. These have included:

- Advance Care Planning in RACFs Project (June 2017 – December 2018)
- The Advance Project (1 Jan 2019 – 30 March 2020)
- Enhanced Primary Care (Clinical Educator- Palliative) (1 June 2019 – 30 June 2020)
- Greater Choices for at Home Palliative Care (June 2017 – October 2021)
- Specialist Palliative Care in Aged Care (SPACE) (1 Nov 2020 – 30 June 2024)

People at risk of developing mild and moderate mental illness

Local health needs and service issues

- Evolving service system results in general practitioners (GPs) being unclear about available services and the pathways to access these services.
- Limited promotion and support of low intensity services to GP to support complementary use with other primary health interventions.
- Limited use and accessibility of evidence based electronic (digital) mental health services.
- System navigation is difficult for GPs and patients.
- Timely access to services for people seeking mental health support is crucial.
- There is increasing demand for all mental health services.

Key findings

- In 2020-21, Gold Coast Primary Health Network (GCPHN) rate of GP mental health services, clinical psychologists' and psychiatrist services was above the national rate.
- Top reasons for Gold Coast residents accessing Beyond Blue services included anxiety, depression, and family/relationships.
- While there are a broad range of quality online and telephone services (eMH services) available for people with low acuity mental health issues, there is limited data on local usage.
- There is limited integration of eMH services as complementary service options within existing primary healthcare service delivery.
- Consultations indicated that effective early intervention can prevent deterioration but there are limited soft entry point models (coaching, wellness focused, and peer-support) that focus on social and community connectedness.

Low intensity interventions are critical in bridging the need–treatment gap

Depression and anxiety are the leading global causes of burden of disease in young people and contribute to considerable illness burden across the lifespan[1]. Effective prevention and early intervention can significantly reduce disease burden by halting, delaying, or interrupting the onset and progression of depression and anxiety[2]. Less than half of Australians with depression or anxiety seek help from a health professional, thus missing opportunities for intervention[3].

Low intensity mental health services aim to target the most appropriate psychological interventions to people experiencing or at risk of developing mild mental illness (primarily low acuity anxiety and/or depressive disorders). Defining target populations, educating consumers and providers and developing low intensity service models can contribute to improved outcomes for a wide group of consumers. Within a stepped care approach, low intensity mental health services target lower intensity mental health needs. This enables the provision of an evidence based and cost-efficient alternative to the higher cost psychological services available through programs such as Better Access and other primary mental healthcare services.

The costs of providing mental health services are increasing, providing the motivation to develop more efficient intervention modes of delivery that do not place more pressure on the existing systems of care. Rapid developments in treatment models employing low intensity support to people in earlier phases of illness show potential for meeting this need, particularly for depression and anxiety[4].

The role of primary care

General practices play a central role in the delivery of mental healthcare In Australia. Mental healthcare in general practice is easily accessed without referral.

In 2018-19, 68,466 Gold Coast residents saw a GP for a mental health-related service which led to 117,860 services[5].

As general practice can be the first and/or only setting an individual seeks help for their mental health it is vital that promotion and support of low intensity services to general practice to support complementary use with other primary health interventions is evident to GPs and general practice staff.

Prevalence and service usage

One in seven Australians (15%) aged 16 to 85 have experienced depression in their lifetime[6]. This is equivalent to 61,295 Gold Coast residents.

One quarter of Australians (26.3%) aged 16 to 85 have experienced an anxiety disorder in their lifetime[4]. This is equivalent to 107,471 Gold Coast residents.

Low intensity services can include online, telephone, individual and group-based interventions. As depicted through the below service mapping table, there are myriad telephone and online services that could be

[1] Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. The Lancet. 2013;382(9904):1575-86

[2] Muñoz RF, Cuijpers P, Smit F, Barrera AZ, Leykin Y. Prevention of major depression. Annual Review of Clinical Psychology. 2010; 6:181-212.

[3] Whiteford HA, Buckingham WJ, Harris MG, Burgess PM, Pirkis JE, et al. Estimating treatment rates for mental disorders in Australia. Australian Health Review. 2014;38(1):80-85.

[4] DOH. Low intensity mental health services for early intervention. http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/2PHN%20 Guidance%20-%20Low%20Intensity%20services.pdf: Australian Government Department of Health

[5] Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data, 2018–19.

[6] ABS National Survey of Mental Health and Wellbeing: Summary of Results, 2007 (2008)

accessed by people in the GCPHN region. While there is limited local usage data for these services, data from Beyond Blue's telephone counselling service indicated that in 2015, approximately 26% of calls from the GCPHN region were related to depression, and 18% to anxiety.

Access to online low intensity service options requires internet connectivity, which may present a barrier for some people. In 2016, 11.4% of Gold Coast households did not have access to the internet; areas with the most households without access to the internet were Coolangatta (15.6%, 3,194 households) and Gold Coast North (14.9%, 3,915 households)[7].

Medicare Benefits Schedule

Patients suffering from poor mental health can see their GP who will assess the patient and what may be of assistance for the patient. This could include:

- making a mental health assessment,
- creating a mental health treatment plan,
- referring the patient to a psychiatrist or other mental health professional,
- giving the patient a prescription for medicines to treat the illness.

These interactions with GP and mental health workers are captured in Medicare-subsidised data. GP mental health services may include early intervention, assessment, and management of patients with mental disorders through planning patient care and treatments, referring to other mental health professionals, ongoing management, and review of the patient's progress.

A mental health treatment plan is a support plan for someone who is going through mental health issues. If a doctor agrees that the individual requires additional support, the patient and the doctor will make the plan together.

People may not always see a clinical psychologist and may see a general psychologist, counsellor, or social worker for a consultation. General psychologists, counsellors and social workers data is limited because psychologists (clinical or other) may also provide some services listed for general psychologist, counsellors, and social workers. Implications of this is that psychologists (clinical or other) cannot be readily separated from other mental health workers, which creates duplication in reporting. Due to this, in Health Needs Assessment, GCPHN reports on GP mental health services, clinical psychologists and psychiatrists MBS services provided and acknowledge that this excludes services delivered by general psychologist, counsellors, or social worker services.

All data presented in this chapter are mapped to the patients Medicare residential address.

General Practitioners

In 2020-21, GCPHN's rate for GP mental health services (20.0 per 100 people) was above the national rate (15.4 per 100 people).

Between 2013-14 and 2020-21, there has been a 65% increase in the number of mental health services delivered by GPs on the Gold Coast. In 2020-21, 76,131 Gold Coast residents had a mental health consultation with a GP leading to 129,860 mental health consultations in total.

[7] Australian Bureau of Statistics, 2016, Gold Coast (SA 4), Quick Stats

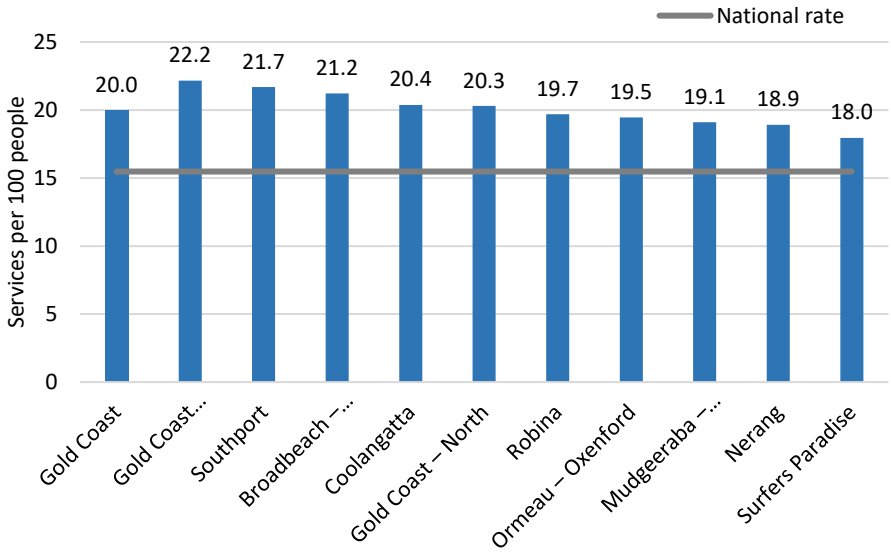
Table 1. GP mental health services per 100 people, Gold Coast, 2013-14 to 2020-21

Year	Number of patients	Number of services	Services per 100 people
2013-14	46,226	78,886	14.2
2014-15	49,980	83,219	14.7
2015-16	54,586	90,289	15.7
2016-17	59,253	99,886	16.9
2017-18	63,051	108,020	17.8
2018–19	68,446	117,860	19.0
2019-20	71,075	71,075	19.1
2020-21	76,131	129,860	20.0

Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population.

All Gold Coast's Statistical Area Level 3 (SA3) regions were above the national rate in 2020-21 for claiming GP Mental Health Medicare Benefits Schedule services. Gold Coast Hinterland SA3 region had the highest rate (22.2 per 100 people) while Surfers Paradise had the lowest rate (18.0 per 100 people). Ormeau-Oxenford had the highest number of services claimed in the same period (30,640).

Figure 1. General Practitioner Mental Health Services per 100 people, Gold Coast SA3 regions, 2020-21



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population. Please note all data is mapped to the patients Medicare residential address.

Clinical psychologists

Psychologists are health professionals who can work in a range of areas such as clinical, neuropsychology, health, community, forensic, organisational and sports and exercise psychology. Clinical psychologists have skills in the following areas:

- assessment and diagnosis
- treatment

- learning

For the purpose of this report, psychological therapy services provided by eligible clinical psychologists includes individual attendances, group therapy, and telehealth video consultations.

In 2020-21, the GCPHN region rate for clinical psychologists' services (15.2 per 100 people) was above the national rate (11.8 per 100 people). Table 2 shows that 20,755 Gold Coast residents had a consultation with a psychologist, leading to 98,596 consultations in total.

Table 2. Clinical psychologists services per 100 people, number of patients and number of services, Gold Coast, 2013-14 to 2020-21

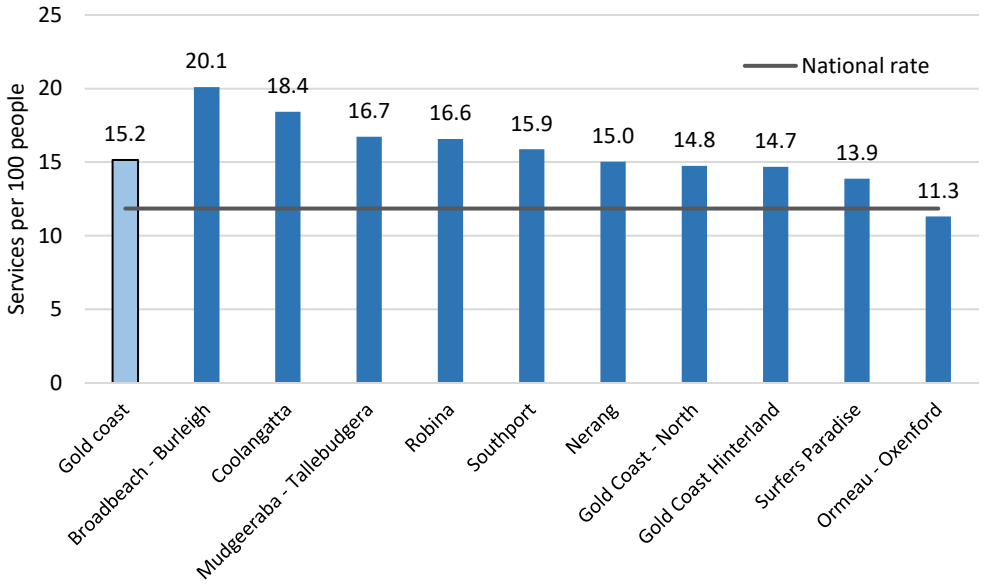
Year	Number of patients	Number of services	Services per 100 people
2013-14	12,144	52,027	9.4
2014-15	13,146	56,791	10.1
2015-16	15,214	64,842	11.3
2016-17	16,283	68,665	11.6
2017-18	17,790	74,999	12.4
2018-19	19,101	80,083	12.9
2019-20	19,990	85,793	13.5
2020-21	20,755	98,596	15.2

Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population.

All GCPHN SA3 regions were above the national rate (11.8) in 2020-21 claiming clinical psychologists' services other than Ormeau – Oxenford (11.3). Broadbeach-Burleigh SA3 region had the highest rate per 100 people (20.1) while Ormeau-Oxenford had the least on the Gold Coast (11.3) claimed per 100 people.

Although Broadbeach-Burleigh had the highest number of clinical psychologists' services per 100 people, the total number of services claimed was 2,547 while Ormeau-Oxenford had 14,684 services claimed in the same period.

Figure 2. Clinical Psychologists services per 100 people, Gold Coast SA3 regions, 2020-21



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population.

Psychiatrists

Psychiatrists are doctors who have undergone further training to specialise in the assessment, diagnosis, and treatment of mental health conditions. Psychiatrists can make medical and psychiatric assessments, conduct medical test, provide therapy, and prescribe medication.

For the purpose of this report, Medicare-subsidised services provided by a psychiatrist included patient attendances (or consultations), group psychotherapy, tele-psychiatry, case conferences and electroconvulsive therapy.

The GCPHN region rate for clinical psychologists' services (8.4 per 100 people) was above the national rate (6.8 per 100 people) in 2020-21 (Table 3). In 2020-21, 15,507 Gold Coast residents had a consultation with a psychiatrist, leading to 54,332 consultations in total.

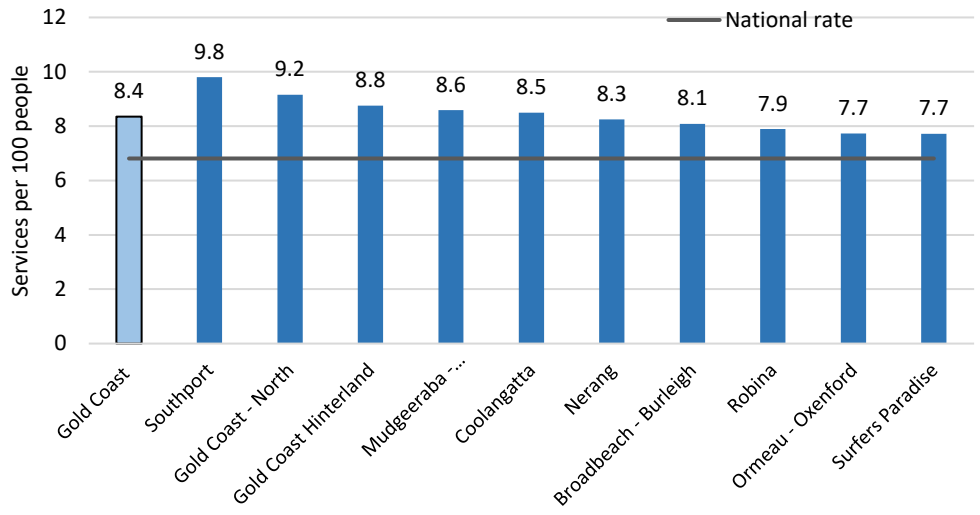
Table 3. Psychiatrist's services per 100 people, number of patients and number of services, Gold Coast, 2013-14 to 2020-2021

Year	Number of patients	Number of services	Services per 100 people
2013-14	11,723	61,446	11.1
2014-15	12,815	66,019	11.7
2015-16	13,364	66,960	11.6
2016-17	13,784	65,774	11.2
2017-18	14,332	63,134	10.4
2018-19	14,667	60,272	9.7
2019-20	15,079	57,262	9.0
2020-21	15,507	54,332	8.4

Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population.

All GCPHN SA3 regions were above the national rate in 2020-2021 for claiming psychiatry services (Figure 3). Southport SA3 region had the highest rate (9.8 per 100 people) while Ormeau-Oxenford and Surfers Paradise had the lowest rate on the Gold Coast (7.2 per 100 people). Although Ormeau-Oxenford had the lowest rate of services per 100 people, it had the highest number of actual services among Gold Coast SA3 regions with 12,178 claimed services.

Figure 3. Psychiatrist's services per 100 people, Gold Coast SA3 regions, 2020-21



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population.

Social isolation and loneliness

Social isolation and loneliness can be damaging to mental and physical health and are considered significant health and wellbeing issues in Australia. Both concepts do not necessarily co-exist—a person may be socially isolated but not lonely, or socially connected but feel isolated[8].

- Social isolation: state of having minimal contact with others
- Loneliness: subjective state of negative feeling about having a lower level of social contact than desired[9].

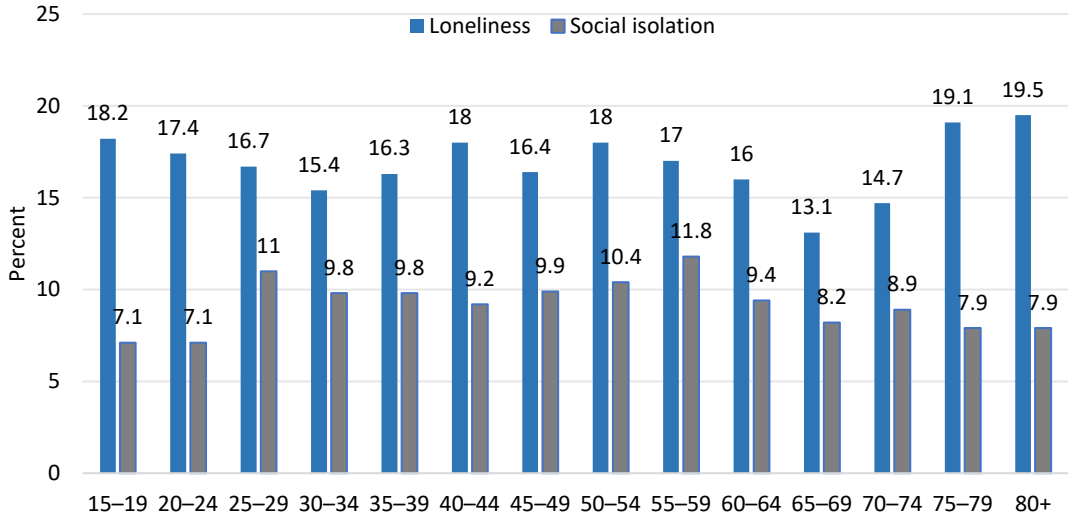
One in three Australians reported experiencing loneliness between 2001 and 2009, with 40% of these people experiencing more than one episode[10].

- one in ten Australians aged 15 and over report lacking social support[11],
- one in four report they are currently experiencing an episode of loneliness[12],
- one in two report they feel lonely for at least one day each week.

[8] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS.
[9] Peplau L & Perlman D 1982. Perspectives on loneliness. In: Peplau L & Perlman D (eds). Loneliness: A sourcebook of current theory, research, and therapy. New York: Wiley.
[10] Baker D 2012. All the lonely people: loneliness in Australia, 2001–2009. Canberra: The Australia Institute.
[11] Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey. Canberra: Relationships Australia.
[12] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS

Loneliness and social isolation have been linked to mental illness, emotional distress, suicide and development of dementia[13]. Part of the challenge in reporting on social isolation and loneliness comes from no universally agreed upon definitions. Figure 4 shows how social isolation and loneliness vary across age groups.

Figure 4. Proportion of people experiencing social isolation and loneliness by age, Australia, 2018



Source: Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey. Canberra: Relationships Australia.

NewAccess

NewAccess is a mental health coaching program, designed to provide accessible, quality services for anyone finding it hard to manage life stresses such as work, study, relationships, health, or loneliness. People can access six coaching sessions delivered over the phone, via skype or in person by trained mental health coaches.

The program uses low-intensity psychological therapy and aims to help people break the cycle of negative or unhelpful thoughts. Developed by Beyond Blue and delivered by Primary and Community Care Services (PCCS), NewAccess provides support from a coach who assesses the person's needs, then works with them in setting practical and effective strategies to help get them on track. This program provides support for individuals aged 16 years and over. Individuals can self-refer to the program.

Data from Beyond Blue show an increase of average recovery rate and average retention rate from 2019-20 to 2020-21 in the GCPN region. Consultation has suggested that there is limited promotion and support of low intensity mental health services to general practice to support complementary use with other primary health interventions. Data also showed that there is currently no waitlist to NewAccess on the Gold Coast.

[13] Hawthorne G 2006. Measuring social isolation in older adults: development and initial validation of the friendship scale. Social Indicators Research 77:521–48

Single session of psychological support and/or referrals

Beyond Blue offers a support service, 24 hours a day, seven days a week. This support service is offered through phone, chat online and email. All calls and chats are one-on-one with a trained mental health professional, and confidential. In 2020, there was more than 254,000 services delivered.

In the GCPHN region, 2,871 people used the above services between July 2020 and March 2021. The top three reasons for people calling were anxiety, depression, and family/relationships. People aged between 15 to 24 and 25 to 34 had the highest rate of usage with females using the service at a higher rate compared to males.

Stepped care approach

Stepped care is an evidence-based approach that aims to match people to the right level of support to meet their current need. In a stepped care system, the care and supports around a person 'expand' as their needs increase. As a person recovers and their needs change, the level of care and supports can be decreased. Throughout a person's recovery journey, there are different supports available to compliment support from their GP.

Stepped care provides guidance to Primary Health Networks in our role in planning, commissioning, and coordinating primary mental healthcare services. Embedding a stepped care approach is fundamental objective for mental health and service planning and commissioning to be undertaken by Gold Coast Primary Health Network. The joint regional plan completed by Gold Coast Primary Health Network and Gold Coast Health offered an opportunity for both organisations to partner in identifying gaps and priorities against the stepped care framework, and to identify workforce and service needs to address these.

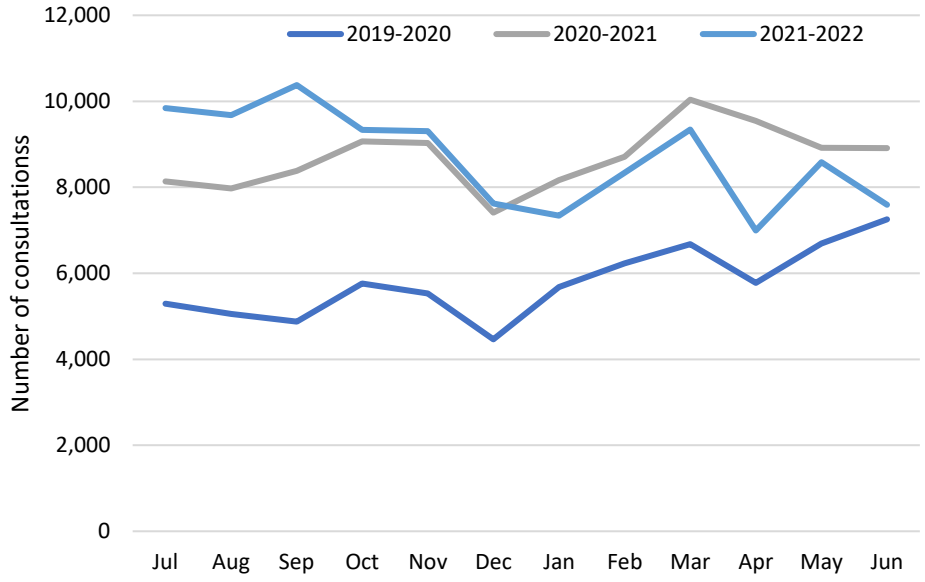
While there are multiple levels within a Stepped Care approach, they do not operate in silos or as one directional step, but rather offer a continuum of service interventions matched to the spectrum of mental health. The spectrum and the levels of needs associated with it at a population level are illustrated below.

In 2020/21, GCPHN funded providers saw over 8,000 unique clients access the Stepped Care programs. The rate of referrals to PHN funded services across low intensity, psychological therapy and clinical care coordination continued to rise in Q4 (October, November, December) as compared to Q3 (July, August, September). These high referral rates are placing significant pressure on all services.

Data extracted through Primary Sense™ (GCPHN data extraction and population health management clinical audit tool) shows that demand on services as evidenced by presentations to general practice for anxiety and depression increased from 2019-2020 to 2020-2021 (Figure 5). This presents a challenge as some GCPHN Psychological Service providers (PSP) have very high waiting times for appointments. Psychological Services

have continued to express their preference to take MBS clients over PSP clients as the administrative burden of the MBS program is smaller with no reporting or performance monitoring requirements.

Figure 5. Mental health consultations with anxiety/depression as the reason for visit, 159 Gold Coast General Practices, 2019-20 to 2021-22



Source: Primary Sense

System Navigation

Consultation throughout the 2020 Gold Coast Joint Regional Plan between Gold Coast Health and Gold Coast Primary Health Network identified that there is a high demand for system navigation support and to support people to assess and determine suitable options. Two main elements to services navigation have been identified:

1) Uncoordinated and inconsistent approach to assessment, referrals, and intake.
    - Most services operate an assessment and intake component for their service meaning individuals and referrers often have to share their story at each transition point or when ascertaining eligibility. When people are not matched to the right service initially, they have to retake the intake process, which can be a system inefficiency and can contribute to a poor experience and poor outcomes. Additionally, the frustrating experience of trying to find the right fit can result in disengagement and opportunities for early intervention may be lost with people presenting to the system later in crisis.
    - An inconsistent approach to assessment (e.g various tools) leads to inconsistent assigned levels of care, resulting in discrepancies in the type of care provided across providers and regions, for similar clinical presentations
    - Referrals to services are often inappropriate, resulting in people being under or over serviced.
2) Limited awareness/understanding of service infrastructure, including availability and capability of services.
    - Referrals to services are often inappropriate, resulting in people being under or over serviced.
    - There are many pathways to mental health, AOD and suicide prevention and support services. Community members and service providers perceive that the local service system changes frequently

due to funding changes, resulting in providers and people being unclear about available services and the pathways to access these services. There is a need for timely and accurate information and easily identifiable access points for individuals seeking care, so that they can be matched with the service which optimally meets their needs.

MBS changes and workforce issues

The Better Access initiative aims to improve treatment and management for people who have mild to moderate mental health conditions through Medicare rebates. GPs are encouraged to work more closely and collaboratively with psychiatrists, clinical psychologists, registered psychologists, occupational therapists, and appropriately trained social workers to support patients.

The tables below highlight the increase in Medicare-subsidised mental health-specific services from 2015-2016 to 2019-20 on the Gold Coast. The increase in GPs, clinical psychologists, and other allied health providers Medicare-subsidised mental health-specific services is above the Gold Coast population growth rate, as well as faster that the employment rate for clinical psychologists and medical practitioners.

- Number of medical practitioners (working in all settings) employed on the Gold Coast increased by 23.3% (2,070 in 2015 to 2,552 in 2020).
- Number on clinical psychologists (working in all settings) employed on the Gold Coast increased by 23.2% (514 in 2015 to 633 in 2020)[2].
- During the same period, the Gold Coast population increased by 10.3% (575,629 in 2015 to 635,191 in 2020)[1].

Table 4. Number of Medicare-subsidised mental health-specific services, Gold Coast, 2015-16 to 2019-20

Provider type	2015-16	2016-17	2017-18	2018-19	2019-20	Change from 2015-16 to 2019-20 (%)
Psychiatrists	82,241	84,033	84,162	85,276	87,138	6.0%
General practitioners	93,462	102,199	110,186	120,163	122,516	31.1%
Clinical psychologists	65,549	69,438	75,266	80,405	85,333	30.2%
Other psychologists	95,942	92,091	100,336	105,059	106,073	10.6%
Other allied health providers	5,790	7,422	7,675	7,484	8,501	46.8%
All providers	342,984	355,183	377,625	398,387	409,561	19.4%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

The number of GP Medicare-subsidised mental health-specific services on the Gold Coast (including Mental Health Treatment items, review of a GP Mental Health Treatment Plan, and GP Mental Health Treatment Consultation) have increased by 31.1% from 2015-16 to 2019-20. The increase was the largest in Robina (42.6%), while Ormeau-Oxenford had the greatest number of services (n=28,221).

[2] Sources: Department of Health 2020; ABS 2018
[1] Queensland Government Population Projections, 2018 edition (medium series)

Table 5. Number of General Practitioner Medicare-subsidised mental health health-specific services, Gold Coast SA3 regions, 2015-16 to 2019-20

Region	2015-16	2016-17	2017-18	2018-19	2019-20	Change from 2015-16 to 2019-20 (%)
Broadbeach - Burleigh	10,026	10,828	11,489	12,686	13,232	32.0%
Coolangatta	9,829	10,403	11,229	11,530	11,424	16.2%
Gold Coast - North	11,562	12,276	13,082	14,102	14,559	25.9%
Gold Coast Hinterland	3,449	3,538	3,874	4,349	4,302	24.7%
Mudgeeraba - Tallebudgera	4,998	5,388	5,967	6,643	6,869	37.4%
Nerang	10,008	11,350	11,676	12,700	13,028	30.2%
Ormeau - Oxenford	20,416	23,149	25,135	27,788	28,221	38.2%
Robina	7,220	8,243	8,865	9,991	10,295	42.6%
Southport	10,248	11,031	12,350	13,173	13,154	28.4%
Surfers Paradise	5,726	6,012	6,544	7,227	7,457	30.2%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

The number of Medicare-subsidised services by clinical psychologists has increased by 30.2% from 2015-16 to 2019-20 on the Gold Coast. Table 6 shows that Broadbeach-Burleigh had the largest percentage increase with 47% (7,830 in 2015-16 to 11,508 in 2019-20). Ormeau-Oxenford had the greatest number of clinical psychologists' services with 15,872 in 2019-20.

Table 6. Number of Medicare-subsidised services by clinical psychologists, Gold Coast SA3 regions, 2015-16 to 2019-20

	2015–16	2016–17	2017–18	2018–19	2019–20	Rate change from 2015-16 to 2019-20
Broadbeach - Burleigh	7,830	8,987	9,832	10,616	11,508	47.0%
Coolangatta	7,836	7,943	8,318	8,982	9,422	20.2%
Gold Coast - North	7,346	7,678	8,286	8,390	9,061	23.3%
Gold Coast Hinterland	2,114	2,287	2,393	2,442	2,438	15.4%
Mudgeeraba - Tallebudgera	3,892	4,066	4,481	5,009	5,386	38.4%
Nerang	7,975	8,109	7,841	8,990	9,342	17.1%
Ormeau - Oxenford	11,652	12,222	14,912	14,922	15,872	36.2%
Robina	5,956	5,971	6,495	7,452	8,011	34.5%
Southport	7,038	7,664	8,379	8,445	8,780	24.8%
Surfers Paradise	3,926	4,525	4,349	5,177	5,531	40.9%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

Accessibility of evidence based electronic (digital) mental health services

The term electronic mental health (e-mental health) refers to the use of the internet and related technologies to deliver mental health information, services, and care[14]. The use of online interventions for the prevention and treatment of mental illness is one of the major applications of e-mental health.

There is strong evidence to suggest that these e-mental health interventions are effective for use in the management of mild to moderate depression and anxiety and can be distributed in the primary care setting[15].

Benefits of evidence based electronic mental health services are the following:

- convenient and flexible
- low, or no service cost to patients
- fill service gaps
- saves practitioner's time
- cost effective to the health system
- easily accessible

There are numerous considerations that need to be managed for evidence based digital mental health services to be fully and effectively integrated into Australia mental healthcare services, such as:

- training in evidence based digital mental health services,
- confidentiality,
- record keeping,
- clinical risk,
- healthcare planning,
- reimbursement, and
- establishing care boundaries.

COVID-19

The potential for COVID-19 to impact mental health and wellbeing was recognised early in the pandemic[16]. In addition to concerns around contracting the virus itself, some of the pressures necessary to contain its spread, such as the sudden loss of employment, limited social interaction, and the added stressors of moving to remote work or schooling, were also likely to negatively impact mental health[17].

Use of MBS subsidised mental health items

Between 16 March 2020 and 24 January 2021, almost 11.5 million MBS-subsidised mental health-related services were delivered nationally ($1.3 billion paid in benefits); almost $3.7 million (32.1%) of these services were delivered via telehealth (as opposed to face to face) and $428 million was paid in benefits for telehealth services[18].

In the 4 weeks to 24 January 2021, 736,344 services were delivered, slightly exceeding the services provided in the 4-week periods to 26 January 2020 and 27 January 2019 (noting that in 2019 and 2020 these weeks

[14] Eisenach G. What is e-health? J Med Internet Res 2001;3(2):e20.
[15] Richards D, Richardson T. Computer-based psychological treatments for depression: a systematic review and meta-analysis. Clin Psychol Rev 2012;32(4):329–42
[16] WHO (World Health Organization) 2020a. Substantial investment needed to avert mental health crisis, https://www.who.int/news-room/detail/14-05-2020-substantial-investmentneeded-to-avert-mental-health-crisis
[17] NMHC (National Mental Health Commission) 2020. National mental health and wellbeing pandemic response plan, https://www.mentalhealthcommission.gov.au/getmedia/1b7405ce5d1a-44fc-b1e9-c00204614cb5/National-Mental-Health-and-Wellbeing-PandemicResponse- Plan
[18] Medicare Benefits Schedule data

include a national public holiday). Services in the 4 weeks to 31 January 2021 were 3.4% and 6.0% higher than services in the 4 weeks to 2 February 2020 and 3 February 2019, respectively.

Pharmaceutical Benefits Scheme (PBS) prescriptions

In the 4 weeks to 20 December 2020, there was a 3.6% increase in mental health-related prescriptions dispensed under the PBS, compared to the 4 weeks to 19 December in 2019. Prescriptions for antidepressants increased by 4.6% in this period. A spike in PBS-subsidised prescriptions and under co-payments, including all mental health-related prescriptions, was observed in March 2020. This represented an 18.6% increase in the number of prescriptions dispensed in the 4 weeks to 29 March 2020, compared to the 4 weeks to 28 March 2019[19].

Use of crisis/support organisations and online mental health information services

There are a range of crisis, support, and information services to support Australians experiencing mental health issues. These services have reported an increase during the COVID-19 pandemic.

In the four weeks to 24 January 2021:

- Over 85,000 calls were made to Lifeline, which is a 10.0% increase from the 4 weeks to 26 January 2020 and 21.4% from the 4 weeks to 27 January 2019.
- Kids Helpline received almost 23,000 answerable contact attempts (including calls, web chats and emails), which is an 8.7% decrease from the 4 weeks to 26 January 2020 and a 1.3% increase from the 4 weeks to 27 January 2019.
    - In the same period, 2.9% of contacts with Kids Helpline were related to COVID-19.
- Over 22,000 contacts were made to Beyond Blue (including calls, web chats and emails), which is a 27.2% increase from the 4 weeks to 26 January 2020 and 29.6% from the 4 weeks to 27 January 2019.
    - Contacts to the Coronavirus Mental Wellbeing Support Service accounted for 11.6% of all contacts to Beyond Blue in the 4 weeks to 24 January 2021.

COVID-19 Better Access

As part of the Australian Government's COVID-19 response, changes were made to the Better Access initiative including:

- an increase from 10 to 20 in Medicare subsisded individual psychological services each calendar year,
- expanded eligibility to include residents of aged care facilities,
- expanded access to telehealth.

Local stakeholders report that the changes to Better Access have impacted on the workforce and consequently, and timely access to services for people seeking mental health support. NGOs service providers report increased wait times for their services due to difficulty in recruiting staff as many private practitioners are choosing to work from home and see patients through Better Access. This is particularly an issue in the northern corridor of the Gold Coast as there is already a limited workforce and high demand in the area.

Underserviced Groups

Many underserviced groups have higher rates of psychological distress and may not access services due to numerous determinants, such as location, cost, culturally appropriateness of the service provider, and language barrier. These characteristics may make it difficult for people to participate, especially if the ways

[19] PBS/RPBS data maintained by the Department of Health and soured from Services Australia

in which they are expected to contribute do not make allowances for the barriers they may face. As a result, careful consideration of services to best meet their needs are required.

A current barrier for underserviced population groups accessing the Medicare Benefits Schedule Better Access initiative is the out-of-pocket cost for the patient. Australian Bureau of Statistics survey identified that high out-of-pocket costs prevent people with long-term or chronic conditions from seeking healthcare and place financial strain on low-income consumers[20]. An increasing number of people delay visits to GPs and psychologists because of cost consideration[21].

In 2016-17, 43.1% of Gold Coast residents had an out-of-pocket cost for a non-hospital Medicare service. For these patients with a cost, the median amount spent per year was $145 per patient[22].

In 2020-21, the total fees charged by the clinical psychologists for 98,596 services amounted to $16,308,149, comprising the benefits paid by Medicare and patients' out-of-pocket cost[23].

Data, research and consultation with service users, service providers, community members and Clinical Council identified the following groups as potentially underserviced and people in distress (including those who do not have a current mental health diagnosis and maybe at increased risk of suicide on the Gold Coast):

- Aboriginal and Torres Strait Islanders
- Culturally and Linguistically Diverse
- LGBTIQAP
- perinatal – have had a baby in the last 12 months
- children up to 12 years old
- children in out of home care (up to 12 years old)
- experiencing or at risk of homelessness
- people who have attempted, or are at risk of suicide or self-harm
- veterans
- youth justice
- older adults (aged 65 and over)
- children with autism
- people with a dual diagnosis
- complex families
- people with an eating disorder
- men linked to family court
- victims of family and/or domestic violence

[20] Patient Experiences in Australia, Summary of Findings, Australia Bureau of Statistics, 2020
[21] Patient Experiences in Australia: Summary of Findings, 2011-12, Australian Bureau of Statistics
[22] Australian Institute of Health and Welfare analysis of Department of Health, Medicare Benefits claims data, 2016–17
[23] Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data, 2020-21

Service system

Services	Number in GCPHN region	Distribution	Capacity Discussion
NewAccess, Beyondblue, Low intensity CBT Coaching (funded by GCPHN)	1 service	Online, outreach locations based in Mermaid Beach	• NewAccess is a new service with increasing referrals. • online, telephone and face to face services • Due to the paucity of local service usage, it is unclear if there are significant capacity issues with telephone or online services.
Counselling helplines and websites	10 national help lines (men's line, Veterans and veterans families counselling service, Qlife, CAN, Carers Australia, eheadspace, 1800 Respect, Relationships Australia, Counselling online, Child abuse preventions service	Online and telephone services. Public knowledge of these services and connectivity capacity would drive uptake/demand. Service offers online, telephone and face to face services. Outreach locations based in Northern corridor and Varsity lakes.	• Issues may arise during peak periods of call volumes and web activity. • Potential access barriers include internet infrastructure and associated costs, digital literacy and consumer and health provider awareness.
Information and referral helplines and websites.	9 national (MindHealthConnect, Mi networks, SANE Australia, beyond blue, ReachOut.com, R U Ok? Black Dog Institute, Mental Health Online, Commonwealth Health Website)	Online and telephone services. Public knowledge of these services and connectivity capacity needed to drive uptake/demand.	
eTherapy. Information and referral helplines and websites.	57 (online programs recommended through MindHealth Connect to promote eTherapy and self-care).	Online and telephone services. Public knowledge of these services and connectivity capacity is needed to drive uptake/demand.	
General practice	212	Clinics are generally distributed across the Gold Coast; majority located in coastal and central areas.	• General practice is a key point of contact for people with mental health needs.

Consultations

Various consultation activity was undertaken across the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one-to-one interviews, industry presentations, working groups and co-design processes.

Service provider consultation

- The ability of the GP to maintain an awareness of local services and confidently refer clients has a significant positive impact on recovery. It means that the care of the GP can be augmented with services that best fit the needs of the client. Examples are coaching services, community-based self-help groups and soft entry e-services that use activities to engage clients and build skills and confidence.
- If GPs know about and refer patients to online, self-help, low intensity services, it can assist the recovery journey for the patient.
- Balanced against service provider feedback, a comment received from a GP: "If patients are able to articulate what their needs are, this is associated with a level of satisfaction, but sometimes they don't want what is offered, so it is difficult to find the most appropriate solution or referral pathway".
- High numbers of child and youth service need (mild to moderate intensity).
- Possible gap with mild to moderate service availability (e.g., brief intervention).
- Need to look at service options in northern corridor on the Gold Coast:
    - Most services tend to end around Southport yet there is significant growth in Northern Corridor (Pimpama and Ormeau).
    - Since COVID, single practitioners in the Northern Corridor area are attending to mental health issues for 20-30% of daily practice.
    - Northern corridor community actively seeking after hours options, when crisis happens Southport is too far away, especially for young families. Many of these young families include migrants and FIFO workers, with additional challenges in accessing services.
- GCPHN's Clinical Council provided feedback during consultation session in May 2021 that there is significant strain on GPs in the Coomera, Ormeau and Oxenford area:
    - Number of consultations GPs are having with patients with mental health concerns has significantly increased over the past 2 years (particularly in the past 12 months)
    - GPs report that they deliver increased number of consultations due to significant lack of allied health service availability in the GCPHN region.
    - GPs in this area also report very high levels of work stress due to patients' mental health needs escalating over time, and GPs "holding" a reasonable degree of patient risk whilst the patient/s are waiting to access a service.

Service user consultation

Service users report that the identification and development of flexible evidence-based services would add value to existing available options. Additionally, a campaign to inform general practice about the services available would add value for consumers. Digital mental health services do fulfil a need for some consumers, and effective pathways can increase the accessibility of these evidence based electronic services.

Consultation and feedback from stakeholders:

- Increasing numbers evident of middle-aged females who are exhibiting potentially harmful numbers use of alcohol which have been frequently reported to be in relation to increased psycho-social stressors.
- Underserviced groups, including Aboriginal and Torres Strat Islander, LGBTIQAP+ people, CALD communities and individual's using substances or experiencing psychosocial stressors, can benefit low intensity services.
- Low intensity mental health services must be supported to be the primary referral point for mental health support.
- Concerns with health literacy and awareness of prevention.

Primary and Community Care Community Advisory Group

Primary needs/gaps identified included:

- Crisis accommodation, particularly for domestic violence.
- Domestic violence services to support people to access safety.
- Transport options for homeless. Many of the foodbanks etc require transport. An idea that was raised was transport concession cards for homeless people.
- Advocacy for the homeless particularly in regard to the Gold Coast City Council. We are aware the Gold Coast City Council now has 2 Public Space liaison workers (for the whole Gold Coast). It is identified that homeless people are being served notice to move on from an area, but then their belongings are confiscated when they're not looking (so to speak) and there doesn't seem to be a pathway to get their belonging back. We identified that this cohort need advocacy to prevent it getting to the point where all their worldly possessions are taken from them.
- Bulk billing psychiatrists.
- Bulk billing psychology.
- Cardiometabolic monitoring - this is interesting because we are developing our cardiometabolic monitoring & deprescribing clinic.

COVID-19 Impacts

The Wesley Mission Queensland COVID-19 Recovery Service was established to provide responsive wellbeing support for people aged 16 years and over living in the GCPHN region whose wellbeing has been impacted by the ongoing effects of COVID-19. Below are the most common reasons for presentations to the service:

- Loneliness and social isolation,
- Suicidal ideation,
- Problems with secure housing,
- Financial barrier's such as loss of employment/struggles to secure adequate ongoing employment,
- Overall anxiety and depressive presentations – low mood and lack of motivation,
- Struggles with accessing services such as Centrelink and NDIS,
- Loss of routine,
- Grief and loss,
- Difficulties in accessing appropriate higher mental health services in a timely manner due to long waitlists.

In addition to the above, very early on in the rollout of this service it became apparent that schools needed support as children's anxiety levels had increased; anecdotally, home-schooling had a massive impact on

some students finding it difficult to re-engage in face-to-face learning. Parents were also struggling with how to deal with the impact of COVID-19 on the mental health and wellbeing of their children.

Stepped care approach to mental health service

Consultation indicated some elements of a Stepped Care approach are functioning well in the Gold Coast region; however, commitment is required to continue to engage local stakeholders in a shared understanding. The Stepped Care model was primarily developed within the mental health sector. While it does not preclude suicide prevention or alcohol and other drugs services it does not specifically address some of the unique issues within these specialist areas. While some services are associated with a single level of care, most contribute to multiple levels.

Severe and complex mental illness

Local health needs and service issues

- Evolving service system results in general practitioners being unclear about available services and the pathways to access these services.
- Current electronic systems limit communication and shared care planning with consumers across the network or services.
- System navigation is difficult for general practitioners and people.
- Some people may need ongoing support (e.g., when diagnosed with personality disorders) but do not meet the criteria for care coordination or supports designed for severe and complex mental illness.
- Many general practitioners feel they do not have the information and resources required to assist patients with severe and persistent mental illness.
- Timely access to services is needed for people seeking mental health support.
- There is increasing demand for all mental health services.

Key findings

- A greater focus on early intervention is required to prevent escalation of mental health conditions to avoid crisis and hospital presentations, with a focus on improving health literacy and self-management. This is relevant for both community and service providers.
- Southport has the highest rates and greatest numbers related to severe and complex metal health.
- Gold Coast patients had the 13th highest rate of patients prescribed a mental health-related medication among the 31 PHNs, with 19% of the Gold Coast population being prescribed a medication for mental health.
- In 2018-19, Gold Coast PHN rate of mental health overnight hospitalisations was aligned with the national rate.
- Mood (affective) disorders were most common primary mental health diagnoses for participants in the Gold Coast Partners in Recovery program.
- Estimated prevalence of eating disorders on the Gold Coast is consistent with national trends.
- Peer workers are acknowledged by both providers and consumers as important support for people with severe and complex mental health needs, however the present workforce is small.
- It is import for consumers to feel empowered to be involved in decision-making about their care; providers have a key role to act as facilitators to enable this.
- Clinical care coordination is consistently at capacity and has a waitlist of 6 to 8 weeks generally.

Prevalence and service use

People with severe and complex mental illness have varying needs requiring a range of supports. Some have episodic illness which can be supported through time-limited clinical services in the primary care setting. Others have persistent illness requiring acute hospital-based services coupled with some form of psychosocial support, ranging from group-based activities to extensive and individualised disability support.

Within the primary care setting, almost half the people with severe mental illness are currently supported by a psychiatrist. Many others rely primarily on general practitioners (GPs) to provide both mental and physical health services. Given that many people with severe and complex mental illness also experience poor physical health outcomes, it is critical that psychiatrists and GPs are supported in delivering care to this vulnerable group.

The Australian Bureau of Statistics 2017-18 National Health Survey estimated that 1 in 5 (20%) Australians had a mental or behavioural condition during the collection period. The survey estimates are based on self-reported data and record a survey participant as having a mental or behavioural condition during the collection period only if it was also reported as long-term (had lasted, or was expected to last, a minimum of 6 months).

Another insight into the mental health and wellbeing of Australians is provided by measures of psychological distress. Psychological distress can be described as unpleasant feelings or emotions that affect a person's level of functioning and interfere with the activities of daily living.

In 2017-18, around one in eight (13% or 2.4 million) Australians aged 18 years and over were currently experiencing high or very high levels of psychological distress, an increase from 2014-15 (11.7%). Between 2014-15 and 2017-18, rates of high or very high psychological distress remained reasonably stable across most age groups, except for an increase in 55-64-year-old women (from 12.3% to 16.9%)[1].

Applying the above figure to the 2021 census Gold Coast population, 83,301 Gold Coast people aged 20 years and over are currently experiencing high or very high levels of psychological distress.

It is difficult to pinpoint the areas of the Gold Coast with the greatest severe and complex mental health need. However, a review of Medicare Benefits Schedule (MBS), PBS, hospital, and service usage data indicate Southport Statistical Area Level 3 (SA3) region is the area with the highest rates and greatest numbers related to severe and complex metal health. In addition to this, Southport is a highly disadvantaged area with multiple characteristics of vulnerability. This disadvantage is further compounded by Southport being the region with the highest number of people who are homeless, people who did not speak English well or at all, living in one parent families, and having the second highest percentage of people requiring assistance with a profound or severe disability on the Gold Coast.

Partners in Recovery

Between 2013 and 2019, the Partners in Recovery (PIR) program supported people with severe mental illness, experiencing severe and persistent symptoms living on the Gold Coast. This group of people had significant functional impairment and psychosocial disability, may be disconnected from social or family support networks, and had complex multiagency needs. Many of these people were the focus of the National Disability Insurance Scheme (NDIS) Tier 3 individual support packages.

[1] Australian Bureau of Statistics. (2018). National Health Survey: First Results 2017-18. Canberra: ABS

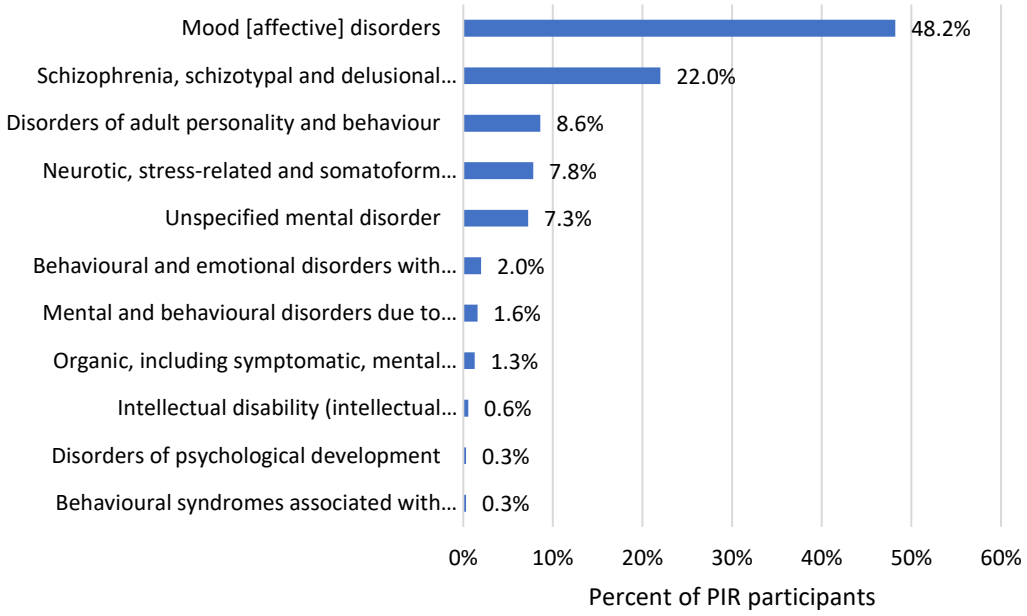
The GCPHN PIR program supported 1,363 people with severe mental illness from November 2013 to June 2019. While this does not represent the entire Gold Coast population with severe and complex mental health conditions, PIR program data provides insight to the health needs of this group of service users.

Among PIR participants:

- 59.1% were female, 40.8% male and 0.1% were of 'other' sex.
- 4.5% were aged 25 and under, 42.4% were aged 25 to 44, 46.8% were aged 45 to 64, and 6.2% were aged 64 and over.

As shown in Figure 1, the most common primary mental health diagnosis among PIR participants was a mood (affective) disorder (48%), followed by schizophrenia, schizotypal and delusional disorders (22%).

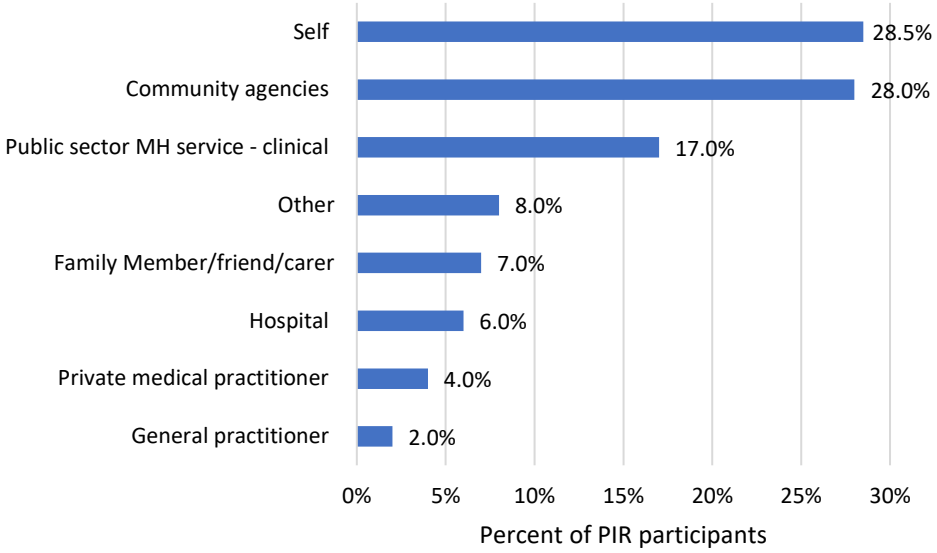
Figure 1. Primary mental health diagnosis for Partners in Recovery participants, November 2013-June 2019



Source: PIR-FIXUS

Figure 2 illustrates that 29% of the participants were self-referred, 28% were referred by community agencies and 17% by public sector mental health service

Figure 2. Principal mental health service providers for Partners in Recovery participants, November 2013-June 2019

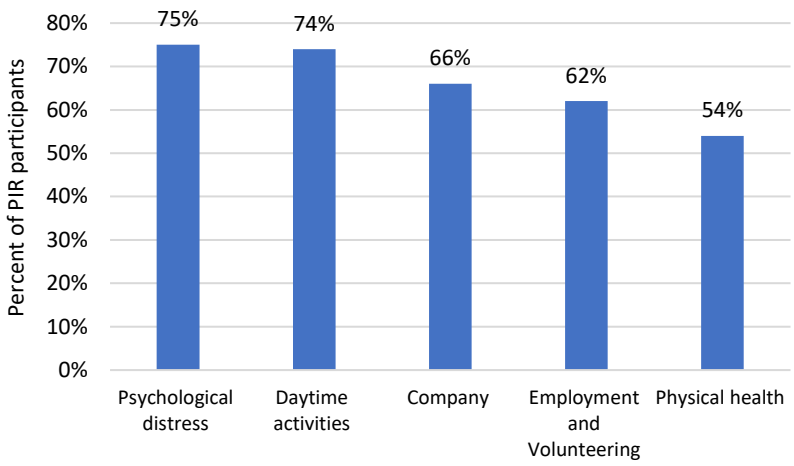


Source: PIR-FIXUS

PIR participants identified their unmet needs at intake of the program. Psychological distress (75%) was the most common unmet need, closely followed by daytime activities (74%) (Figure 3).

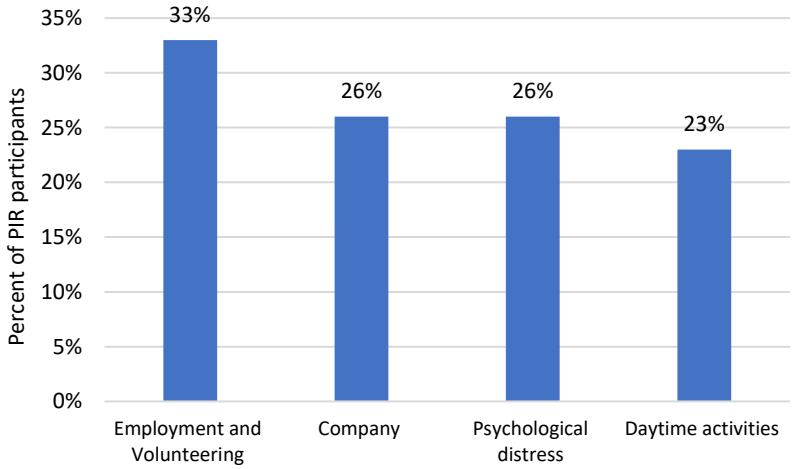
Among PIR participants exiting the program, 33% stated their unmet need was employment/ volunteering followed by company (26%). This change in unmet needs from intake and exit identifies that participants in the PIR program received the care they required which changed their unmet needs from intake to exit.

Figure 3. Most identified unmet needs at intake, Partners in Recovery participants, November 2013-June 2019



Source: PIR-FIXUS

Figure 4. Most identified unmet needs at exit, Partners in Recovery participants, November 2013-June 2019



Source: PIR-FIXUS

The Partners in Recovery program was decommissioned in June 2019. At that point, there was a total of 197 participants in the PIR service. These 197 participants transitioned into:

- 103 participants (52.3%) - NDIS (eligible for NDIS)
- 65 participants (33.0%) - National Psychosocial Support Program (yet to test eligibility for NDIS)
- 29 participants (14.7%) - Continuity of Support Program (not eligible for NDIS)

Mental health overnight hospitalisations

Just as people may require admission to hospital for assessment and treatment of their physical health problems, some people may require admission to a mental health (psychiatric) inpatient unit for the assessment and treatment of their mental health. For most people, an admission to a mental health unit is

planned between themselves and their doctor or mental healthcare specialist. For others, it is the result of a person being in a mental health crisis requiring immediate treatment or access and manage risk and alleviate stress. This may be the person's first experience of mental illness, a repeat episode, or the worsening symptoms of an often-continuing mental illness. Admission under these circumstances may be voluntary or involuntary.

In 2018-19, Gold Coast Primary Health Network (GCPHN) region had a rate of separations (episodes of admitted patient care) for mental health related reasons of 108 per 10,000 people, which was in line with the national rate 107.6. In total in 2018-19 on the Gold Coast, there were:

- 6,742 separations on the Gold Coast
- 96,757 patient days
    - 1,556 patient days per 10,000 population which was above the national rate of 1,214.
- 83,540 psychiatric care days
    - 1,343 psychiatric care days per 10,000 population which was above the national rate of 1,207.
- 16,657 procedures
    - 268 procedures per 10,000 population which was above the national rate of 170.

Table 1 shows 31 Primary Health Networks and the number and rate per 10,000 for separations, patient days, psychiatric care days and procedures (please refer to appendices one for key concepts for overnight admitted mental health-related care).

Table 1. Overnight admitted mental health-related population rates of separations, bed days, psychiatric care days, and procedures, with and without specialised psychiatric care, by Primary Health Network, 2018-19

PHN	Separations		Patient days		Psychiatric care days		Procedures	
	Number	Rate per 10,000	Number	Rate per 10,000	Number	Rate per 10,000	Number	Rate per 10,000
Western Queensland	859	137.2	760.3	2,827	2,827	451.8	868	138.7
North Coast	6,589	125.5	88,498	1,685.4	70,425	1,341.2	14,535	276.8
Country SA	6,235	124.3	55,467	1,105.3	36,124	719.9	10,547	210.2
Brisbane North	12,687	123.7	164,021	1,599.8	138,243	1,348.4	35,671	347.9
Perth North	12,804	119.5	198,926	1,857.3	173,030	1,615.5	28,617	267.2
South-eastern Melbourne	18,506	117.0	240,982	1,523.0	190,824	1,206.0	42,480	268.5
South-eastern NSW	7,250	116.0	97,123	1,554.4	78,788	1,260.9	17,329	277.3
Hunter New England and Central Coast	14,391	113.4	211,961	1,669.8	177,105	1,395.2	34,257	269.9
Nepean Blue Mountains	4,285	113.2	56,799	1,500.6	45,753	1,208.7	11,915	314.8
Tasmania	5,803	109.9	97,346	1,843.0	79,165	1,498.8	9,412	178.2
Gippsland	3,091	109.2	37,268	1,316.7	29,407	1,039.0	6,974	246.4
Gold Coast	**6,742**	**108**	**96,757**	**1,556**	**83,540**	**1,343**	**16,657**	**268**
Northern Territory	2,678	108.3	23,365	944.7	15,972	645.8	2,244	90.7
Western NSW	3,349	108.1	47,531	1,534.9	40,098	1,294.9	8,187	264.4
Adelaide	13,212	107.0	160,047	1,296.3	124,372	1,007.4	29,878	242.0
Brisbane South	12,417	106.8	170,414	1,465.5	145,640	1,252.5	35,165	302.4
Northern Queensland	7,446	106.7	99,627	1,427.0	85,112	1,219.1	14,745	211.2
Country WA	5,552	104.6	53,271	1,003.7	40,468	762.5	8,654	163.0
Darling Downs and West Moreton	6,013	104.1	78,992	1,367.6	66,251	1,147.0	12,587	217.9
Central and Eastern Sydney	16,848	103.3	254,728	1,561.4	191,990	1,176.8	44,126	270.5
Murrumbidgee	2,522	102.8	32,396	1,320.6	26,521	1,081.1	4,392	179.0
Southwestern Sydney	10,359	102.4	131,354	1,298.5	102,033	1,008.7	17,538	173.4
Murray	6,242	101.2	84,620	1,371.4	63,641	1,031.4	12,125	196.5
Perth South	10,016	100.6	142,658	1,432.5	123,078	1,235.9	25,569	256.8
Central Queensland, Wide Bay, Sunshine Coast	8,416	97.5	95,876	1,111.1	76,751	889.5	19,942	231.1
Northern Sydney	9,027	95.9	156,815	1,665.9	132,217	1,404.6	26,015	276.4
Australian Capital Territory	3,984	94.6	56,131	1,333.4	47,187	1,120.9	8,430	200.3
Eastern Melbourne	14,582	93.8	200,125	1,287.6	158,753	1,021.4	39,121	251.7
North-western Melbourne	16,862	92.3	255,033	1,396.0	205,344	1,124.0	39,357	215.4

Western Victoria	5,937	91.2	85,890	1,319.8	64,802	995.8	12,644	194.3
Western Sydney	8,290	82.9	153,994	1,540.2	133,983	1,340.1	20,391	204.0

Source: National Hospital Morbidity Database.

Analysis of Gold Coast SA3 regions shows that the Ormeau-Oxenford the largest number of separations with 1,004, although the rate per 10,000 population was the lowest among the ten GCPHN SA3 regions (Table 2).

Table 2. Overnight admitted mental health-related population rates of separations and patient days, GCPHN SA3 regions, 2018-19

Region	Separations		Patient days	
	Number	Rate per 10,000	Number	Rate per 10,000
Coolangatta	866	152.8	12,030	2,122.9
Southport	919	146.2	11,709	1,862.1
Gold Coast - North	939	134.0	13,891	1,982.5
Robina	665	123.9	15,098	2,812.2
Surfers Paradise	501	111.7	7,108	1,584.7
Broadbeach - Burleigh	725	110.5	9,960	1,518.0
Nerang	687	96.5	8,596	1,207.0
Gold Coast Hinterland	171	86.8	2,221	1,127.4
Mudgeeraba - Tallebudgera	266	74.6	3,709	1,039.5
Ormeau - Oxenford	1,004	70.9	12,448	878.6

Source: National Hospital Morbidity Database

Eating disorders

Eating disorders are group of mental illness typically characterised by problems linked with disturbed eating or body weight control, and a severe concern with body weight or shape. Eating disorders may occur at any stage of life, though they most often occur in young women. Eating disorders require a comprehensive, multidisciplinary approach from both mental and medical health disciplines. There are four types of commonly recognised eating disorders:

- Anorexia nervosa- characterised by the persistent restriction of food and water intake, intense fear of gaining weight and disturbance in self-perceived weight or body shape.
- Bulimia nervosa- characterised by repeated binge-eating episodes followed by compensatory behaviours like self-induced vomiting or laxative misuse.
- Binge eating disorder- characterised by repeated episodes of binge-eating, often with a sense of loss of control while eating.
- Other specified feeding or eating disorder- people with this disorder present with many of the symptoms of anorexia nervosa, bulimia nervosa or binge-eating disorder, but may not meet the full criteria for diagnoses for one or more of the disorders.

In 2015-16, 95% of Australian hospitalisations with a principal diagnosis of an eating disorder were for females. Females aged 15-24 made up the largest proportion of these hospitalisations (57%). Estimated prevalence of eating disorders in the Gold Coast PHN is consistent with the national prevalence.

Eating disorders such as anorexia and bulimia can be treated. The treatment outcomes are best when the disorder is identified early and treated promptly. Best outcomes are achieved when treatment plans are comprehensive and include media care, psychological intervention, and nutritional counselling.

On the 1st of November 2019, eating disorders became the first diagnostic category among mental illness to have their own item numbers under the MBS. The eating disorder treatment plan (EDP) items describe services for which Medicare rebates are payable where practitioners undertake the development of treatment and management plan for patients with a diagnosis of anorexia nervosa and patients with other specified eating disorders diagnoses who meet the eligibility of criteria.

The EDP items trigger eligibility for items which provide delivery of eating disorders psychological treatment (EDPT) services (up to 40 psychological services in a 12-month period) and dietetic services (up to a total of 20 hours in a 12-month period).

Data extracted though Primary Sense, GCPHN's data extraction and population health management clinical audit tool, identified slightly over 200 MBS items have been claimed by individuals for eating disorders from the 1st of November 2019 to 30th June 2020 in the 81 general practices submitting data on the Gold Coast during that period. Of all the eating disorders MBS items claimed on the Gold Coast, 91% were claimed by females, and young people aged 20 to 29 had the highest number of items claimed which mirrors national trends.

Pharmaceutical Benefits Scheme

Pharmaceutical Benefits Scheme (PBS) data provides insight into medication dispensing relating to mental health conditions.

The drug groups defined for this report as mental health-related medications in the PBS and RPBS are:

- psycholeptics
- anxiolytics
- hypnotics and sedatives
- psychoanaleptics
- antidepressants
- psychostimulants, agents used for ADHD and nootropics

Of the 39 million mental-health related prescriptions (subsidised and under co-payment) provided in 2018-19, the majority (86.3%) were prescribed by GPs, 7.7% were prescribed by psychiatrists and 4.5% by non-psychiatrist's specialist.

The majority of mental health-related prescriptions were for antidepressants (70.9%, or 27.6 million), followed by antipsychotics (10.7%), anxiolytics (9.0%), hypnotics and sedatives (5.6%) and psychostimulants, agents used for ADHD and nootropics (3.8%).

The Gold Coast had the 13th highest rate of patients prescribed a mental health-related medication among the 31 PHNs, with 19% of the 621,931 people living on Gold Coast population. Additionally, the Gold Coast had the 15th highest rate of rate of prescriptions (per 1,000 of the specific population) with 1,612 in 2018-19.

Table 3. Patients and mental health-related prescriptions (subsidised and under co-payment), by PHN, 2018–19

PHN	Patients		Prescriptions	
	Number	% of total population	Number	Rate per 1,000
Tasmania	118,421	1,112,643	22.4	2,106.5
North Coast	116,897	1,059,065	22.3	2,016.9
Central Queensland, Wide Bay, Sunshine Coast	187,038	1,712,166	21.7	1,984.2
Hunter New England and Central Coast	272,518	2,571,436	21.5	2,025.7
Murray	131,995	1,259,823	21.4	2,041.8
Gippsland	59,803	581,788	21.1	2,055.5
Western Victoria	136,568	1,309,902	21.0	2,012.8
Darling Downs and West Moreton	118,128	1,161,999	20.5	2,011.7
Western NSW	62,587	588,263	20.2	1,899.7
Murrumbidgee	49,168	459,341	20.0	1,872.5
South-eastern NSW	122,873	1,113,039	19.7	1,781.3
Country SA	98,521	916,343	19.6	1,826.0
Gold Coast	**118,406**	**1,002,660**	**19.0**	**1,612.2**
Brisbane North	194,278	1,779,774	18.9	1,736.0
Adelaide	230,494	2,107,275	18.7	1,706.8
Perth North	190,861	1,706,442	17.8	1,593.2
Northern Queensland	123,411	1,094,672	17.7	1,568.0
Country WA	93,692	838,352	17.7	1,579.6
Perth South	172,506	1,529,208	17.3	1,535.6
Nepean Blue Mountains	65,336	596,375	17.3	1,575.6
Brisbane South	200,069	1,796,075	17.2	1,544.6
South-eastern Melbourne	260,425	2,332,031	16.5	1,473.9
Australian Capital Territory	67,627	592,006	16.1	1,406.3
Eastern Melbourne	234,632	2,105,750	15.1	1,354.8
Western Queensland	9,229	76,514	14.8	1,222.8
North-western Melbourne	252,294	2,302,786	13.8	1,260.5
Northern Sydney	129,534	1,037,562	13.8	1,102.3
Southwestern Sydney	133,198	1,131,471	13.2	1,118.6
Central and Eastern Sydney	206,595	1,685,402	12.7	1,033.1
Western Sydney	114,495	985,985	11.5	986.2

Northern Territory	22,520	172,124	9.1	695.9

Source: PBS/RPBS data maintained by the Department of Health and sourced from DHS.

In 2018/19, Ormeau-Oxenford SA3 region had the highest number of patients who were prescribed a mental health medication (n=24,150) and the largest number of prescriptions (subsidised and under co-payment) with 198,447. Gold Coast-North had the second largest number of patients who were prescribed a mental health medication (n=15,337), the second largest number of prescriptions (subsidised and under co-payment) with 137,295, and the largest rate of patients who were prescribed a mental health medication (21.9%).

Gold Coast-North SA3 region had the highest rate of people aged 65 and over (23.7%) amongst the GCPHN SA3 regions data identified that people aged 85 years and over had the highest prescription rate per 1,000 population among the age cohorts[2].

Table 4. Patients and mental health-related prescriptions (subsidised and under co-payment), Gold Coast SA3 regions, 2018–19

Region	Patients		Prescriptions	
	Number	% of population	Number	Rate per 1,000
Gold Coast - North	15,337	21.9	137,295	1,959.5
Broadbeach - Burleigh	13,340	20.3	106,071	1,616.6
Southport	12,660	20.1	117,929	1,875.5
Gold Coast Hinterland	3,959	20.1	32,983	1,674.3
Coolangatta	11,293	19.9	98,533	1,738.8
Nerang	13,483	18.9	115,386	1,620.2
Surfers Paradise	8,152	18.2	65,038	1,450.0
Mudgeeraba - Tallebudgera	6,438	18.0	51,663	1,448.0
Robina	9,622	17.9	79,527	1,481.3
Ormeau - Oxenford	24,150	17.0	198,447	1,400.6

Source: PBS/RPBS data maintained by the Department of Health and sourced from DHS.

[2] ABS 3235.0, Population by Age and Sex, Regions of Australia

Cognitive impairment and mental illness

Cognition refers to the mental capabilities or thinking skills that allow a person to perceive, acquire, understand, and respond to information from their environment[3]. Cognitive impairment can be mild, or severe, or anything in between. There are long-standing gaps in health system information on cognitive impairment. These data gaps limit the ability to know the full extent and impacts of cognitive impairment and mental illness.

Research on cognitive impairment indicates that it is a primary symptom or core feature of schizophrenia and affective disorders[45]. Studies reporting on bipolar disorder indicate that increased cognitive dysfunction is associated with greater severity of symptoms, the number of affective episodes and the overall duration of illness[6] .There is also evidence suggesting that depression is associated with several deficits in cognitive functions such as memory and learning[7] .

A Project between the Mental Health Coordinating Council and the University of Sydney Faculty of Health Sciences identified no standards, guidelines or key studies could be found regarding the training and knowledge needs of mental health workers regarding working with people with mental illness and cognitive impairment despite a comprehensive search strategy internationally[8].

Ongoing support

People with severe and complex mental illness (such as personality disorder) often have long treatment histories. A coordinated ongoing community treatment model, which supports continuity of care and is understood within a relational model, is essential to the effective treatment of severe and complex mental illness[9].

It has been recognised that people with severe and complex mental illness needs may not meet the criteria for care coordination or supports designed for severe and complex mental illness. Due to this, some people may become more vulnerable resulting in exacerbation of issues and higher use of treatment services.

Peer workers

Peer workers are an essential workforce within the Queensland public mental health system. They come from a wide variety of backgrounds and have a range of skills, knowledge, and life experiences. Peer workers provide a unique perspective and offer hope to individuals on their recovery journey by showing that recovery is possible.

Peer workers draw on their lived experience to play unique roles in encouraging and supporting the recovery of people experiencing mental health issue by:

- Offering hope and supporting consumers and carers to develop a recovery-oriented perspective.
- Supporting consumers and carers to develop important life skills.

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[3] Medalia, A., & Revheim, N. (2002). Dealing with cognitive dysfunction associated with psychiatric disabilities: A handbook for families and friends of individuals with psychiatric disorders. New York State Office of Mental Health. DOI:10.5014/ajot.63.6.797

4 Green, M. F. (2006). Cognitive impairment and functional outcome in schizophrenia and bipolar disorder. Journal of Clinical Psychiatry, 67(10), e12-e12. DOI:10.4088/JCP.1006e12

[5] O'Carroll, R. (2000). Cognitive impairment in schizophrenia. Advances in Psychiatric Treatment, 6(3),161-168. DOI:10.1007/978-3-642-25758-2_2

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[8] Mental Health Coordinating Council Inc. (MHCC) 2015, Cognitive functioning: supporting people with mental health conditions, Authors: Henderson C (edit). Clements, S Corney, S Humin, Y & Karmas, R

[9] Project Air Strategy for Personality Disorders* (2015). Treatment Guidelines for Personality Disorders 2nd Ed. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

- Supporting consumers and carers to move beyond being a patient or carer to develop a personal sense of empowerment.
- Empathising with consumers and carers from a position of experience[10].

A key recommendation from the National Mental Health Commission national review of mental health programmes and services was the development of the mental health peer workforce to work together with consumers, families, support people, and multi-disciplinary teams to provide proactive and person-centred services and support[11].

Exposure or victim to domestic and family violence

Being exposed to or being a victim of family and/or domestic violence can have a wide range of detrimental impacts on one's mental and physical health, housing situation and general wellbeing. A range of mental health issues are linked with exposure to family and/or domestic violence including:

- depressive disorder
- anxiety
- sufficient self-harm
- alcohol use disorders

Data on reported domestic violence made by police or through private applications identified that 26% (n=760) of all domestic violence reported cases were reported in Ormeau-Oxenford SA3 region. It has been identified that a local service issue is access to a mental health clinician who would have a high degree of understating family and domestic violence issues.

Underserviced Groups

Many underserviced groups have higher rates of psychological distress and may not access services due to numerous determinants including location, cost, culturally appropriateness of the service provider and language barrier.

These characteristics may make it difficult for people to engage with health care, especially if the ways in which they are expected to contribute do not make allowances for the barriers they may face. Some of the key factors that can impact people's ability to access and successfully engage in services include language, age, gender identity, geographic location, income, ethnicity, education, residential status, sexual orientation, health, and religion. As a result, careful consideration of services to best meet their needs are required.

A current barrier for underserviced population groups accessing the Medicare Benefits Schedule Better Access initiative is the out-of-pocket cost for the patient. Australian Bureau of Statistics survey identified that high out-of-pocket cost prevent people with log-term or chronic conditions from seeking healthcare and place financial strain on low-income consumers[12]. An increasing number of people delay visits to (GP) and psychologists because of cost consideration[13].

In 2016-17, 43.1% of Gold Coast residents out an out-of-pocket cost for a non-hospital Medicare service. For these patients with a cost, the median amount spent in the year was $145 per patient. This means that half of patients with cost spent more than $145, and half spent less[14]. In 2018-19, the total fees charged by the

10 Austin, E., Ramakrishnan, A. & Hopper, K. (2014). Embodying recovery: A qualitative study of peer work in a consumer-run service setting. Community Mental Health Journal, 50(8), 879-885
11 National Mental Health Commission (2014). The National Review of Mental Health Programmes and Services. Sydney.
12 Patient Experiences in Australia, Summary of Findings, Australia Bureau of Statistics, 2020
13 Patient Experiences in Australia: Summary of Findings, 2011-12, Australian Bureau of Statistics
14 Australian Institute of Health and Welfare analysis of Department of Health, Medicare Benefits claims data, 2016–17

clinical psychologists were $12,148,391, comprising the benefits paid by Medicare and patients' out-of-pocket cost with 80,083 services being claimed[15].

Data, research and consultation with service users, service providers, community members and Clinical Council identified the following groups as potentially underserviced and people in distress (including those who do not have a current mental health diagnosis and may be at increased risk of suicide) on the Gold Coast:

- Aboriginal and Torres Strait Islanders
- Culturally and Linguistically Diverse
- LGBTIQAP
- perinatal – have had a baby in the last 12 months
- children up to 12 years old
- children in out of home care (up to 12 years old)
- experiencing or at risk of homelessness
- people who have attempted, or are at risk of suicide or self-harm
- veterans
- youth justice
- older adults (aged 65 and over)
- children with autism
- people with a dual diagnosis
- complex families
- people with an eating disorder
- men linked to family court
- victims of family and/or domestic violence

MBS changes and workforce issues

The Better Access initiative aims to improve treatment and management for people who have mild to moderate mental health conditions through Medicare rebates for people accessing care. GPs are encouraged to work more closely and collaboratively with psychiatrist, clinical psychologists, registered psychologists, occupational therapists, and appropriately trained social workers to support patients.

The tables below highlight the increase in Medicare-subsidised mental health-specific services from 2015-2016 to 2019-20 on the Gold Coast. This increase in GP, clinical psychologists, and other allied health providers Medicare-subsidised mental health-specific services is above the Gold Coast population growth rate and employment rate for clinical psychologists and medical practitioners.

- During the same period, the Gold Coast population increased by 10.3% (575,629 in 2015 to 635,191 in 2020)[16].
- Number of medical practitioners (working in all settings) employed on the Gold Coast working as a medical practitioner increased by 23.3% (2,070 in 2015 to 2,552 in 2020).

[15] Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data, 2018–19
[16] Queensland Government Population Projections, 2018 edition (medium series)

- Number of clinical psychologists employed on the Gold Coast increased by 23.2% (514 in 2015 to 633 in 2020)[17].

Table 5. Number of Medicare-subsidised mental health-specific services, Gold Coast, 2015-16 to 2019-20

Provider type	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Psychiatrists	82,241	84,033	84,162	85,276	87,138	6.0%
General practitioners	93,462	102,199	110,186	120,163	122,516	31.1%
Clinical psychologists	65,549	69,438	75,266	80,405	85,333	30.2%
Other psychologists	95,942	92,091	100,336	105,059	106,073	10.6%
Other allied health providers	5,790	7,422	7,675	7,484	8,501	46.8%
All providers	342,984	355,183	377,625	398,387	409,561	19.4%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

The number of GP Medicare-subsidised mental health-specific services (Mental Health Treatment items, review of a GP Mental Health Treatment Plan, and GP Mental Health Treatment Consultation) have increased by 31.1% from 2015-16 to 2019-20 on the Gold Coast. Table 6 shows that Robina had the largest increase with 42.6% (7,720 in 2015-16 to 10,295 in 2019-20). Ormeau-Oxenford had the greatest number of GP Medicare-subsidised mental health-specific services with 28,221 in 2019-20.

Table 6. Number of General Practitioner Medicare-subsidised mental health health-specific services, Gold Coast SA3 regions, 2015-16 to 2019-20

Region	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Broadbeach - Burleigh	10,026	10,828	11,489	12,686	13,232	32.0%
Coolangatta	9,829	10,403	11,229	11,530	11,424	16.2%
Gold Coast - North	11,562	12,276	13,082	14,102	14,559	25.9%
Gold Coast Hinterland	3,449	3,538	3,874	4,349	4,302	24.7%
Mudgeeraba - Tallebudgera	4,998	5,388	5,967	6,643	6,869	37.4%
Nerang	10,008	11,350	11,676	12,700	13,028	30.2%
Ormeau - Oxenford	20,416	23,149	25,135	27,788	28,221	38.2%
Robina	7,220	8,243	8,865	9,991	10,295	42.6%
Southport	10,248	11,031	12,350	13,173	13,154	28.4%
Surfers Paradise	5,726	6,012	6,544	7,227	7,457	30.2%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

[17] Sources: Department of Health 2020; ABS 2018

The number of Medicare-subsidised services by clinical psychologists has increased by 30.2% from 2015-16 to 2019-20 on the Gold Coast. Table 7 shows that Broadbeach-Burleigh had the largest increase with 47% (7,830 in 2015-16 to 11,508 in 2019-20), while Ormeau-Oxenford had the greatest number of clinical psychologists' services with 15,872 in 2019-20.

Table 7. Number of Clinical Psychologists Medicare-subsidised services, GCPHN SA3 regions, 2015-16 to 2019-20

Region	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Broadbeach - Burleigh	7,830	8,987	9,832	10,616	11,508	47.0%
Coolangatta	7,836	7,943	8,318	8,982	9,422	20.2%
Gold Coast - North	7,346	7,678	8,286	8,390	9,061	23.3%
Gold Coast Hinterland	2,114	2,287	2,393	2,442	2,438	15.4%
Mudgeeraba - Tallebudgera	3,892	4,066	4,481	5,009	5,386	38.4%
Nerang	7,975	8,109	7,841	8,990	9,342	17.1%
Ormeau - Oxenford	11,652	12,222	14,912	14,922	15,872	36.2%
Robina	5,956	5,971	6,495	7,452	8,011	34.5%
Southport	7,038	7,664	8,379	8,445	8,780	24.8%
Surfers Paradise	3,926	4,525	4,349	5,177	5,531	40.9%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

COVID-19

As part of the Australian Government's COVID-19 response, changes were made to the Better Access initiative including:

- an increase from 10 to 20 in Medicare subsisded individual psychological services each calendar year
- expanded eligibility to include residents of aged care facilities
- expanded access to telehealth.

Early data suggest utilisation of MBS funded psychological services remained high during 2020-21 on the Gold Coast.

Local stakeholders report that the changes to Better Access have impacted on the workforce and consequently, timely access to services for people seeking mental health support. NGOs service providers report increased wait times for their services due to difficulty in recruiting staff as many private practitioners are choosing to work from home and see patients through Better Access. This is particularly an issue in the northern corridor of the Gold Coast as there is already a limited workforce and high demand in the area.

System Navigation

Consultation throughout the 2020 Gold Coast Joint Regional Plan between Gold Coast Health and Gold Coast Primary Health Network identified a high demand for system navigation support and to support people to assess and determine suitable options. Two main elements of services navigation have been identified:

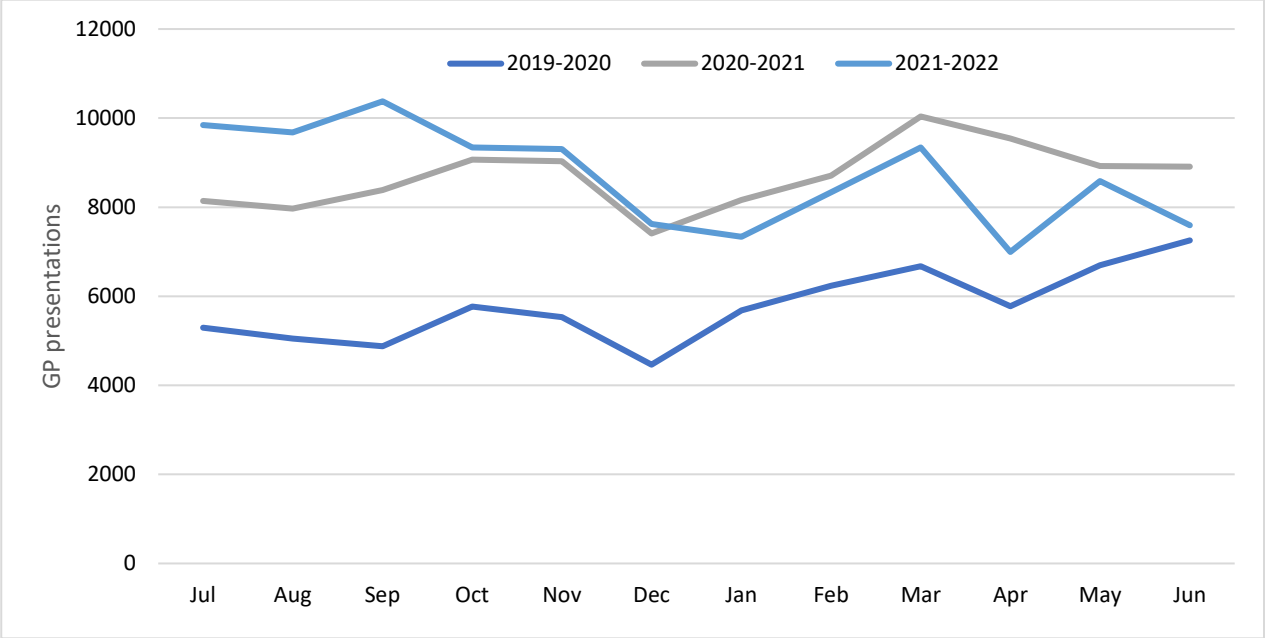
1) Uncoordinated and inconsistent approach to assessment, referrals, and intake:
    - Most services operate an assessment and intake component for their service, which means that individuals and referrers often have to share their story at each transition point or when ascertaining eligibility. When people are not matched to the right service initially, they have to retake the intake process, which can be a system inefficiency and can contribute to a poor experience and poor outcomes. Additionally, the frustrating experience of trying to find the right fit can result in disengagement and opportunities for early intervention may be lost with people presenting to the system later in crisis.
    - An inconsistent approach to assessment (e.g various tools) leads to inconsistent assigned levels of care, resulting in discrepancies in the type of care provided across providers and regions, for similar clinical presentations
2) Limited awareness/understanding of service infrastructure, including availability and capability of services:
    - Referrals to services are often inappropriate, resulting in people being under or over serviced.
    - There are many pathways to mental health, AOD and suicide prevention and support services. Community members and service providers perceive that the local service system changes frequently due to funding changes, resulting in providers and people being unclear about available services and the pathways to access these services. There is a need for timely and accurate information and easily identifiable access points for individuals seeking care, so that they can be matched with the service which optimally meets their needs.

Increasing demand management across the Stepped care approach

In 2020-21, GCPHN funded providers saw over 8,000 unique clients access the Stepped Care programs. The rate of referrals to PHN funded services across low intensity, psychological therapy and clinical care coordination continued to rise in Q4 (October, November, December) as compared to Q3 (July, August, September). These high referral rates are placing significant pressure on all services.

Data extracted through Primary Sense™, GCPHN data extraction and population health management clinical audit tool, shows that demand on services as evidenced by presentations to general practice for anxiety and depression increased from 2019-2020 to 2020-2021 (Figure 5). This presents a challenge as some GCPHN Psychological Service providers (PSP) have very high waiting times for appointments. Psychological Services have continued to express their preference to take MBS clients over PSP clients as the administrative burden of the MBS program is less with no reporting, or performance monitoring requirements.

Figure 5. Mental health consultations for anxiety or depression, Gold Coast, 2019-20 to 2021-22



Source: Primary Sense. Data collected from 159 general practices.

National Psychosocial Support (NPS)

In June 2018, the Commonwealth government announced funding for national psychosocial support measures for people with severe mental illness who are not more appropriately supported through the National Disability Insurance Scheme (NDIS), to be matched by State and Territory governments through bilateral agreements.

The Commonwealth component of the NPS measure is being implemented through purpose specific funding to Primary Health Networks (PHN) to commission these services. The PHN commissioned services will need to be implemented in a flexible way to complement the State and Territory funded psychosocial support.

People with a severe mental illness can access several Commonwealth funded psychosocial support services that provide support which aim to help people increase their ability to do everyday activities.

Psychosocial support can be provided individually or in a group and might focus on one or more of the following areas:

- developing social skills and friendships
- building relationships with family
- managing money
- finding and looking after a home
- building skills and qualifications
- developing work goals
- staying physically well, including exercise
- support with drug alcohol and smoking issues
- building life skills including confidence and resilience

Local health needs and service issues

- Short-term, non-clinical, recovery-focused psychosocial support services for people of all ages.
- The most frequently identified areas of unmet psychosocial needs include:
    - obtaining employment/volunteering opportunities
    - managing physical health issues
    - engaging in a fulfilling social life
    - participating in daytime activities
- Limited engagement in services with people who
    - identify as Aboriginal and/or Torres Strait Islander
    - are from culturally and linguistically diverse (CALD) backgrounds
    - identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+)
- Diverse workforce required including peer support workers, life coaches and support workers able to provide client-centred, trauma-informed, culturally appropriate, and recovery-orientated support in both outreach and centre-based settings.
- Limited office space available for psychosocial and clinical services to collocate.
- Improved service coordination for individuals with severe mental illness and associated psychosocial functional impairment, while considering supports available across levels of governments, the community, and relevant sectors.
- Increased awareness of psychosocial services in primary care to support complementary use with other primary health interventions.
- Efficient referral pathways required to increase accessibility to new psychosocial services.

Key findings

- Individual and group psychosocial support and rehabilitation services for clients and their carers/ families that is focused on building capacity and connectedness at times when it is most needed rather than providing ongoing support.
- Greater support and intervention are required to prevent escalation of mental health conditions to avoid crisis and hospital presentations.
- Peer workers are acknowledged by both providers and consumers as important supports for people with severe mental health needs, however the present workforce is small.
- It is important for consumers to feel empowered to be involved in decision-making about their care and providers have a key role to act as facilitators to enable this.
- General practice is a key point of contact for people with mental health needs, however many GPs feel they do not have the information and resources required to assist patients with severe mental illness to access psychosocial supports.

Eligible for assistance

People whose mental health condition severely affects their ability to function day to day can benefit from support that meets their individual needs through the National psychosocial support programs for people with severe mental illness.

People with severe mental illness who are not accessing psychosocial supports through the National Disability Insurance Scheme (NDIS) or state and territory funded services can get support through:

- The National Psychosocial Support Measure
- The National Psychosocial Support Transition program
- The Continuity of Support program for psychosocial support

It's anticipated that the above three programs will be consolidated into one program at the end of 2021 - The Commonwealth Psychosocial Support Program.

It has been recognised there are unmet psychosocial needs for people with severe mental illness who are not eligible for assistance through the NDIS, and who are not receiving psychosocial services through National Psychosocial Support Measure programs. Due to this, some people may become more vulnerable resulting in exacerbation of issues and higher use of treatment services.

Service system

Services	Number in the GCPHN region	Distribution	Capacity discussion
Plus Social service funded by GCPHN	1 which offers psychosocial support, after hour's safe space, as well as clinical care coordination.	Mermaid Beach	• Plus Social is a comprehensive clinical support service for people who experience the impact of severe mental illness. The program supports individuals who are finding it difficult to maintain their regular day to day activities using clinical care coordination. The program includes structured, recovery and goal-oriented services focused on creating significant improvements in quality of life, health and wellbeing.
Lighthouse Youth Enhanced	1	Southport	• Provides trauma informed, recovery orientated clinical care coordination and specialised treatment
headspace Early Psychosis	2	Southport and Upper Coomera	• Multidisciplinary service of consultant psychiatrists, peer workers and clinicians that support young people at risk of or experiencing a first episode of psychosis. • The Early Psychosis team is equipped to intervene early to improve the lives of young people, and their families, who are impacted by psychosis.
Crisis helplines	6 (lifeline, suicide call-back service, men's line, kids helpline, 13 health, 1300 MH call).	24hour telephone services. Public knowledge of these	• Support for people in crisis.

		services would drive uptake/demand.	
Gold Coast Health crisis services	3 (1 Acute Care Treatment Team [ACT], 2 emergency departments).	Emergency departments at Robina and Southport. ACT team telephone service available 24hrs. Clinic in Southport and outreach to all of GCPHN region.	
Gold Coast Health Inpatient services	5 (Acute Adult (16-65), Older Persons (65+, 16 beds) and an Extended Treatment Unit (16 bed) all located at Robina. Acute Adult unit (16-65) in Southport. A 27-bed mental health rehabilitation unit is located at Robina and focuses on adults with severe and complex needs that cannot be serviced by current community support).	4 in Robina, 1 in Southport	
Gold Coast Health Community services	4 (Mobile intensive rehabilitation team, older persons mental health, Continuing Care Teams, Eating Disorder Service).	Southport, Palm Beach and outreach	• Education programs and groups are run by various NGOs aimed at supporting consumers and carers. • 4-5 peer navigators and a mental health navigator to be appointed by Gold Coast Health in 2018
Gold Coast Health Consumer and Carer consultants	1 team comprising both consumer and carer peer consultants.	Across all Gold Coast Health locations as needed	
Private mental health facility	2 (fully comprehensive private mental health facilities equipped to support people with severe and complex needs).	1 in Currumbin and 1 in Robina	
Employment and volunteering	A number of federally-funded employment providers support clients with a disability and these providers also support clients whose primary	Office locations are based across the Gold Coast	• Mental Health NGOs provider support and programs for individuals to engage with employment and volunteering, however,

	disability is a mental health issue		most do not have specific programs dedicated to this area. • Education programs and groups are run by various NGOs aimed at supporting consumers and carers. • Active and Healthy Providers who have undertaken Mental Health First Aid Training are noted in the listing on City of Gold Coast website.
Social life/company	9 services (8 are NGO providers, 1 is an Aboriginal Medical Service, 1 is an Aboriginal & Torres Strait Islander service, 1 is a culturally and linguistically diverse (CALD) service, 2 are peer- based providers, A number employ peer workers).	Programs are a combination of outreach and centre-based activities. 3 in Southport, 1 in Arundel, 1 in Mermaid Beach, 1 in Varsity Lakes, 1 in Miami, 2 in Robina, 1 in Oxenford, 1 in Bilinga (11 listed due to multiple locations).	
Physical health (non-clinical)	8 (7 NGO providers and 1 community-based program, "Active and Healthy," funded by City of Gold Coast with 15 providers available)	Activities funded by City of Gold Coast are located across the entire GCPHN region.	
Daytime activities	5 providers (3 NGO providers, 1 private provider, 1 community-based program funded by City of Gold Coast with 15 providers available)	Distribution is predominately in Palm Beach, Southport and Currumbin. Activities funded by City of Gold Coast are located across the entire GCPHN region.	

Consultation

Various consultation activity was undertaken across the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one-to-one interviews, industry presentations, working groups and co-design processes.

Joint regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services

- Consultation from the mental health regional plan discussed numerous priority areas on the Gold Coast including:
    - northern corridor
    - stepped Care Approach – care of those with Chronic Conditions that are not 'severe'
    - access to psycho-social and community support
    - physical Health & Care Coordination and Navigation
    - assessment and Referral

- gender Diverse Services for Adults
- vulnerability/Life Triggers
- alternate Crisis Response

Service provider consultation

The following key findings emerged through the consultation process with community mental health service providers, Gold Coast Health, and community members.

- Psychological services don't adequately meet the needs of someone with severe and persistent mental illness, childhood trauma or complexity in their lives.
- Often limited capacity to be responsive to consumer needs and provide timely access due to demand and existing waitlists.
- Current services are limited in their ability to support people who are escalating and require face to face support in a non-clinical environment.
- Concern that implementation of the National Disability Insurance Scheme (NDIS) will create gaps in service delivery particularly for individuals that are not eligible for NDIS.
- Multi agency care plans, or shared care planning, identified as a priority throughout the sector to support sharing of information and timely communication between services.
- Existing integration, communication, and coordination across services, including non-health services can be improved.
- Variation exists among providers as to how they define and therefore service the needs of, people with severe and complex mental health conditions.
- Recognise the value of including Peer Workers in the care approach, however capacity to do so is limited.
- Addressing the physical wellbeing of people with severe and complex mental health conditions must be prioritised, the collaboration between mental health and primary care services should be strengthened.
- Some GPs reported limited confidence in working with severe and complex mental illness, not having access to enough information about most appropriate services available and referral pathways into the community.
- Emerging as more families move out towards the main freeway to access cheaper housing options, populations are increasing in more isolated suburbs of the northern corridor such as Coomera, Ormeau, Pimpama etc. Access to services therefore becomes limited to the individual's ability to access personal forms of transport or timely public transport.
- Drug and alcohol concerns continue to present in this (and most communities). The emergence of increased ease of access to and low-cost methamphetamines such as Ice, Fantasy (Frank), GBH, MDMA and Flakka brings its problems for families and individuals
- The introduction and rollout of the NDIS and more recently COVID-19 impacts have seen a marked and decreased capacity of services to be able to connect regularly to support extreme complexity in cases.
- People presenting with acute intoxication to mental health services for short term crisis support.
- Current service needs that have emerged from COVID-19 is related to service delivery (providing web-based support, PPE access and use, access to technology for participants etc)
- Clinical care coordination is consistently at capacity and has a waitlist of 6-8 weeks generally.

- Affordability may be a barrier but not sure if people's expectation of therapy is realistic i.e, a quick fix for complex issues.
- It seems like, at times, patients must wait for an extended time to access social workers through the plus social program.
- Mental illness is not always been able to be quantified as simply many people think it is normal, or typical and do not realise they could get help.
- If all GPs screened every new client and routine screened existing clients for mental health concerns, there is simply not enough mental health workers to refer to. Most referrals come from a very few GPs and therefore if they all become as aware of the issues, we would be inundated with referrals, which has clearly become the case since COVID has brought the attention of mental health to many primary health assessors.
- QAS and QPS response times for clients experiencing psychotic episodes or severely unwell remain inadequate.
- Ongoing challenge to recruit suitably qualified and experienced clinicians.
- Need to look at service options in northern corridor on the Gold Coast
    - Most services tend to end around Southport yet there is significant growth in Northern Corridor (Pimpama and Ormeau).
    - Since COVID, single practitioners in the Northern Corridor area are attending to mental health issues for 20-30 per cent of daily practice.
    - Northern corridor community actively seeking after hours options, when crisis happens Southport is too far away, especially for young families. Many of these young families include migrants and FIFO workers, with additional challenges in accessing services.
- GC PHN's Clinical Council provided feedback during consultation session in May 2021 that there is significant strain on GPs in the Coomera, Ormeau and Oxenford area:
    - Number of consultations GPs are having with patients with mental health concerns has significantly increased over the past 2 years (particularly in the past 12 months).
    - GPs report that they deliver increased number of consultations due to significant lack of allied health service availability in the GCPHN region.
    - GPs in this area also report very high levels of work stress due to patients' mental health needs escalating over time, and GPs "holding" a reasonable degree of patient risk whilst the patient/s are waiting to access a service.

Service user consultation

- Consumers often feel they do not have adequate support to actively participate in the decision-making and planning of their care.
- There is a desire for more formalised opportunities to build confidence in their ability to self-manage.
- The importance of including families and carers in the care planning process was identified.
- Families and carers require support to maintain their capacity to assist loved ones.
- Consumer, families, and carers want opportunities to be involved in the planning, design, delivery, and evaluation mental health service.
- Consumers have limited options to access face to face support outside an emergency department or clinical setting when they are feeling distressed, particularly acute in the after-hours.

- Consumers identify accessing the right information and services at the time they need it is challenging due to a lack of local centralised system navigation.
- The capacity of GPs to respond to the needs of this client group was variable.
- GPs don't have the time to adequately meet the needs of severe and complex or acutely ill patients in the brief, time limited consultations that are generally available.
- Trust in the worker, consistency in the support provided, having someone available to provide advice, care coordination, and flexibility made a significant difference to user satisfaction and outcomes.
- Stigma was identified as a significant issue and a barrier to seeking support and maintaining wellness.
- Broader social determinants of health such as access to transport, employment, adequate housing, and effective social support impact on the capacity to recover and remain well.

Consultation and feedback from stakeholders

- Limited awareness for some clinicians of the services and supports available.
- It has been identified that clients can become dependent on one support provider, making it difficult to move to new provider and some clinicians may at times enable client. dependence, not referring to services that may better suit their non-clinical needs.
- Emerging issues / concerns regarding NDIS:
    - Concerns remain around the adequate training and experience of Mental Health support workers.
    - The impact of the closure of FSG a large NGO service provider in 2018 reducing choice for participants who will need to access NDIS services.
    - Primary Health Clinicians are supporting patients with their NDIS application but there is no suitable MBS item number given the time required.
    - Limited understanding for some of the role primary healthcare providers in assisting people to access NDIS for lifelong support.
- 25% of patients with frequent presentations to the ED have a mental health issue.
- Limited access to safe spaces in the northern Gold Coast with the large and growing population.
- Concern with homeless with clients with mental health issues and accessing services or meeting with service providers.
- Psychosocial supports with a focus on accessing training and education, increased physical activity and wellbeing groups, social groups and activities that are flexible to access and is inclusive of family and carers, and use of peer workers to step individuals up for more intense support or less support as needed.
- The lack of self-referring psychosocial support services has been reported as a community concern by all organisations.
- There is evident need for education and awareness of cultural training, focusing on ATSI and CALD specific issues and interactions for the GCPHN region.
- Challenges in both recruitment and sustainability of the peer workforce as this is an extremely limited workforce and not a clearly defined.
- People with intellectual disability, autism and acquired brain Injury are often not able to get psychological support
    - Some private psychologists do not feel confident or have skills to provide support to these people.

- These people fall through the gaps as they are not able to access disability services for mental health support, but mental health services won't provide services.

Primary and Community Care Community Advisory Group

Primary needs/gaps identified:

- Crisis accommodation, particularly for domestic violence.
- Domestic violence services to support people to access safety.
- Transport options for homeless. Many of the foodbanks etc require transport. An idea that was raised was transport concession cards for homeless people.
- Advocacy for the homeless particularly in regard to the Council. We are aware the Gold Coast City Council now has 2 Public Space liaison workers (for the whole Gold Coast). But it is identified that homeless people are being served notice to move on from an area, but then their belongings are confiscated when they're not looking (so to speak) and there doesn't seem to be a pathway to get their belonging back. We identified that this cohort need advocacy to prevent it getting to the point where all their worldly possessions are taken from them.
- bulk billing psychiatrists
- bulk billing psychology
- Cardiometabolic monitoring – this is interesting because we are developing our cardiometabolic monitoring & deprescribing clinic.

COVID-19 Impacts

The Wesley Mission Queensland COVID-19 Recovery Service was established to provide responsive wellbeing support for people aged 16 years and over living in the GCPHN region whose wellbeing has been impacted by the ongoing effects of COVID-19. Below are some of the common presentations to the service:

- loneliness and social isolation
- suicidal ideation
- problems with secure housing
- Financial barrier's such as loss of employment/struggles to secure adequate ongoing employment.
- overall anxiety and depressive presentations – low mood and lack of motivation
- struggles with accessing services such as Centrelink and NDIS
- loss of routine
- grief and Loss
- Difficulties in accessing appropriate higher mental health services in a timely manner due to long waitlists.

In addition to the above, very early on in the rollout of this service it became apparent that schools needed support as children's anxiety levels had increased; anecdotally home-schooling had a massive impact on some students finding it difficult to re-engage in face-to-face learning. Parents were also struggling with how to deal with the impact of COVID-19 on the mental health and wellbeing of their children.

Appendix 1 - Key concepts

Separation	**Separation** is the term used to refer to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). 'Separation' also means the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital, or changing type of care. Each record includes information on patient length of stay. A same-day separation occurs when a patient is admitted and separated from the hospital on the same date. An overnight separation occurs when a patient is admitted to and separated from the hospital on different dates. The numbers of separations and patient days can be a less reliable measure of the activity for establishments such as public psychiatric hospitals, and for patients receiving care other than acute care, for which more variable lengths of stay are reported.
Patient day	**Patient day** means the occupancy of a hospital bed (or chair in the case of some same day patients) by an admitted patient for all or part of a day. The length of stay for an overnight patient is calculated by subtracting the date the patient was admitted from the date of separation and deducting days the patient was on leave. A same-day patient is allocated a length of stay of 1 day. Patient day statistics can be used to provide information on hospital activity that, unlike separation statistics, account for differences in length of stay. The patient day data presented in this report include days within hospital stays that occurred before 1 July provided that the separation from hospital occurred during the relevant reporting period (that is, the financial year period). This has little or no impact in private and public acute hospitals, where separations are relatively brief, throughput is relatively high and the patient days that occurred in the previous year are expected to be approximately balanced by the patient days not included in the counts because they are associated with patients yet to separate from the hospital and therefore yet to be reported. However, some public psychiatric hospitals provide very long stays for a small number of patients and, as a result, would have comparatively large numbers of patient days recorded that occurred before the relevant reporting period and may not be balanced by patient days associated with patients yet to separate from the hospital.
Psychiatric care days	**Psychiatric care days** are the number of days or part days the person received care as an admitted patient in a designated psychiatric unit or ward.
Procedure	**Procedure** refers to a clinical intervention that is surgical in nature, carries an anaesthetic risk, requires specialised training and/or requires special facilities or services available only in an acute care setting. Procedures therefore encompass surgical procedures and non-surgical investigative and therapeutic procedures, such as X-rays. Patient support interventions that are neither investigative nor therapeutic (such as anaesthesia) are also included. Procedures are grouped together in blocks (**Procedure blocks**) based on the area of the body, health professional or intervention involved.

Child, youth and families' mental health

There is increasing recognition at a regional, state and national level that a focus on preventing or intervening early in the progression of mental health difficulties not only benefits infants and children, but also creates a solid foundation for health outcomes later in life. Services that recognise the significance of family and social support and functional recovery are particularly important for children and young people.

In line with a stepped care model, there will likely be a need to support region-specific, cross sectoral approaches to early intervention for children and young people experiencing, or at risk of mental illness including those with severe mental illness who are being managed in primary care.

The Gold Coast Primary Health Network (GCPHN) region is relatively well-serviced with a wide range of service providers that contribute to children, young people, and families' wellbeing. Mental health concerns may first be identified through primary healthcare services, including general practice, Aboriginal Medical Services, or Community Health Centres. Other initial contact points for identifying mental health concerns include Early Childhood Care Centres, schools, neighbourhood centres and other human services, including family support, child safety and non-government welfare agencies. For children and young people with a mental health concern that requires specific expertise and skills, services are available through private allied health providers, non-government agencies and PHN funded primary mental healthcare services. For children and young people who require more comprehensive support, public and privately funded specialist services provide both inpatient and community-based treatment options.

The child and youth sector incorporates all agencies that are delivering services to the child and youth population. For the purposes of the needs assessment the age cohort is defined as 0 – 17 years. It is acknowledged that government agencies define the child and youth sectors differently e.g. Education (completes Year 12), Department of Children, Youth Justice and Multicultural Affairs (0-18 years), Department of Health (0-12 years and 12-25 years), Queensland Health (0-18 years – with exceptions in specialist services e.g. Early Psychosis).

Local health needs and service issues

- Northern corridor has an increasing population of young people with limited early intervention and therapeutic services available locally.
- Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs.
- Addressing these mental health issues for children in care is impacted by:
    - Long wait times for assessment and treatment in the public system,
    - Cost of private services,
    - Barriers sharing information and centralised depository from medical history that non-health professionals can contribute to, and
    - Limited availability of low-cost assessments for diagnosis and NDIS applications.
- There are multiple barriers for families and carers to support the health of young people including a consistent understanding of confidentiality and consent for sharing information.
- Funded models often require the service to work with an individual client and do not have the capacity to work with the family unit.

- Evolving service system results in GPs being unclear about available services and the pathways to access these services.
- Limited services that provide support for young people with highly complex situations.
- System navigation is difficult for GPs and people seeking to access services.
- Timely access to services for people seeking mental health support.
- Increasing demand for all mental health services.

Key findings

- On some indicators, the GCPHN region, such as lower rates of prescriptions for antidepressant and anti-psychotic medication for under 18's and a lower rate of youth suicide, fairs slightly better than state and national comparators.
- Broadbeach-Burleigh, Southport and Ormeau-Oxenford are highlighted areas with higher than national rates for prescribing mental health medication for those under 18.
- Data indicates geographic areas that potentially have higher numbers of vulnerable young children are in the northern growth corridor areas of Upper Coomera and Pacific Pines, as well as the central Southport areas.
- Services report an increase in high complexity for young service users requiring coordinated, family-based, and multiple agency response.
- There are limited services that provide support for young people with highly complex situations (family, housing, justice, education etc.) but have mild and moderate mental health conditions. The few care coordination and case management-based services available are targeted towards those with severe and complex mental health conditions.
- There is a concentration of services in the Southport region, including the large youth health service headspace.
- Age and other access criteria vary across the sector and consultation and service mapping indicates that access to services for younger children (aged 0 to 14) is more difficult, particularly for primary school aged children.
- Consultation highlighted the importance of schools as an early intervention opportunity for young people.
- Children in care are a particularly vulnerable group and service delivery for this cohort is particularly complicated.

Prevalence and utilisation of health services

Findings from the Young Minds Matter Survey (2016-2017) indicated one in seven Australians aged four to 17 had a mental disorder in the previous 12 months with slightly higher prevalence in males than females. Attention deficit hyperactivity disorder (ADHD) was the most common emotional or behavioural disorder in Australian school students and was more common in males than females. ADHD affected one in ten males but fewer than one in 20 females. After ADHD, the most prevalent disorders affecting students were anxiety disorders, and oppositional problem behaviours. Major depressive disorder was uncommon in children aged 4 to 11 years although was more common in adolescents 12 to 17 years, affecting almost one in 20 adolescents, and was also the most common disorder in older adolescent girls[1].

Mental disorders are more common in students living in families experiencing various forms of socioeconomic disadvantage, including low household income, parental unemployment, and family breakup. In general, students from lower socioeconomic status backgrounds had lower test scores, for both students with and without mental disorders. Similarly, students with a mental disorder generally had lower test scores than students without a mental disorder, irrespective of their socioeconomic status. The impact of both socioeconomic factors and mental disorders compound, meaning that in general, students with no mental disorder in better socioeconomic situations scored the highest, and students with mental disorders and in lower socioeconomic situations scored the lowest[2].

Adverse childhood experiences (ACEs) correspond to sources of stress that people may suffer early in life usually before the age of 18. They are recognised as a public health problem, which can affect children's health and wellbeing not only at the time the ACE is experienced, but also later in life[3]. Robust prospective epidemiological and neurological studies confirm that ACEs, such as physical and emotional (including non-verbal interactions) abuse and neglect, sexual abuse, witnessing sibling or maternal abuse, peer bullying, and household dysfunction with one or more parents absent, intoxicated, hospitalised or incarcerated) have long term health impacts[3].

The impacts of these forms of trauma and neglect include changes to health risk behaviour such as marked increase in suicidality, substance abuse, aggression and intimate partner violence, promiscuity, and work-absenteeism, as well as health impact independent of behaviour change that include increased cancer rates, autoimmune diseases, cardiac death rates, obesity, panic, anxiety, depressed affect and multiple somatic complaints[4].

A study completed in 2017 of 279 children attending community paediatric clinics with ACE checklist completed by patients found that 60% attended child developmental clinics and 40% attended vulnerable child clinics. Among people attending the clinics, more than a quarter had a significant burden of ACE. Those attending specialised clinics for vulnerable children, those from particular ethnic groups and from older age groups, had the highest burden of ACE[5].

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[1] Goodsell B, Lawrence D, Ainley J, Sawyer M, Zubrick SR, Maratos J (2017) Child and Adolescent Mental health and educational outcomes. An analysis of educational outcomes from Young Minds Matter: the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Perth: Graduate School of Education, The University of Western Australia

[2] Child and Adolescent Mental Health and Educational Outcomes, An analysis of educational outcomes from Young Minds Matter, the second Australian Child and Adolescent Survey of Mental Health and Wellbeing

[3] Felitti V.J., Anda R.F., Nordenberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P., Marks J.S. Relationship of childhood abuse and household dysfunction too many of the leading causes of death in adults The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine. 1998;14(4):245–258

[4] Felitti, V.J., et al., Relationship of childhood abuse and household dysfunction too many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American journal of preventive medicine, 2019. 56(6): p. 774-786.

[5] Wickramasinghe YM, Raman S, Garg P, et al. Burden of adverse childhood experiences in children attending paediatric clinics in South Western Sydney, Australia: a retrospective audit BMJ Paediatrics Open 2019; 3: e000330. doi: 10.1136/bmjpo-2018-000330

The Australian Early Development Census (AEDC) is a nationwide data collection of early childhood development. Most recent data (2018) indicate the rates of developmentally vulnerable children in the GCPHN region across the domains of social competence (9.5%) and emotional maturity (8.2%) are comparable to Queensland and national figures (Table 1).

Table 1. Percent of developmentally vulnerable children across the Gold Coast, Queensland, and Australia, by domain, 2018.

	Gold Coast	Queensland	Australia
Social competence	9.5%	11.9%	9.8%
Emotional maturity	8.2%	10.5%	8.4%

Source: The Australian Early Development Census

In Gold Coast, the SA3s with greatest percentage of developmentally vulnerable children across both domains were Ormeau-Oxenford, Nerang and Gold Coast-North. Furthermore, increasing numbers of children and young people are entering into the child protection system from the northern corridor. This is reflective of the larger populations in these areas.

Medicare Benefits Schedule

Patients suffering from poor mental health can see their general practitioner (GP) who will assess the patient and what may be of assistance for the patient. This could include:

- making a mental health assessment,
- creating a mental health treatment plan,
- referring the patient to a psychiatrist or other mental health professional,
- giving the patient a prescription for medicines to treat the illness.

The interactions with GPs and mental health workers are captured in Medicare-subsidised data. Mental health services provided by GPs may include early intervention, assessment, and management of patients with mental disorders. These services include assessments, planning patient care and treatments, referring to other mental health professionals, ongoing management, and review of the patient's progress.

A mental health treatment plan is a support plan for someone who is going through mental health issues. If a doctor agrees that the individual requires additional support, the patient and the doctor will make the plan together.

GCPHN acknowledge that people may not always see a clinical psychologist and may see a general psychologist, counsellor, or social worker for a consultation. General psychologists, counsellors and social workers data is limited due to psychologists (clinical or other) may also provide some services listed for general psychologist, counsellors, and social workers. Consequently, psychologists (clinical or other) cannot be readily separated from other mental health workers and leading to duplication in reporting. Due to this GCPHN will report on GP mental health services, clinical psychologists and psychiatrists MBS services provided and acknowledge data is not included for services delivered by general psychologist, counsellors, or social worker services.

General practitioners

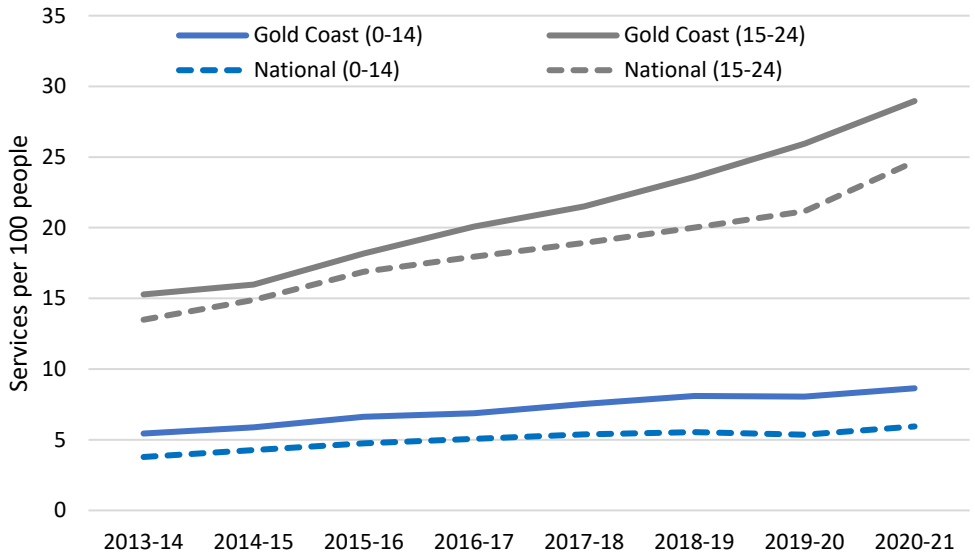
For the purpose of this report, GP metal health services include early intervention, assessment and management of patients with mental disorders by GPs or other medical practitioners who are not specialists

or consultant physicians. These services include assessments, planning patient care and treatments, referring to other mental health professionals, ongoing management, and review of the patient's progress.

In the GCPHN region, the rate for GP mental health services in 2020-2021 was:

- ages 0-14: above the national rate (8.4 vs 5.9 per 100 people)
    - 7,656 residents had mental health consultation with a GP leading to 10,166 mental health consultations.
- ages 15-24: above the national rate (28.9 vs 24.7 per 100 people)
    - 14,122 residents had mental health consultation with a GP leading to 23,803 mental health consultations.

Figure 1. General Practitioner mental health services per 100 people, national and Gold Coast, 2013-14 to 2020-21.



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population, please note all data is mapped to the patients Medicare residential address.

Clinical psychologists

Psychologists are health professionals who can work in a range of areas such as clinical, neuropsychology, health, community, forensic, organisational, sports and exercise psychology. Clinical psychologists have skills in the following areas:

- assessment and diagnosis
- treatment
- learning

For the purpose of this report, psychological therapy services provided by eligible clinical psychologists includes individual attendances, group therapy, and telehealth video consultations.

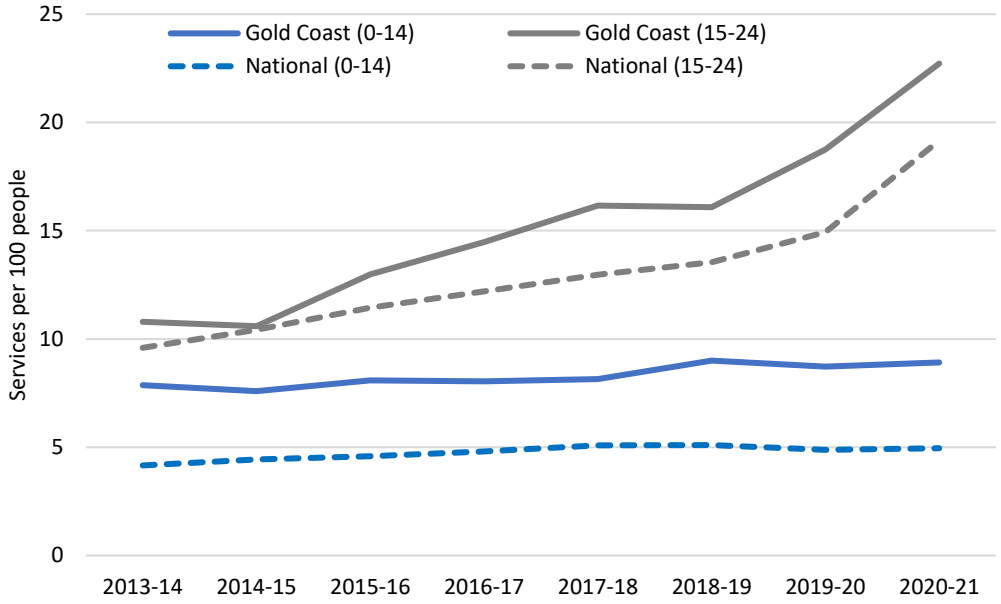
The GCPHN region's rate for clinical psychologists' services in 2020-2021:

- ages 0-14: above the national rate (8.9 vs 4.9 per 100 people)

- 2,354 residents had a clinical psychologist's consultation leading to 10,483 consultations.

- ages 15-24: above the national rate (22.7 vs 19.2 per 100 people)
  - 3,819 residents had a clinical psychologists consultation leading to 18,676 consultations.

Figure 2. Clinical Psychologists services per 100 people, national and Gold Coast, 2013-2014 to 2020-21.



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population, please note all data is mapped to the patients Medicare residential address.

Psychiatrists

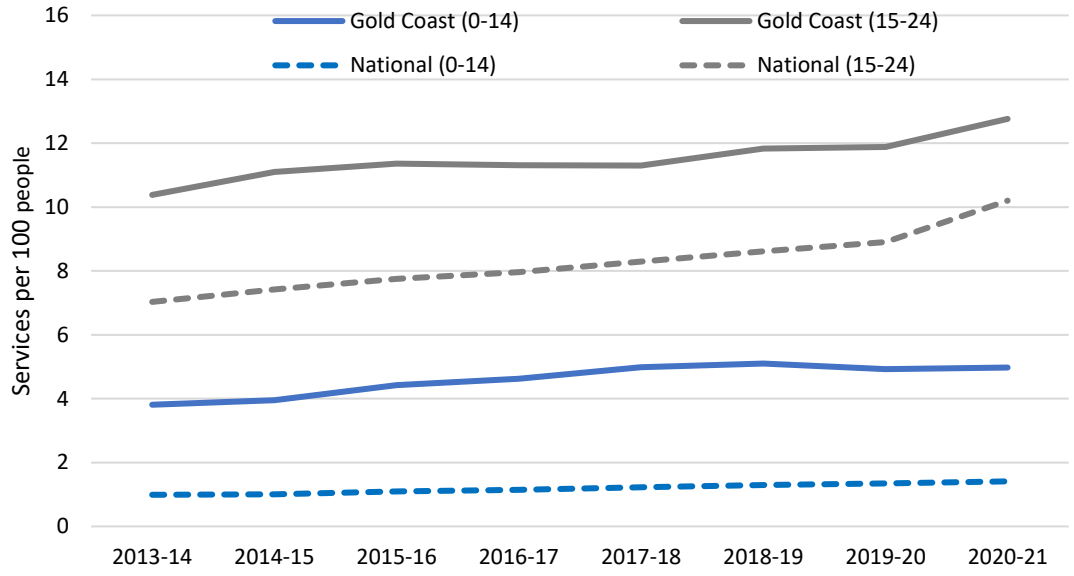
Psychiatrists are doctors who have undergone further training to specialise in the assessment, diagnosis and treatment of mental health conditions. Psychiatrists can make medical and psychiatric assessments, conduct medical test, provide therapy, and prescribe medication.

For the purpose of this report Medicare-subsidised services provided by a psychiatrist, included patient attendances (or consultations), group psychotherapy, tele-psychiatry, case conferences and electroconvulsive therapy. Electroconvulsive therapy may be provided by either a psychiatrist or another medical practitioner together with an anesthetist.

The GCPHN region's rate for psychiatry services in 2020-21:

- Ages 0-14: above the national rate (4.9 vs 1.4 per 100 people)
  - 1,693 residents had a psychiatry consultation leading to 5,847 consultations.
- ages 15-24: above the national rate (12.8 vs 10.2 per 100 people)
  - 3,150 residents had a psychiatry consultation leading to 10,488.

Figure 3. Psychiatrist services per 100 people (age standardised), by national and Gold Coast, 2013-2014 to 2018-20[illegible]



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population, please note all data is mapped to the patients Medicare residential address.

General practice data

Prevalence

Data from GCPHN's PATCAT system[6] shows that as of March 2022, of the 101,451 active patients (three visits in the past two years) aged 0 to 17, 6.3% (n=6,339) had a coded mental health diagnosis[7]. Table 2 shows numbers of patients with mental health diagnoses and details anxiety/depression diagnosis. Please note an individual may have a coded diagnoses of anxiety *and* depression.

Table 2. Active population aged 0 to 16 with a coded mental health diagnosis, Gold Coast, March 2022

	Number	Rate
Patients aged 0 to 17	100,451	
Patients aged 0 to 17 with a mental health diagnosis	6,339	6.3%
Patients aged 0 to 17 with an anxiety diagnosis	6,023	95.0%
Patients aged 0 to 17 with a depression diagnosis	1,261	19.9%

Source: GCPHN PATCAT, all results indicate no date ranges was applied

Medication and mental health treatment plans

While psychological and social interventions are available for people experiencing mental illness, there are suggestions that too often the first-line treatment is medication. The 1950s marked the introduction of medication as a treatment for mental illness, and in the 1990s this treatment expanded extremely. New

[6] PAT CAT is a web-based interface that aggregates de-identified General Practice data for population health management and research programs.

[7] Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the GCPHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

classes of antidepressants, the development of second-generation antipsychotic medication, and the use of medication not traditionally regarded as psychiatric, profoundly influenced the treatment of mental illness.

In the past 10 years, the use of medication to treat mental illness has increased by 58% in Australia[8], which has the second highest per capita antidepressant consumption of all OECD countries[9].

In 2018-2019, 39 million mental health-related prescriptions (subsidised and under co-payment) were provided. 17.1% of the Australian population or 4.3 million patients received mental health-related prescriptions, an average of nine prescriptions per patient. The majority (86%) of mental health-related prescriptions were prescribed by GPs, 7.7% prescribed by psychiatrist and 4.5% prescribed by non-psychiatrist specialist in 2018-2019. Of the 39 million mental health-related prescriptions, 70.9% were antidepressants[10].

Analysis of data from GCPHN's PATCAT system[11] shows that as of March 2022, of the 6,085 active patients (three visits in the past two years) aged 0 to 17 with a coded mental health diagnoses. Of these patients, 34% (n=2,075) had a current prescribed mental health medication and 68% (n=4,168) had claimed a mental health treatment plan in the last 12 months.

Table 3 highlights active population with coded mental health diagnoses and prescribed mental health medication, Mental Health Treatment Plan (MHTP) and Body Mass Index (BMI) record for those with a coded mental health diagnosis.

[8] Roughead L. Presentation to Safety and Quality Partnership Standing Committee. 11 July 2014. (As cited in National Mental Health Commission (2014): The National Review of Mental Health Programmes and Services. Sydney: National Mental Health Commission).
[9] OECD (2011). Health at a Glance 2011: OECD Indicators, OECD Publishing. http://dx.doi.org/10.1787/health_glance2011-en
[10] Mental health services in Australia, Australian Institute of Health and Welfare, 2021.
[11] PAT CAT is a web-based interface that aggregates de-identified General Practice data for population health management and research programs. Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

Table 3. Active population aged 0 to 16 with a coded mental health diagnoses management, March 2022.

	Number	Rate
Active population with a coded mental health diagnoses	6,085	
Patients with a mental health diagnoses who have a current prescribed mental health medication	2,075	34.1%
Patients with a coded mental health diagnoses and claimed a MHTP in the last 12 months	4,168	68.5%
Patients with a mental health diagnoses and claimed a MHTP review in the last 12 months	1852	30.4%
Patients with a coded mental health diagnoses and claimed a MHTP consult in the last 12 months	1545	25.4%
Active patients with a coded mental health diagnoses and BMI recorded	3,146	51.7%
Morbid: BMI 40+	37	1.2%
Obese: BMI 30 to 39.9	138	4.4%
Overweight: BMI 25 to 29	302	9.6%
Healthy: BMI 18.5 to 24.9	1,256	39.9%
Underweight: BMI <18.5	1,413	44.9%
Active patients with a coded mental health diagnoses and physical activity recorded	14	0.2%

Source: GCPHN PATCAT, all results indicate no date ranges was applied

Psychological Services Program

The Psychological Services Program (PSP) provides short term psychological interventions for financially disadvantaged people with non-crisis, non-chronic, moderate mental health conditions or for people who have attempted, or at risk of suicide or self-harm. This program particularly targets several underserviced groups including children. Children aged 0-12 years in the GCPHN region with mild to moderate mental health needs can access psychological services through the PSP.

From the 1 July 2021 to 30 June 2022, PSP had 1,620 total referrals and 6,999 sessions delivered.

Table 4. Number of persons accessing Psychological Services Program, Gold Coast, 2021-22

	Referrals (number)	% of all referrals	Sessions	Sessions as % of referrals
Adult Suicide Prevention	1,056	65%	4,909	70%
Children	235	15%	849	12%
Aboriginal and Torres Strait Islander	111	7%	383	5%
Homeless	55	3%	197	3%
CALD	47	3%	248	4%
Perinatal	68	4%	215	3%
LGBTIQAP+	48	3%	197	3%
General (COVID19 Response)	0	0	1	0

Program data indicates a steady increase in referrals to PSP across years from 2013-2022. While this is likely due to increased awareness among referrers resulting from significant promotion, it demonstrates an ongoing demand. Of the children that are referred to the children stream, 35.2% came from clients located in Coomera, Pimpama, and Upper Coomera, followed by 15.8% from Southport. Most referrals were for children aged 5-12 years, seeking support for anxiety.

Pharmaceutical Benefits Scheme

The rate of prescriptions dispensed for anti-depressant, antipsychotic and ADHD medicines for people aged 17 years and under in the GCPHN region was lower than for Queensland and comparable to national rates (Table 5).

Table 5. Rate of Pharmaceutical Benefit Scheme prescriptions dispensed for anti-depressant, antipsychotic and ADHD medicines per 100,000 people aged 17 and under, Gold Coast, Queensland and national, 2013-14

	Gold Coast	Queensland	National
Anti-depressant medicines	8,021	9,072	7,989
Antipsychotic medicines	1,971	2,544	2,070
ADHD medicines	10,799	12,555	10,780

Source: ACSQHC Australian Atlas of Healthcare Variation, 2015.

There was a noticeable variation between rates among SA3s of the GCPHN region with some areas exceeding both state and national figures. For anti-depressant medicine dispensing, the three areas within the GCPHN region with the highest rates were Broadbeach–Burleigh (n=9,408), Southport (n=8,874) and Ormeau-Oxenford (n=8,871). These were above both the national and GCPHN region's rates, with Broadbeach-Burleigh also exceeding the Queensland rate.

For antipsychotic medicine dispensing, the three areas within the GCPHN region with the highest rates were Broadbeach–Burleigh (n=2,485), Coolangatta (n=2,327) and Mudgeeraba-Tallebudgera (n=2,299). These were above both the national and total Gold Coast rates.

For ADHD medicine dispensing, the three SA3s within the GCPHN region with the highest rates were Nerang (n=12,621), Gold Coast North (n=12,525) and Southport (n=11,810). These were above both the national and overall region's rates.

Emergency Department presentations

In 2019-2020, there were 568 presentations to the Emergency Department (ED) from Gold Coast residents aged 0 to 17 years for mental and behavioral disorders. There was a 29% decrease from 2018-2019 to 2018-2019 for this age cohort, which could be partly due to hospital avoidance during the COVID-19 pandemic.

The leading presentation for mental and behavioral disorders were mental and behavioral disorders due to the use of alcohol, acute intoxication making up 18% of all mental health presentations. This was followed by acute stress reaction with 11%. Please note that alcohol intoxication data may be skewed by end of year school celebrations where many school leavers celebrate in the Gold Coast region from around Australia.

Children in care

Children in care (children subject to Child Safety orders) are likely to have poorer mental health as well as physical and developmental health than their peers. In 2019, Queensland data identified[12]:

- only 3% of young people in care without health problems
- more than half (54%) have emotional or behavioral problems
- 14% have abnormal growth
- 45% aged 10-17 years have moderate or high health risks associated with substance use
- 24% have incomplete vaccinations
- up to 63% have an eating disorder or obesity
- 20% have abnormal vision screening
- 28% have an abnormal hearing test
- 30% have dental problems

Age (years)	Meet criteria for diagnosis	Risk factors indicative of requiring specialist mental health support	Current level of population accessing specialist mental health services
0-5	16-18%	16.1% (0-1 years) 12.1% (2-3 years)	**Commonwealth** MBS any provider 0.9% (0-4 years) **ATAPS** 0.3% (0-11 years) **State Ambulatory** 0.4% (0-4 years)
4-11	13.6%	19.2% (4-5 Years) 25.2% (6-7 years) 28.9% (8-9 years) 32.8% (10-11 years)	**Commonwealth** MBS any provider 5.7% (5-11 years) **ATAPS** 0.3% (0-11 years) **State Ambulatory** 1.4% (5-11 years)

Family therapy

Funded models of care within the Australian health system often require the service to work with an individual and do not have the capacity to work with the family unit. This was identified as a gap within the Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol, and Other Drugs Services in the Gold Coast region (Joint Regional Plan). The current literature indicates that there is strong evidence of success when family involvement is integrated in interventions reducing time spent by juvenile delinquents in institutions, additionally family therapy for depression in general also shows promising results[13].

Currently there are three available psychological service MBS items numbers for multisystemic family therapy: 170, 171 and 172. These items numbers refer to family group therapy referred by a GP, specialist, or consultant physician (other than consultant psychiatrists). To be used, these items require a formal intervention with a specific therapeutic outcome. It should be noted that only one fee applies in respect of each group of patients.

[12] Support a child in care. (2019), Department of Child Safety, Youth and Women, Queensland Government

[13] Woolfenden, S., Williams, K. J., Peat, J., & Woolfenden, S. (2001). Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10-17.

The use of these MBS item numbers across Australia between July 2019 and June 2020 indicates that there is limited-service utilisation within Queensland (1,141 MBS items claimed), in comparison to Victoria (3,184 MBS items claimed) and New South Wales (3,018 MBS items claims)[14].

Eating disorders

In 2015-2016, 95% of Australian hospitalisations with a principal diagnosis of an eating disorder were for females. Among these hospitalisations, females aged 15-24 made up the largest proportion (57%). Estimated prevalence of eating disorders in the GCPHN region is consistent with the national prevalence (see Mental Health – Severe and Complex needs assessment for more information).

Complex presentations

Feedback from providers on the Gold Coast indicated there is a gap where young people with more complex presentations cannot be appropriately supported through the MBS system. These patients may require additional sessions which are not covered by MBS.

Adolescent to parent abuse

Adolescent-to-parent abuse is any behaviour used by a young person to control, dominate, or persuade parents. It is intended to threaten and intimidate and puts family safety at risk. Most abused parents have difficulty admitting even to themselves that their child is abusive. They feel ashamed, disappointed, and humiliated and blame themselves for the situation which has led to this imbalance of power. There is also an element of denial where parents convince themselves that their son or daughter's behaviour is part of normal adolescent conduct. Abuse is broadly defined to three categories – verbal, emotional/psychological and physical.

It is recognised that when a parent or other adult is concerned, they should arrange for an evaluation by a mental health professional, early treatment by a professional can often help. Anecdotal feedback suggests there are limited services in the GCPHN region for adolescent to parent abuse.

Social isolation and loneliness

Social isolation and loneliness can be damaging to both mental and physical health. They are considered significant health and wellbeing issues in Australia because of the impact they have on people lives.

- Social isolation: state of having minimal contact with others.
- Loneliness: subjective state of negative feeling about having a lower level of social contact than desired[15].

Both concepts do not necessarily co-exist—a person may be socially isolated but not lonely, or socially connected but feel lonely[16].

One in three Australians reported an episode of loneliness between 2001 and 2009, with 40% of these people experiencing more than one episode[17].

[14] http://medicarestatistics.humanservices.gov.au/statistics/do.jsp?_PROGRAM=%2Fstatistics%2Fmbs_item_standard_report&DRILL=ag&group=170%2C171%2C172&VAR=services&STAT=count&RPT_FMT=by+state&PTYPE=finyear&START_DT=201907&END_DT=202006.

[15] Peplau L & Perlman D 1982. Perspectives on loneliness. In: Peplau L & Perlman D (eds). Loneliness: A sourcebook of current theory, research, and therapy. New York: Wiley.

[16] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS.

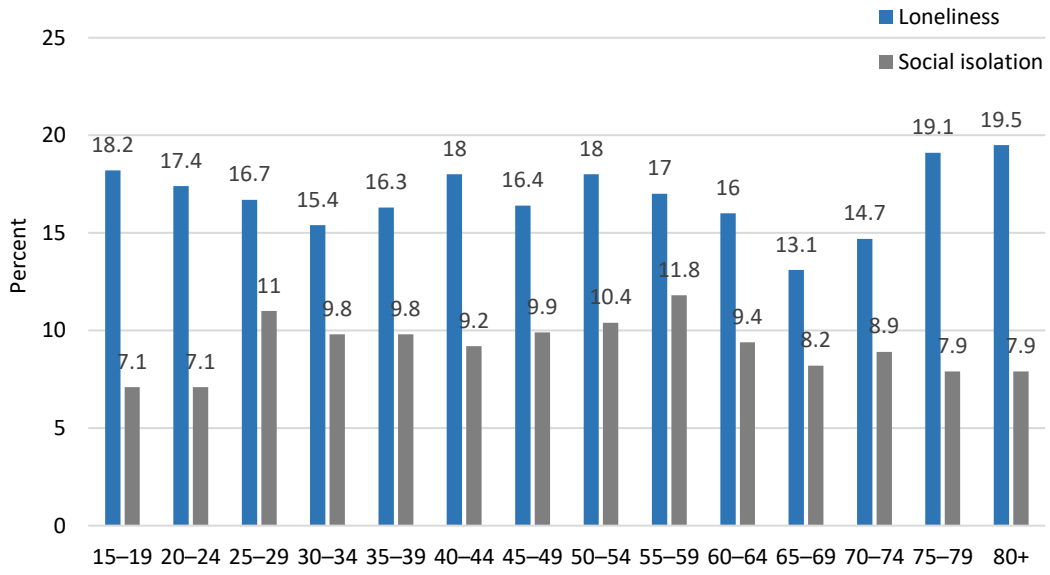
[17] Baker D 2012. All the lonely people: loneliness in Australia, 2001–2009. Canberra: The Australia Institute.

- one in ten Australians aged 15 and over report lacking social support[18].
- one in four report they are currently experiencing an episode of loneliness[19].
- one in two report they feel lonely for at least one day each week.

Social distancing during the pandemic was never meant to prevent social connections, but many people were staying away from each other to avoid exposing their loved ones to the virus.

Loneliness and social isolation have been linked to mental illness, emotional distress, suicide, and development of dementia[20]. Part of the challenge in reporting on social isolation and loneliness comes from no universally agreed upon definitions. Figure 4 shows how social isolation and loneliness vary across age groups.

Figure 4. People experiencing social isolation and loneliness, by age groups, Australia, 2018



Source: Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labor Dynamics of Australia Survey. Canberra: Relationships Australia.

System navigation

Consultation throughout the development of the Joint Regional Plan identified a high demand for system navigation support and to support people to assess and determine suitable options. There are two elements to services navigation that have been identified:

1) Uncoordinated and inconsistent approach to assessment, referrals, and intake:

- Most services operate an assessment and intake component for their service meaning individuals and referrers often have to share their story at each transition point or when ascertaining eligibility. When people are not matched to the right service initially, they have to retake the intake process, which can be a system inefficiency and can contribute to a poor experience and poor outcomes.

[18] Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey. Canberra: Relationships Australia.
[19] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS.
[20] Hawthorne G 2006. Measuring social isolation in older adults: development and initial validation of the friendship scale. Social Indicators Research 77:521–48.

Additionally, the frustrating experience of trying to find the right fit can result in disengagement and opportunities for early intervention may be lost with people presenting to the system later in crisis.

- An inconsistent approach to assessment (e.g., various tools) leads to inconsistent assigned levels of care, resulting in discrepancies in the type of care provided across providers and regions, for similar clinical presentations.
- Referrals to services are often inappropriate, resulting in people being under or over serviced.

2) Limited awareness/understanding of service infrastructure, including availability and capability of services:
   - Referrals to services are often inappropriate, resulting in people being under or over serviced.
   - There are many pathways to mental health, AOD and suicide prevention and support services. Community members and service providers perceive that the local service system changes frequently due to funding changes, resulting in providers and people being unclear about available services and the pathways to access these services. There is a need for timely and accurate information and easily identifiable access points for individuals seeking care, so that they can be matched with the service which optimally meets their needs.

Underserviced groups

Many underserviced groups have higher rates of psychological distress and may not access services due to numerous determinants including location, cost, culturally appropriateness of the service provider and language barrier. These characteristics may make it difficult for people to participate, especially if the ways in which they are expected to contribute do not make allowances for the barriers they may face. As a result, careful consideration of services to best meet their needs are required.

A current barrier for underserviced population groups accessing the MBS Better Access initiative is the out-of-pocket cost for the patient. An Australian Bureau of Statistics (ABS) survey identified that high out-of-pocket cost prevent people with long-term or chronic conditions from seeking health care and place financial strain on low-income consumers[21]. An increasing number of people delay visits to general practitioners and psychologists because of cost consideration[22].

In 2016-2017, 43.1% of residents of the GCPHN region paid an out-of-pocket cost for a non-hospital Medicare service. For these patients with an out-of-pocket cost, the median amount spent in the year was $145 per patient.[23].

In 2018-2019, $12,148,391 was the total fees charged by the clinical psychologists, comprising the benefits paid by Medicare and patients' out-of-pocket cost with 80,083 services being claimed[24].

Data, research and consultation with service users, service providers, community members and GCPHN's Clinical Council identified the following groups as potentially underserviced and people in distress (including those who do not have a current mental health diagnosis and maybe at increased risk of suicide on the Gold Coast:

- Aboriginal and Torres Strait Islanders
- Culturally and Linguistically Diverse

[21] Patient Experiences in Australia, Summary of Findings, Australia Bureau of Statistics, 2020.
[22] Patient Experiences in Australia: Summary of Findings, 2011-12, Australian Bureau of Statistics.
[23] Australian Institute of Health and Welfare analysis of Department of Health, Medicare Benefits claims data, 2016–2017.
[24] Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data, 2018–2019.

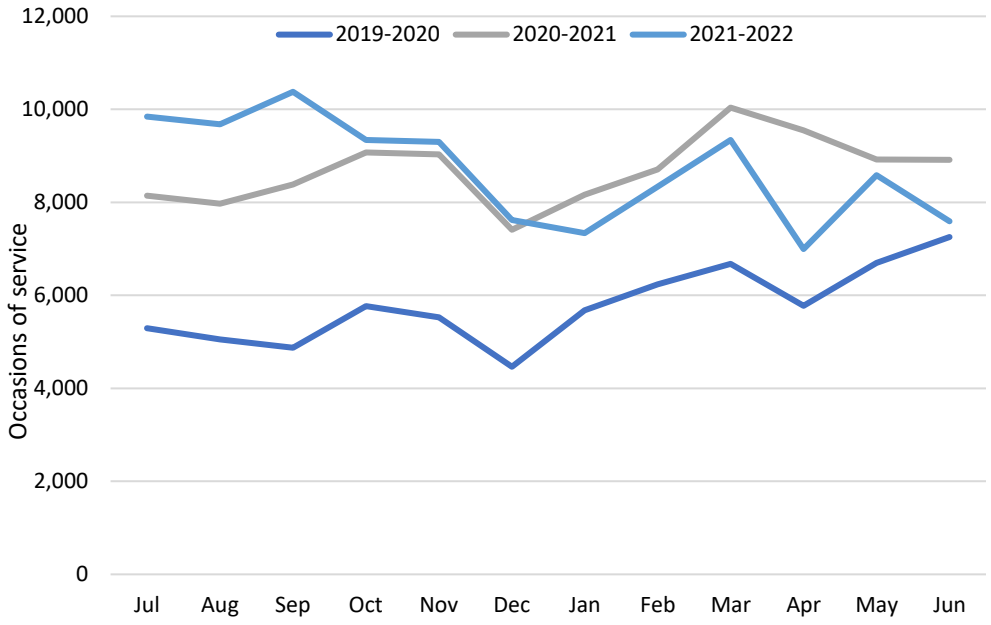
- LGBTIQAP
- perinatal – have had a baby in the last 12 months
- children up to 12 years old
- children in out of home care (up to 12 years old)
- experiencing or at risk of homelessness
- people who have attempted, or are at risk of suicide or self-harm
- veterans
- youth justice
- older adults (aged 65 and over)
- children with autism
- people with a dual diagnosis
- complex families
- people with an eating disorder
- men linked to family court
- victims of family and/or domestic violence

Increasing demand management across the Stepped Care continuum

In 2020-2021, 8,000 unique clients access programs across the programs funded by GCPHN across the Stepped Care continuum. The rate of referrals to PHN funded services across low intensity, psychological therapy and clinical care coordination continued to rise in Quarter 4 (October, November, December) as compared to Quarter 3 (July, August, September). These high referral rates are placing significant pressure on all services.

Data extracted through Primary Sense™, GCPHN data extraction and population health management clinical audit tool, shows that demand on services as evidenced by presentations to general practice for anxiety and depression, which flow onto community mental health services, increased from 2019-2020 to 2020-2021 (Figure 5). This presents a challenge as some GCPHN Psychological Service providers (PSP) have very high waiting times for appointments. Psychological Services have continued to express their preference to take MBS clients over PSP clients as the administrative burden of the MBS program is less with no reporting, or performance monitoring requirements.

Figure 5. Mental health consultations for anxiety or depression, Gold Coast, 2019-20 to 2021-22



Source: Primary Sense. Data includes 159 Gold Coast general practices.

MBS changes and workforce issues

The Better Access initiative aims to improve treatment and management for people who have mild to moderate mental health conditions through Medicare rebates for people accessing care. GPs are encouraged to work more closely and collaboratively with psychiatrist, clinical psychologists, registered psychologists, occupational therapists, and appropriately trained social workers to support patients.

The three tables below highlight the increase in Medicare-subsidised mental health-specific services from 2015-2016 to 2019-2020 in the GCPHN region. This increase in Medicare-subsided mental health-specific services by GP, clinical psychologists, and other allied health providers is above the GCPHN region's population growth rate and employment rate for clinical psychologists and medical practitioners. During this same time period in the GCPHN region the:

- Gold Coast population increased by 10.3% (575,629 in 2015 to 635,191 in 2020)[25].
- number of medical practitioners employed in the GCPHN region increased by 23.3% (2,070 in 2015 to 2,552 in 2020).
- number of clinical psychologists employed in the GCPHN region increased by 23.2% (514 in 2015 to 633 in 2020)[26].

[25] Queensland Government Population Projections, 2018 edition (medium series).

[26] Sources: Department of Health 2020; ABS 2018.

Table 6. Number of Medicare-subsidised mental health-specific services, Gold Coast, 2015-16 to 2019-20

Provider type	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Psychiatrists	82,241	84,033	84,162	85,276	87,138	6.0%
General practitioners	93,462	102,199	110,186	120,163	122,516	31.1%
Clinical psychologists	65,549	69,438	75,266	80,405	85,333	30.2%
Other psychologists	95,942	92,091	100,336	105,059	106,073	10.6%
Other allied health providers	5,790	7,422	7,675	7,484	8,501	46.8%
All providers	342,984	355,183	377,625	398,387	409,561	19.4%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

The number of GP Medicare-subsidised mental health-specific services (Mental Health Treatment items, review of a GP Mental Health Treatment Plan, and GP Mental Health Treatment Consultation) have increased by 31.1% from 2015-16 to 2019-20 in the GCPHN region. Table 8 shows that at an SA3 level, Robina had the largest% increase in GP Medicare-subsidised mental health-specific services with 42.6% (7,720 in 2015-2016 to 10,295 in 2019-2020). Ormeau-Oxenford had the greatest number of GP Medicare-subsidised mental health-specific services with 28,221 in 2019-20.

Table 7. Number of General Practitioner Medicare-subsidised mental health health-specific services, Gold Coast SA3 regions, 2015-16 to 2019-20

Region	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Broadbeach - Burleigh	10,026	10,828	11,489	12,686	13,232	32.0%
Coolangatta	9,829	10,403	11,229	11,530	11,424	16.2%
Gold Coast - North	11,562	12,276	13,082	14,102	14,559	25.9%
Gold Coast Hinterland	3,449	3,538	3,874	4,349	4,302	24.7%
Mudgeeraba - Tallebudgera	4,998	5,388	5,967	6,643	6,869	37.4%
Nerang	10,008	11,350	11,676	12,700	13,028	30.2%
Ormeau - Oxenford	20,416	23,149	25,135	27,788	28,221	38.2%
Robina	7,220	8,243	8,865	9,991	10,295	42.6%
Southport	10,248	11,031	12,350	13,173	13,154	28.4%
Surfers Paradise	5,726	6,012	6,544	7,227	7,457	30.2%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

The number of clinical psychologists Medicare-subsidised services have increased by 30.2% from 2015-16 to 2019-20 in the GCPHN region. Table 9 shows that Broadbeach-Burleigh had the largest increase with 47% (7,830 in 2015-2016 to 11,508 in 2019-2020). Ormeau-Oxenford had the greatest number of clinical psychologists' services with 15,872 in 2019-2020.

Table 8. Number of Clinical Psychologists Medicare-subsidised services, Gold Coast SA3 regions, 2015-16 to 2019-20

Region	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Broadbeach - Burleigh	7,830	8,987	9,832	10,616	11,508	47.0%
Coolangatta	7,836	7,943	8,318	8,982	9,422	20.2%
Gold Coast - North	7,346	7,678	8,286	8,390	9,061	23.3%
Gold Coast Hinterland	2,114	2,287	2,393	2,442	2,438	15.4%
Mudgeeraba - Tallebudgera	3,892	4,066	4,481	5,009	5,386	38.4%
Nerang	7,975	8,109	7,841	8,990	9,342	17.1%
Ormeau - Oxenford	11,652	12,222	14,912	14,922	15,872	36.2%
Robina	5,956	5,971	6,495	7,452	8,011	34.5%
Southport	7,038	7,664	8,379	8,445	8,780	24.8%
Surfers Paradise	3,926	4,525	4,349	5,177	5,531	40.9%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

Impacts of changes to Better Access

As part of the Australian Government's COVID-19 response, changes were made to the Better Access initiative including:

- an increase from 10 to 20 in Medicare subsidised individual psychological services each calendar year,
- expanded eligibility to include residents of aged care facilities,
- expanded access to telehealth.

Early data suggest utilisation of MBS funded psychological services remained high during 2020-2021 in the GCPHN region.

Local stakeholders report that the changes to Better Access have impacted on the workforce and consequently, timely access to services for people seeking mental health support. NGOs service providers report increased wait times for their services due to difficulty in recruiting staff as many private practitioners are choosing to work from home and see patients through Better Access. This is particularly an issue in the northern corridor of the GCPHN region as there is already a limited workforce and high demand in the area.

COVID-19

Since lockdown restrictions were introduced in March 2020 due to COVID-19, the national 24/7 counselling and support service Kids Helpline received a significant increase in the volume of children and young people seeking help, up 24% to the end of August 2020 compared to the same period in 2019[27].

Concerns raised in counselling sessions provide important insights into how governments, parents and educators can better support children and young people through the pandemic. Data was analysed from 2,567 counselling sessions in which children and young people aged 5-25 discussed the impacts of COVID-19 on their lives.

Sex/gender was recorded for 2,449 contacts from children and young people aged five-25 years, 118 were unknown. Of the 2,449 contacts, 1,882 were female, 500 were from males, and 67 were transgender or gender diverse.

Age was recorded for 2,448 contacts. Age for 119 contacts was unknown. Of all contacts, 43% of contacts were from those aged 18-25 years. While this cohort made up the largest percentage of contacts to Kids Helpline who raised concerns related to COVID-19, most contacts where age was recorded (57%) were under 18.

The top five concerns related to COVID-19 raised by all children and young people were:

1. mental health concerns resulting from COVID-19
2. social isolation
3. education impacts
4. impacts on family life
5. changes to plans and usual activities.

COVID-19 Unmasked (Young Children) was an online study launched in Australia to help understand the mental health impacts of the pandemic on young children aged one to five years and their families. In a survey completed between May and July 2020, 998 caregivers started the survey and 776 completed all questions. Most respondents were mothers (93%). Families living in major cities, and university-educated parents with higher-than-average incomes, were overrepresented in the sample. Online surveys into how young children and their families cope with the pandemic found that:

- one in four children are experiencing higher than average levels of anxiety symptoms,
- 5-10% of children may need specialised mental health support,
- one in five parents are struggling with moderate to severe anxiety, depression, or stress,
- young children are most affected by not seeing friends and family.

The survey results also compare changes in young children and parents' emotional and behavioural wellbeing for those that did (Victorians) and didn't (everyone else) go through a second lockdown. In Victoria:

- Children who experienced the second lockdown in Victoria were two-to-five times more likely to show emotional and behavioural difficulties than children in other states.
- Between 27 to 44% of parents who experienced the second lockdown reported a significant increase in mental health difficulties in comparison to other states.
- Victorian children and families require higher levels of social and psychological support.

[27] Yourtown and the Australian Human Rights Commission 2020.

Child safety and child protection

The number of notifications recorded each month fluctuated considerably across March to August 2020. Queensland observed a drop in notifications in April 2020 (during the initial COVID-19 restrictions) followed by an increase in May or June (once restrictions had eased). Period post April increase saw a higher number of notifications than pre-COVID-19 levels (prior to March 2020).

Queensland had an overall 5% increase in the number of children in out-of-home care between March and September 2020, however all other jurisdictions had less than 3% change. When compared to the previous year, in Queensland the number of children in out-of-home care each month in 2020 was consistently higher than the same months in 2019.

Table 9. Queensland notifications, substantiations and out-of-home care, January 2019 to September 2020

	Notifications	Substantiations	Children in out-of-home care
Jan 2019	1,870	578	9,338
Feb 2019	1,997	636	9,427
Mar 2019	2,084	572	9,498
Apr 2019	1,270	560	9,562
May 2019	1,713	593	9,584
Jun 2019	1,576	637	9,650
Jul 2019	1,893	605	9,691
Aug 2019	2,106	731	9,792
Sep 2019	1,854	480	9,876
Oct 2019	2,210	687	9,912
Nov 2019	2,176	718	10,002
Dec 2019	1,787	493	10,034
Jan 2020	1,680	586	9,997
Feb 2020	1,768	682	10,050
Mar 2020	2,192	747	10,176
Apr 2020	1,806	447	10,250
May 2020	1,811	613	10,350
Jun 2020	2,599	492	10,538
Jul 2020	2,242	695	10,673
Aug 2020	2,279	714	10,691
Sep 2020	2,050	590	10,708
Mar–Aug 2019 total	10,642	3,698	
Mar–Aug 2020 total	12,929	3,708	
2019–2020 % change[(a)]	+21.5%	+0.3%	

Source: Australian Institute of Health and Welfare 2021. Child protection in the time of COVID-19

Service system

Services	Number in GCPHN region	Distribution	Capacity discussion
Psychological Services Program (PSP), Child (0-12) stream. Focus is moderate intensity.	18	Organisations are available across the region and are evenly spread.	Community and Gold Coast Health services providing mental health care for youth and children are clustered in Robina and Southport with one located in Burleigh and some outreach. The majority of child and youth mental health services focus on ages 12-25 with eligibility cut offs varying within this age bracket. This can make transitioning between services challenging. Mental health services for children aged 0-12 are very limited. While a mix of mild to moderate and severe and complex providers exist, eligibility requirements may limit access. The services delivered by Gold Coast Health are largely located in Robina and Southport. Overall, there is limited services in the northern part of the Region. Wait times for Fetal Alcohol Syndrome Disorder assessments can be very lengthy (over a year). Mental health services have limited capacity or are not funded to provide the family work required in some cases. There are
headspace (12-25 years)	Two centres in the GCPHN region. Upper Coomera and Southport, with potential for residents in the southern area of the region to access headspace in Tweed Heads.	An accessible 'one-stop shop' for young people aged 12-25 that helps promote wellbeing: mental health, physical health, work/ study support and alcohol and other drug services. A multidisciplinary service of consultant psychiatrists, peer workers and clinicians that support young people aged 12-25 at risk of or experiencing a first episode of psychosis. The Early Psychosis team is equipped to intervene early to improve the lives of young people, and their families, who are impacted by psychosis.	
Youth Clinical Care Coordination - Lighthouse	One located in Southport	Provides trauma informed, recovery orientated clinical care coordination and specialised treatment for young people aged 12-18.	
E-mental health services	headspace, Kids Helpline, Youth beyondblue, eheadspace, ReachOut	Online Services. Public awareness knowledge of these services would drive uptake/demand and could bridge gap between services.	
Phone Services	Kids Helpline (1800 551 800) Beyond Blue (1300 224 636) Headspace (1800 650 890)		
Online Counselling	beyondblue online chat headspace online chat		

Coaching	Reachout (https://parents.au.reachout.com/one-on-one-support)	Phone coaching for parents and carers of 12- to 18-year-olds.	some private providers who offer these services.
Gold Coast Health inpatient services, ages 0-25 years (varied age and other access/ eligibility criteria).	3 (Robina has 2: child and youth and acute young adult aged 18-25 years. Southport has 1 acute adult unit for ages 16-65 years).	2 in Robina, 1 in Southport.	
NewAccess (Beyond Blue) 12+ coaching low intensity CBT.	Phone, online or in person.	Phone, online or in person.	
Gold Coast Health community services, ages 0-25 years (varied age and other access/ eligibility criteria across programs/services).	8 (Child and Youth Mental Health Service [CYMHS], Evolve therapeutic services, child and youth access, perinatal infant mental health, early psychosis, continuing care teams (18+), eating disorder service (18+), acute care treatment team (18+).	2 CYMHS clinics (Robina and Southport), Early Psychosis (Robina), rest outreach.	
Community based mental health NGO services (majority focus on ages 12 - 25 with age and other access/eligibility criteria varying within this. 2 services cater to ages 0-18, predominantly facilitator/ service coordination and counselling).	5 separate NGO providers with programs and services specifically for youth mental health.	1 in Southport, 1 in Burleigh, 3 outreach to all of Gold Coast.	
Community NGO services, (predominantly counselling and referral services)	Eight NGO providers who provide counselling services or refer into specific youth mental health services.	3 in Southport, 2 in Arundel, 1 in Labrador, 1 in Miami, 1 in Robina, 1 in Burleigh.	
Fetal Alcohol Syndrome Disorder (FASD) clinic	One	Gold Coast Health service	

Psychologists	598, across all settings and job roles, in labor force on the Gold Coast in 2017.	Psychologists generally distributed across the GCPHN region with the majority located in coastal and central areas	• Psychologists can be a point of referral for individuals.
Parenting programs for behavior management	11 providers of varying programs, one online.	Across the Gold Coast.	• Run regularly, some are limited to the clients of the service.
Student Wellbeing Package (SWP)	28 schools across the GCPHN region with a wellbeing professional providing a service. This is across, Primary, Secondary, and Special Schools	Across the Gold Coast	
GP Pilot in schools	5 schools participating in the GCPHN region	Across the Gold Coast	

Consultation

Various consultation activity was undertaken across the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one-to-one interviews, industry presentations, working groups and co-design processes.

Joint regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services

- The GCPHN region is relatively well-resourced with a wide range of service providers that contribute to children, young people, and families' wellbeing. For example, there is significant investment in youth early psychosis services in the Gold Coast region. Placing the young person and their families' needs first, there are opportunities to better coordinate these services to get the best benefit for young people.

- Additionally, the rapid population on growth in the Northern Corridor makes this area important for service development. The area has an increasing population on of young people with limited early intervention on and therapeutic services available locally.
- Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs. However, children in care do not have a dedicated health care coordinator and their health needs are not being met with the right practitioner. This contributes to care arrangement failure, further traumatisation, service fatigue and disengagement.
- Schools play an important role in the community and early intervention has potential to prevent longer term ramifications.
- Clinicians in schools often operate in silos and at the discretion of school principals. Involvement in the planning of school principals could facilitate and enhance coordination on of activities.
- People are aware of the important role of families and carers to support the health of young people. There are multiple barriers to that happening, including a consistent understanding of confidentiality and consent for sharing information.
- Additionally, funded models often require the service to work with an individual client and do not have the capacity to work with the family unit.

Service provider consultation

- Services and support for children who are undergoing gender transitioning or who identify early as LGBTIQAP+ are sparse. Local psychosocial support is difficult to find.
- Increasing complexity and/or acuity of presentations to service providers, reported by Gold Coast Health, Department of Child Safety Youth and Women and school guidance officers and school counsellors reported. Not all are eligible for referral to Child and Youth Mental Health Service (CYMHS) and there are limited options for age-specific services.
- The complex needs assessment panel (CNAP) on the Gold Coast were identified as a critical piece of the service system providing a coordinated and multi-service response for youth with the most complex needs. The CNAP for < 10s has been defunded but is still running with increasing demand for the service.
- Spikes in presentations to services occur for early intervention and therapeutic services between the ages of 10-17 years; these children can fall through the gaps as they don't easily fit eligibility criteria. Furthermore, service providers report that the psychological treatment can have limited outcomes for complex cases due to the time it takes build rapport and the time/session limitations for funded services.
- Transport is an access barrier for youth as public transport can be too costly or not available.
- Alcohol and drug treatment options are limited for the youth and there are no withdrawal management options for those under 18 years.
- Collaboration between mental health nurses and school nurses could be improved to support identification and intervention. Education and information around referral options is needed for people working in the school system.
- Primary Health Care Improvement Committee November 2018 indicate:
    - Difficulty in accessing services for children, including Aboriginal and Torres Strait Islander children with or at risk of mental health issues, particularly in the northern growth corridor area (Coomera, Upper Coomera, Oxenford, and surrounds).

    - Approximately 2 out of 3 families needing mental health support for children are in “chaos” hindering ability to access services.
- Reports of barriers for re-entry to school as part of the young person’s recovery.
- There is widespread limited understanding of infant mental health – identification of dysregulation and knowledge of referral pathways.
- Gap for children that need mental health assessment/treatment when they have a neurodevelopment disorder.
- In relation to PSP interventions, GPs think about the suite of interventions that are available, they refer to PSP as easy option. Reason I think this: PSP allows 6 sessions, yet for children stream the full 6 sessions are rarely used, this would indicate that these referrals require a lower intensity service like a parenting program not a hospital/state specialist service for higher intensity.
- There are many parenting programs available, some targeted at more extreme behaviours up to 14-year-olds, these are free, easily accessible, low waits. They are family-based interactions programs which for younger children is more important than addressing psychological needs of child as an individual, - no point if family environment doesn’t support positive behavior.
- Categories and topics discussed at the Gold Coast local level alliance (includes representatives from government and non-government organisations) are listed below:
    - housing- supported housing for young parents
    - housing- youth drop-in accommodation
    - housing- short-term accommodation
    - housing- crisis accommodation for under 15-year-olds
    - youth- engaging with services (outreach)
    - youth- young parents
    - youth- service capacity
- Evident from research and anecdotal reports that client presenting problems in a younger person population attending for low intensity NewAccess appear to typically relate to emotionality, relationships, and school.
- It was also observed (anecdotally) that younger persons in NewAccess tend to attend fewer sessions that older persons and is hypothesised that brief interventions may be more effective given this trend although more direct evidence is needed.
- Need to look at service options in northern corridor on the Gold Coast
    - Most services tend to end around Southport yet there is significant growth in Northern Corridor (Pimpama and Ormeau).
    - Since COVID, single practitioners in the Northern Corridor area are attending to mental health issues for 20-30% of daily practice.
    - Northern corridor community actively seeking after hours options, when crisis happens Southport is too far away, especially for young families. Many of these young families include migrants and FIFO workers, with additional challenges in accessing services.
- GCPHN’s Clinical Council provided feedback during consultation session in May 2021 that there is significant strain on GPs in the Coomera, Ormeau and Oxenford area:
    - Number of consultations GPs are having with patients with mental health concerns has significantly increased over the past 2 years (particularly in the past 12 months)

- GPs report that they deliver increased number of consultations due to significant lack of allied health service availability in the region.
- GPs in this area also report very high levels of work stress due to patients' mental health needs escalating over time, and GPs "holding" a reasonable degree of patient risk whilst the patient/s are waiting to access a service.

Service user consultation

Children themselves were not engaged in providing direct feedback. Dialogue occurred with young people, adult carers, adults with a lived experience of child/adolescent mental illness and service providers.

- School was often identified as a critical early intervention opportunity that was missed or neglected. This was also the case for those with experiences of sexual abuse, childhood trauma and domestic violence who are broadly accepted as being 'at-risk', highlighting that these target groups can still slip through cracks.
- School identification/intervention relating to mental health is limited and can be dependent on which school a child attends.
- Limited opportunities for children or young people to speak out or seek help.
- There are not enough community-based support options for children with mild to moderate needs, therefore these children miss out on the benefit of early intervention.
- Children and young people not connected with education or engaged with other support are hard to reach.
- Access to family support services is limited due to capacity issues.
- Young people reported experiencing severe distress and chaos resulting from the impact of social determinants and contributing to mental health issues and AOD use.
- Many young people stated that meeting a significant adult at the right time was a key factor marking the commencement of their recovery journey.
- Long waitlist on the Gold Coast sexual abuse counselling.

Significant stakeholder consultation was undertaken in 2020-2021 as part of a project focused on strengthening the health assessment response for children and young people in care and found:

- Limited options for orthodontics when children cannot pay privately.
- Low general practice referral to Early Childhood Early Intervention (ECEI), children being missed for early intervention as once in school it's too late:
  - GP may be the only service that picks up on development delay if child is not attending preschool.
  - Parents concerns on labelling their children therefore not accessing NDIS partner ECEI.
- Lack of awareness on infant mental health (identifying emotional dysregulation)- primary care staff not screening for MH concerns for under 5s.
- Young people in care refusal to attend GPs for health checks. Residential care agencies lack of continuity of care related to health needs exacerbates this.
- Children in care are not prioritised for public health services.
- There are no MBS Items numbers for conducting health assessments for children and young people in out of homecare despite widespread evidence of the poor health outcomes upon entry to care and throughout life.

- Care coordination of health needs would be highly beneficial for these children with complex needs, young people in residential care particularly need a coordinated approach.
- Reliance on the public health system for children in care health services does not enable timely health interventions. There is a need for priority access to this service.
- High cost is associated with cognitive and behavioral assessments, done privately with no specific MBS funding for the assessments.
- A long waiting list (approximately 2 years) at Gold Coast University Hospital for fetal alcohol spectrum disorder (FASD) for 7-10-year-olds. Limited services are doing FASD assessments due to the need for a multidisciplinary team and the time to do testing is 32-64 hours a week.
- Limited availability of appropriate and targeted therapy for FASD and it is often misdiagnosed as behavioural issues such as ADHD, finding the right therapy for the disorder is difficult.
- Carers are often not shared information about the child's health needs by health professionals, including appointment times and reports. This has no relation to the information sharing provisions and medical decision-making guidelines for child protection. Carers have a right to information to support the day-to-day health needs of the children they care for. My Health Record has not solved this as carers generally do not have access.
- Concern that funding allocations are a barrier for carers supporting the health needs for their children and especially those with complex needs. This is compounded by limited MBS and PHN funded services that meet the intensity required for long term health outcomes.
- Misdiagnosis of trauma as ADHD and ASD is an extensive problem for children in care meaning they may not receive the right treatment at the right time leading to long term complex problems.
- Some children are referred to other health services that cannot provide treatment until the trauma is addressed by a psychologist.
- Information sharing is a barrier to managing health needs for this cohort and there are multiple challenges with the My Health Record as a tool to do this. Challenges also relate to health care teams working together to support the outcomes of the child/young person.
- Limited understanding of trauma-informed care among some professionals, including lack of screening for trauma, re-traumatisation and clinical approaches/environment leading to children and young people's disengagement from the health system.
- Parents of children in care feel stigmatised and disempowered by the health system due to the power imbalances between carers, Child Safety, health professionals and parents. Parents want to be provided opportunities to be involved in the health care of the children and evidence suggests that doing so increases long term positive health outcomes for the young person.
- While there are some exemplars in delivery of services to Aboriginal and Torres Strait Islander children in care, many mainstream services may have limited understanding of what is culturally appropriate.
- Limited understanding of referral pathways for behavior management by primary care
- COVID-19 saw an increase in removal rate with child safety due to increased reporting on domestic violence, physical abuse, and drug abuse. Health issues for children being removed are related to neglect, homelessness, development delays and nutrition/malnutrition.
- Requests from GPs to extend PSP to people aged over 12 due to need for psychology services for financially disadvantaged adolescents who headspace may not meet needs/not enough sessions.
- Low Paediatric skills set of GPs in northern GC - identified by the GPWSI at HHS, yet high rates of developmental vulnerability risk.

- Low cost allied health services (OT and Speech therapy) for children. Group therapy is not readily available as a low-cost option.
- Assessments from multiple health services - all are different, all require significant input. Need for streamlining these questionnaires.
- Categories and topics discussed at the Gold Coast local level alliance are listed below, issues were identified, what's working well and what can be improved for all the category and topics:
    - Child Protection- Complex Families
    - Child Protection: Young people absconding from home
    - Child Protection- Actioning child safety investigations
    - Child Protection- Ongoing Support
    - Early Intervention- Mentoring services
    - Early Intervention- In-Home Support
    - Early Intervention- Targeted Case Management Support (Step down to IFS)
    - Health and Developmental- Universal Services (0-5 years)
    - Health and Developmental- Specialist Services Access
    - Health and Developmental- Trauma informed services
    - Health and Developmental- Private Practitioners
    - Disability
- Sexual abuse counselling is a 28 week wait for Braveheart sexual abuse counselling (other option is a private psychologist which an Induvial can be referred to through a GP mental health treatment plan.
- People with intellectual disability, autism and acquired brain Injury are often not able to get psychological support:
    - Some private psychologists do not feel confident or have skills to provide support to these people.
    - These people fall through the gaps as they are not able to access disability services for mental health support, but mental health services won't provide services.

Labrador Child Safety Service Centre Transition to Adult team

- Nationally, 45% of young people in care over age of 10 have moderate or high health risks associated with substance use. Locally, 27 out or 63 (43%) have problematic AOD use according to their case workers. Most other young people have casual use of drugs and alcohol.
- Most common AOD use in this cohort: inhalants, ice, MDMA, marijuana.
- Cheaper drugs are preference. Marijuana is not seen by young people as a problematic drug.
- Case planning and AOD:
    - The child safety case plans didn't specifically prompt planning around AOD use. It can be noted in the concerns section and goals section. The case workers offer regular AOD support – often from a harm minimisation perspective. They seemed aware of the available services but most of the young people are not linked in with any services – young people do not see their AOD use a problem and do not want support.
- The priorities are usually:
    - stable placement

    - mental health
    - alcohol and other drugs
        - however, often services cannot medicate for mental health because of the drug use
- Reason why AOD use if high in this cohort:
    - self-medicating – mental health issues (depression, anxiety, anger) due to trauma and parental rejection
    - early access – parent and friends
    - parental role modelling of AOD use

Primary and Community Care Community Advisory Group

Primary needs/gaps identified:

- Crisis accommodation, particularly for domestic violence.
- Domestic violence services to support people to access safety.
- Transport options for homeless. Many of the foodbanks etc require transport. An idea that was raised was transport concession cards for homeless people.
- Advocacy for the homeless particularly in regard to the Council. We are aware the Gold Coast City Council now has 2 Public Space liaison workers (for the whole Gold Coast). But it is identified that homeless people are being served notice to move on from an area, but then their belongings are confiscated when they're not looking (so to speak) and there doesn't seem to be a pathway to get their belonging back. We identified that this cohort need advocacy to prevent it getting to the point where all their worldly possessions are taken from them.
- Bulk billing psychiatrists.
- Bulk billing psychology.
- Cardiometabolic monitoring – this is interesting because we are developing our cardiometabolic monitoring & deprescribing clinic.

COVID-19 Impacts

The Wesley Mission Queensland COVID-19 Recovery Service was established to provide responsive wellbeing support for people aged 16 years and over living in the Gold Coast region whose wellbeing has been impacted by the ongoing effects of COVID-19. Below are some of the common presentations to the service:

- Loneliness and social isolation,
- Suicidal ideation,
- Problems with secure housing,
- Financial barrier's such as loss of employment/struggles to secure adequate ongoing employment,
- Overall anxiety and depressive presentations – low mood and lack of motivation,
- Struggles with accessing services such as Centrelink and NDIS,
- Loss of routine,
- Grief and loss,
- Difficulties in accessing appropriate higher mental health services in a timely manner due to long waitlists.

In addition to the above, very early on in the rollout of this service it became apparent that schools needed support as children's anxiety levels had increased; anecdotally home-schooling had a massive impact on

some students finding it difficult to re-engage in face-to-face learning. Parents were also struggling with how to deal with the impact of COVID-19 on the mental health and wellbeing of their children.

Adult mental health

The adult health sector incorporates all agencies that are delivering services to an adult population. Various government agencies define the adult sector differently: e.g. Education (completes at Year 12), Department of Child Safety, Youth and Women's (18+ years), Department of Health (18+ or 25+ years), Queensland Health (18+ years to 65 – with exceptions in specialist services e.g. Early Psychosis).

Due to the vast age range, people do not seem to identify as experiencing issues specifically as an 'adult.' Rather their experiences are often in relation to a specific time event in their lives. The reason for people accessing mental health services and supports on the Gold Coast varies in intensity, and interactions with the system differ greatly from no existing interaction to multiple interactions across all parts of the service system.

Services are delivered to adults on the Gold Coast by a range of stakeholders including: public hospitals, private hospitals, allied health providers, not-for-profit organisations, fee-for-service organisations, GPs and private practice clinicians.

There has been a dramatic shift in the Gold Coast Primary Health Network (GCPHN) region for service provision since the rollout of the National Disability Insurance Scheme (NDIS) and the new landscape for psychosocial service provision since 1 July 2019. The new infrastructure of service delivery is progressing rapidly, causing major market upheaval and potential risk to the quality of services provided in the community space. The disruption of funding allocations and methods such as block-funding to fee-for-service, has ultimately resulted in the change from a human service model to a business model function. This is a sector that has relied heavily on flexibility in funding to meet the episodic needs of people accessing support. There are several challenges facing service delivery for adults accessing support on the Gold Coast, with funding and eligibility for access the most apparent. Service offers are now limited and restrictive, and many informal touch points no longer exist (e.g. North and South hubs).

Opportunities exist where collaboration and shared resourcing may provide more flexibility in engagement for adults accessing supports, as well as transitioning between care arrangements or services

Local health needs and service issues

- Evolving service system results in General Practitioners (GPs) being unclear about available services and the pathways to access these services.
- People who may need ongoing support (e.g, those diagnosed with personality disorders) but do not meet criteria for care coordination or supports designed for severe and complex mental illness.
- There are unmet psychosocial needs for people with severe mental illness who are not eligible for assistance through the National Disability Insurance Scheme, and who are not receiving psychosocial services through National Psychosocial Support Measure programs.
- System navigation is difficult for GPs and older people.
- People with an existing mental health concern through the perinatal stage.
- Timely access to services for people seeking mental health support.
- Increasing demand for all mental health services.

Key findings

- Sharp increase in psychologist services per 100 people for age cohorts 15-24, 25-44 and 45-64, both nationally and at a GCPHN region level.
- Gold Coast rate for general practitioner mental health services, clinical psychologists and psychiatry per 100 people above national rate for people aged 15-24, 25-44 and 45-64.
- Early data suggest social isolation and loneliness are an ongoing issue and have been amplified by COVID-19 restrictions.

Prevalence and utilisation of services

Among Australians aged 16 to 85, it is estimated that 15% will experience an affective disorder, while 26.3% will experience an anxiety disorder[1]. Applying these rates to the Gold Coast population, 62,183 will experience an affective disorder while 109,029 will experience an anxiety disorder[2].

Medicare Benefits Schedule

Patients suffering from poor mental health can see their GP who will assess the patient and what may be of assistance for the patient. This could include:

- making a mental health assessment,
- creating a mental health treatment plan,
- referring the patient to a psychiatrist or other mental health professional,
- giving the patient a prescription for medicines to treat the illness.

Interactions with GPs and mental health workers are captured in Medicare-subsidised data. GP provided mental health services may include early intervention, assessment, planning patient care and treatments, referring to other mental health professionals, ongoing management, and review of the patient's progress.

Gold Coast Primary Health Network (GCPHN) acknowledge that people may not always see a clinical psychologist and may see a general psychologist, counsellors, or social workers for a consultation. General psychologists, counsellors and social workers data is limited in national reports due to psychologists (clinical or other) may also provide some services listed for general psychologist, counsellors, social workers. Implications of this is (psychologists (clinical or other)) cannot be readily separated from other mental health workers and leading to duplication in reporting. Due to this GCPHN will report on general practitioner mental health services, clinical psychologists and psychiatrists MBS services provided and acknowledge data is not included for services delivered by general psychologist, counsellors, or social workers services.

General practitioner

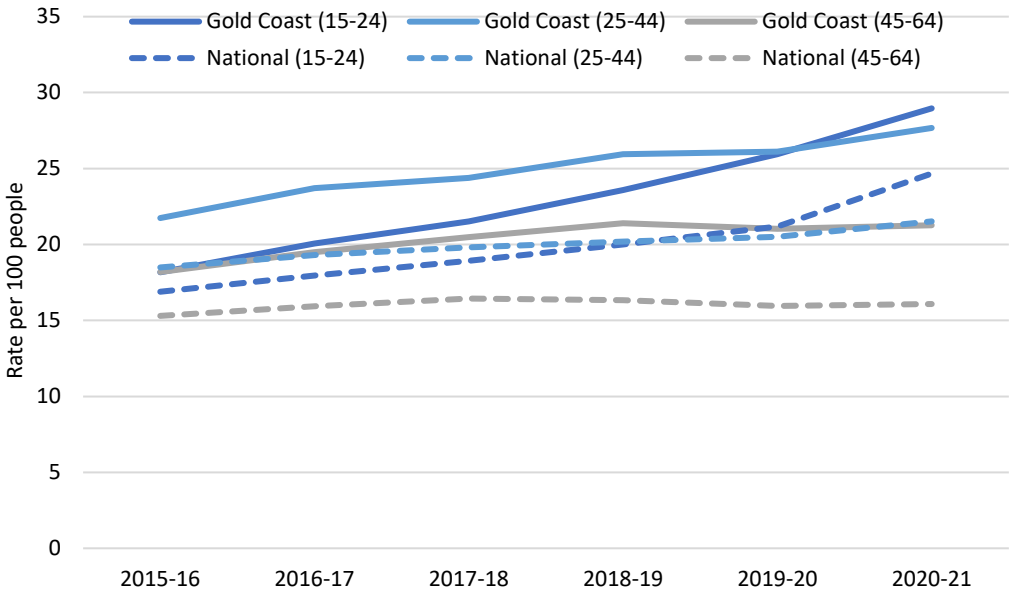
For the purpose of this report, GP metal health includes early intervention, assessment and management of patients with mental disorders by GPs or other medical practitioners (who are not specialists or consultant physicians). These services include assessments, planning patient care and treatments, referring to other mental health professionals, ongoing management and review of the patient's progress.

The Gold Coast rate for general practitioner mental health services per 100 people in 2020-21 were:

- Aged 15-24; above the national rate (28.9 vs 24.8 per 100 people)
    - 14,122 residents saw a GP for mental health concern, leading to 23,803 consultations.
- Aged 25-44; above the national rate (27.7 vs 21.5 per 100 people)
    - 28,664 residents saw a GP for mental health concern, leading to 49,421 consultations.
- Aged 45-64; above the national rate (21.3 vs 16.1 per 100 people)
    - 18,900 residents saw a GP for mental health concern, leading to 34,444 consultations.

[1] ABS National Survey of Mental Health and Wellbeing: Summary of Results, 2007 (2008), p 27
[2] ABS 3235.0, Population by Age and Sex, Regions of Australia

Figure 1. General Practitioner Mental Health Services per 100 people, national and Gold Coast, 2015-16 to 2020-21



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population, please note all data is mapped to the patients Medicare residential address

Clinical psychologists

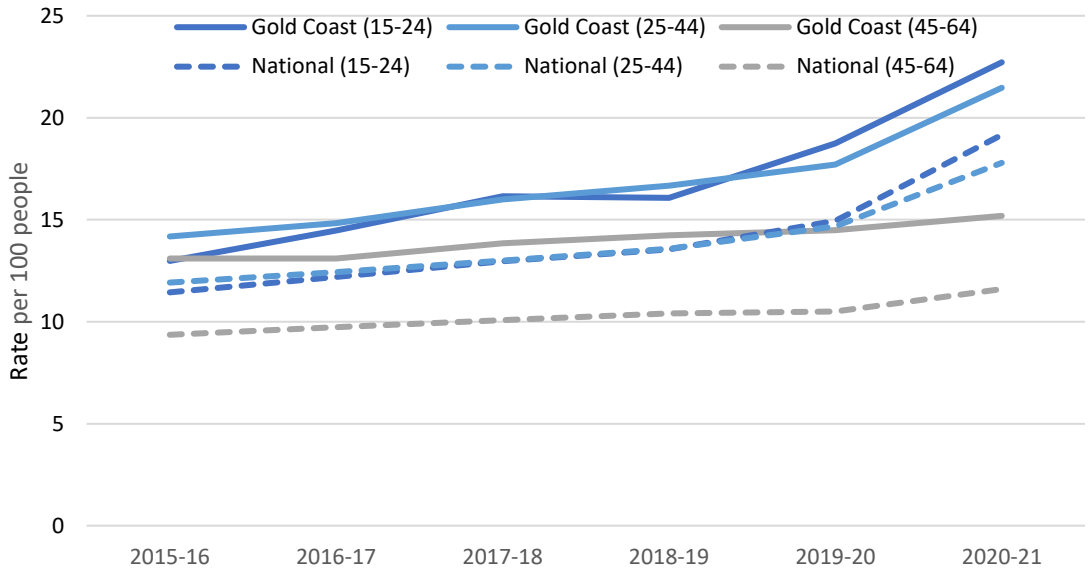
Psychologists are health professionals who can work in a range of areas such as clinical, neuropsychology, health, community, forensic, organisational and sports and exercise psychology. Clinical psychologists have skills in the assessment and diagnosis, treatment, and learning.

For the purpose of this report Psychological therapy services provided by eligible clinical psychologists includes individual attendances, group therapy, and telehealth video consultations.

The Gold Coast rate for clinical psychologists' services per 100 people in 2020-21 were:

- Aged 15-24; above the national rate (22.7 vs 19.2 per 100 people)
    - 3,819 residents saw a clinical psychologist, leading to 18,676 consultations.
- Aged 25-44; above the national rate (21.5 vs 17.8 per 100 people)
    - 7,991 residents saw a clinical psychologist, leading to 38,338 consultations.
- Aged 45-64; above the national rate (15.2 vs 11.6 per 100 people)
    - 5,159 residents saw a clinical psychologist, leading to 24,603 consultations.

Figure 2. Clinical Psychologists services per 100 people, national and Gold Coast, 2015-16 to 2020-21



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population, please note all data is mapped to the patients Medicare residential address

Psychiatrists

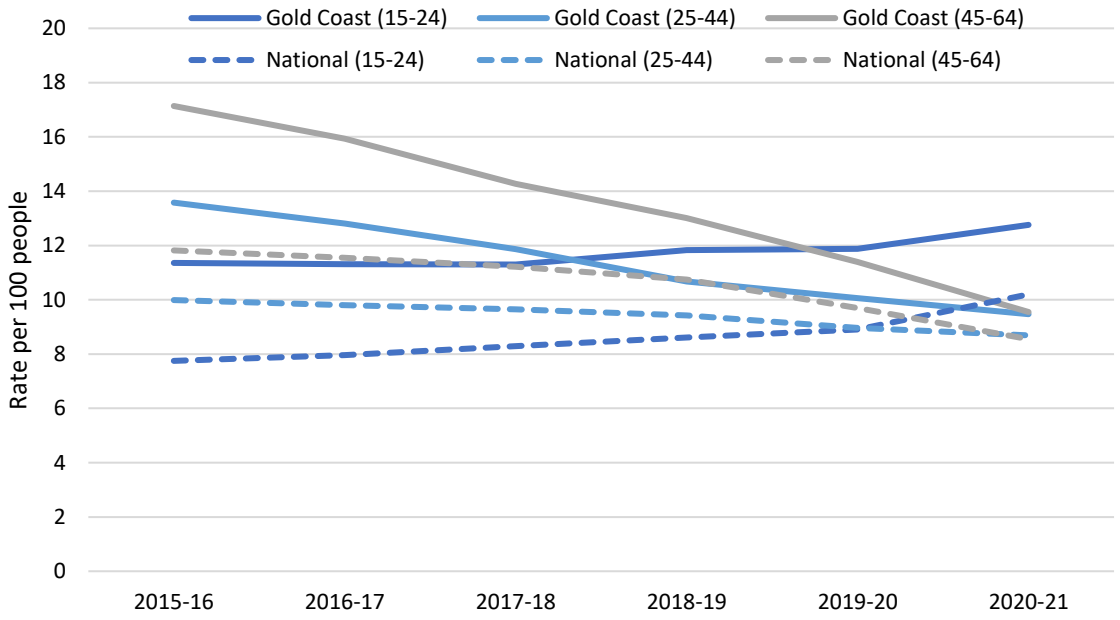
Psychiatrists are doctors who have undergone further training to specialise in the assessment, diagnosis and treatment of mental health conditions. Psychiatrists can make medical and psychiatric assessments, conduct medical test, provide therapy and also prescribe medication.

For the purpose of this report, Medicare-subsidised services provided by a psychiatrist, included patient attendances (or consultations), group psychotherapy, tele-psychiatry, case conferences and electroconvulsive therapy. Electroconvulsive therapy may be provided by either a psychiatrist or another medical practitioner together with an anaesthetist.

The Gold Coast rate for psychiatry services per 100 people in 2020-21 were:

- Aged 15-24; above the national rate (12.8 vs 10.2 per 100 people)
    - 3,150 residents had a psychiatry consultation leading to 10,488 consultations.
- Aged 25-44; above the national rate (9.5 vs 8.7 per 100 people)
    - 5,094 residents had a psychiatry consultation leading to 16,913 consultations.
- Aged 45-64; above the national rate (9.5 vs 8.5 per 100 people)
    - 3,869 residents had a psychiatry consultation leading to 15,474 consultations.

Figure 3. Psychiatrist services per 100 people, by national and Gold Coast, 2015-16 to 2020-21



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population, please note all data is mapped to the patients Medicare residential address.

Gold Coast General Practice data

Prevalence

Gold Coast PHN's PATCAT system[3] show that in March 2022, of the 367,032 active patients (three visits in the past two years) aged 18 to 64, 22% (n=88,166) had a coded mental health diagnosis. Table 1 highlights active population with coded mental health diagnoses and details anxiety/depression coded diagnosis. Please note, an individual may have a coded diagnoses of anxiety *and* depression.

Table 1. Active population aged 18 to 64 with a coded mental health diagnoses, Gold Coast, March 2022

	Number	Percent
Active patents aged 18 to 64	367,032	
Patients aged 18 to 64 with a coded mental health diagnosis	88,166	24.0%
Patients aged 18 to 64 with anxiety	68,360	77.5%
Patients aged 18 to 64 with depression	49,917	56.6%
Patients aged 18 to 64 with schizophrenia	2,490	2.8%
Patients aged 18 to 64 with bipolar	3,762	4.3%
Patients aged 18 to 64 with dementia	134	0.2%

Source: PATCAT, all results indicate no date ranges was applied, 158 general practices included in data extraction. Please note a patient have more than one coded diagnosis.

[3] Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

Medication

While psychological and social interventions are available for people experiencing mental illness, there are suggestions that too often the first-line treatment is medication. The 1950s marked the introduction of medication as a treatment for mental illness, and in the 1990s this treatment expanded extremely. New classes of antidepressants, the development of second-generation antipsychotic medication, and the use of medication not traditionally regarded as psychiatric, profoundly influenced the treatment of mental illness.

In the past ten years, the use of medication to treat mental illness has increased by 58% in Australia[4], which has the second highest, per capita antidepressant consumption of all OECD countries[5].

In 2018-19, 39 million mental health-related prescriptions (subsidised and under co-payment) were provided. 17.1% of the Australian population or 4.3 million patients received mental health-related prescriptions, an average of 9 prescriptions per patient. The majority (86%) of mental health-related prescriptions were prescribed by GPs, 7.7% by a psychiatrist and 4.5% prescribed by a non-psychiatrist specialist. Of the 39 million mental health-related prescriptions, 70.9% were antidepressants[6].

Data extracted through PATCAT[7] from Gold Coast general practices show that in March 2022, of the 88,166 active patients[8] aged 18-64 with a coded mental health diagnoses, 57,048 (64%) also had a current mental health medication. Table 2 highlights mental health management of these patients.

Table 2. Active population aged 18 to 64 with a coded mental health diagnoses management, Gold Coast, March 2022

	Number	Percent
Active population with a coded mental health diagnoses aged 18 to 64	88,166	
Patients with a mental health diagnosis who have a current prescribed Mental health medication	57,048	64.7%
Patients with a mental health diagnoses and a mental health treatment plan (MHTP) in the last 12 months	46,861	55.7%
Patients with a mental health diagnoses and a MHTP review in the last 12 months	16,764	20.0%
Patients with a mental health diagnoses and a MHTP consult in the last 12 months	28,022	33.3%
Physical activity recorded	998	1.1%
Sufficient	570	57.0%
Insufficient	157	16.0%
Sedentary	271	27.0%
BMI recorded	51,546	64.0%
Morbid 40+	2,870	5.6%

[4] Roughead L. Presentation to Safety and Quality Partnership Standing Committee. 11 July 2014. (As cited in National Mental Health Commission (2014): The National Review of Mental Health Programmes and Services. Sydney: National Mental Health Commission).
[5] OECD (2011). Health at a Glance 2011: OECD Indicators, OECD Publishing. http://dx.doi.org/10.1787/health_glance2011-en
[6] Mental health services in Australia, Australian Institute of Health and Welfare, 2021
[7] PAT CAT is a web-based interface that aggregates de-identified General Practice data for population health management and research programs.
[8] Active population represents the portion of the total population that have had at least three visits to the same practice in the last 2 years as per RACGP Accreditation Standards for general practice

Obese 30 to 39.9	13,867	27.0%
Overweight 25 to 29	15,824	31.0%
Healthy 18.5 to 24.9	17,237	33.0%
Underweight <18.5	1,748	3.40%

Source: PATCAT, all results indicate no date ranges was applied.

Perinatal depression

The perinatal period is a highly volatile time and addressing the complex needs of the mother and baby both as individuals and a dyad is essential to endure the best possible outcomes. Recognising symptoms early and seeking help minimises the risk of potentially devastating outcomes for new parents and their baby[9]. Data from 2010 showed that 1 in 5 mothers of children aged 2 years or under had been diagnosed with depression in Australia. More than half of these mothers reported that their diagnosed depression was perinatal (that is, the depression was diagnosed from pregnancy until the child's first birthday[10]). Data on perinatal depression on the Gold Coast is limited but nationally, perinatal depression was more common reported among mothers who:

- were younger (aged under 25),
- were smokers,
- came from lower income households,
- were overweight or obese,
- had an emergency caesarean section.

Analysing data extracted through PATCAT[11] from 158 Gold Coast general practices, 2,093 active patients had a coded postnatal depression diagnoses. Of those, 47% (n=993) had a current mental health medication. Table 3 highlights mental health management for Gold Coast with a coded postnatal depression diagnoses and management.

Table 3. Active population with a coded postnatal depression diagnoses aged 18 to 64, March 2021

	Number	Percent
Active population with a coded postnatal depression diagnoses aged 18 to 64	2,093	
Have a current mental health medication	993	47.0%
Patients with a Mental Health Treatment Plan (MHTP) in the last 12 months	1	54.0%
Patients with a MHTP review in the last 12 months	399	20.0%
Patients with a MHTP consult in the last 12 months	663	33.0%

Source: PATCAT, all results indicate no date ranges was applied.

[9] Deloitte Access Economics. (2012). the cost of perinatal depression in Australia – Final report. Available from: https://www.deloitteaccesseconomics.com.au/uploads/File/PANDA%20Exec%20Summ%20pdf.pdf

[10] Australian Institute of Health and Welfare, 2010 Australian National Infant Feeding Survey

[11] PAT CAT is a web-based interface that aggregates de-identified General Practice data for population health management and research programs.

Social isolation and loneliness

Social isolation and loneliness can be damaging to both mental and physical health. They are considered significant health and wellbeing issues in Australia because of the impact they have on people lives. Both concepts do not necessarily co-exist—a person may be socially isolated but not lonely, or socially connected but feel lonely[12].

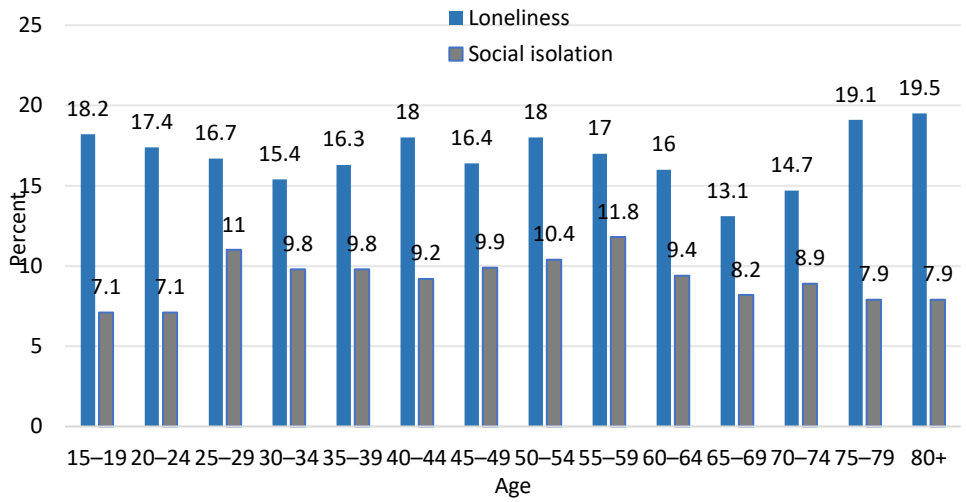
- social isolation: state of having minimal contact with others,
- loneliness: subjective state of negative feeling about having a lower level of social contact than desired[13].

One in three Australians reported an episode of loneliness between 2001 and 2009, with 40% of these people experiencing more than one episode[14].

- one in ten Australians aged 15 and over report lacking social support[15],
- one in four report they are currently experiencing an episode of loneliness[16],
- one in two report they feel lonely for at least one day each week.

Loneliness and social isolation have been linked to mental illness, emotional distress, suicide and development of dementia[17]. Part of the challenge in reporting on social isolation and loneliness comes from no universally agreed upon definitions. Figure 4 shows how social isolation and loneliness vary across age groups.

Figure 4. Proportion of people experiencing social isolation and loneliness, by age groups, Australia, 2018



Source: Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labor Dynamics of Australia Survey. Canberra: Relationships Australia.

[12] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS.
[13] Peplau L & Perlman D 1982. Perspectives on loneliness. In: Peplau L & Perlman D (eds). Loneliness: A sourcebook of current theory, research, and therapy. New York: Wiley.
[14] Baker D 2012. All the lonely people: loneliness in Australia, 2001–2009. Canberra: The Australia Institute.
[15] Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey. Canberra: Relationships Australia.
[16] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS
[17] Hawthorne G 2006. Measuring social isolation in older adults: development and initial validation of the friendship scale. Social Indicators Research 77:521–48

Ongoing support

People with severe and complex mental illness (for example, with personality disorders) often have long treatment histories. A coordinated ongoing community treatment model, which supports continuity of care and is understood within a relational model, is essential to the effective treatment of severe and complex mental illness[18].

It has been recognised that people with severe and complex mental illness needs may not meet the criteria for care coordination or supports designed for severe and complex mental illness. Due to this, some people may become more vulnerable resulting in exacerbation of issues and higher use of treatment services.

Eligible for assistance

People whose mental health illness severely affects their ability to function day to day can benefit from support that meets their individual needs through the National psychosocial support programs for people with severe mental illness.

People with severe mental illness who are not accessing psychosocial supports through the NDIS or state and territory funded services can get support through:

- the National Psychosocial Support Measure
- the National Psychosocial Support Transition program
- the Continuity of Support program for psychosocial support

In 2021, the above three programs were consolidated into one program - Commonwealth Psychosocial Support Program for people with severe mental illness.

It has been recognised there are unmet psychosocial needs for people with severe mental illness who are not eligible for assistance through the NDIS, and who are not receiving psychosocial services through National Psychosocial Support Measure programs. Due to this, some people may become more vulnerable resulting in exacerbation of issues and higher use of treatment services.

ED Presentations

In 2019-20, there was just under 11,000 presentations from people aged 18 to 64 years to Gold Coast University and Robina Hospital EDs for mental and behavioral disorders as outlined in the ICD-10-AM.

The leading presentation for mental and behavioral disorders were mental and behavioral disorders due to the use of alcohol, acute intoxication making up 13% of all mental health presentations. This was followed by anxiety disorder, unspecified with 10%. Of all mental health ED presentations, 23.2% were for lower care (triage category four and five).

Underserviced Groups

Many underserviced groups have higher rates of psychological distress and may not access services due to numerous determinants including location, cost, culturally appropriateness of the service provider and language barrier. These characteristics may make it difficult for people to participate, especially if the ways in which they are expected to contribute do not make allowances for the barriers they may face. Some of the key factors that can impact people's ability to access and successfully engage in services include language,

[18] Project Air Strategy for Personality Disorders* (2015). Treatment Guidelines for Personality Disorders 2nd Ed. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

age, gender identity, geographic location, income, ethnicity, education, residential status, sexual orientation, health, and religion. As a result, careful consideration of services to best meet their needs are required.

A current barrier for underserviced population groups accessing the Medicare Benefits Schedule Better Access initiative is the out-of-pocket cost for the patient. Australian Bureau of Statistics survey identified that high out-of-pocket cost prevent people with log-term or chronic conditions from seeking healthcare and place financial strain on low-income consumers[19]. An increasing number of people delay visits to GPs and psychologists because of cost consideration[20].

In 2016-17, 43.1% of Gold Coast residents occurred out-of-pocket costs for a non-hospital Medicare service. For these patients, the median amount spent in the year was $145 per patient[21].

In 2018-19, total fees charged by the clinical psychologists were $12,148,391, comprising the benefits paid by Medicare and patients' out-of-pocket cost, with 80,083 services being claimed[22]

Data, research and consultation with service users, service providers, community members and Clinical Council identified the following groups as potentially underserviced and people in distress including those who do not have a current mental health diagnosis and maybe at increased risk of suicide on the Gold Coast:

- Aboriginal and Torres Strait Islanders
- Culturally and Linguistically Diverse
- LGBTIQAP+ community
- perinatal – have had a baby in the last 12 months
- children up to 12 years old
- children in out of home care (up to 12 years old)
- experiencing or at risk of homelessness
- people who have attempted, or are at risk of suicide or self-harm
- veterans
- youth justice
- older adults (aged 65 and over)
- children with autism
- people with a dual diagnosis – alcohol/ drugs and cognitive impairment.
- complex families
- people with an eating disorder
- men linked to family court
- victims of family and/or domestic violence

MBS changes and workforce issues

The Better Access initiative aims to improve treatment and management for people who have mild to moderate mental health conditions through Medicare rebates for people accessing care. GPs are encouraged

19 Patient Experiences in Australia, Summary of Findings, Australia Bureau of Statistics, 2020

20 Patient Experiences in Australia: Summary of Findings, 2011-12, Australian Bureau of Statistics

21 Australian Institute of Health and Welfare analysis of Department of Health, Medicare Benefits claims data, 2016–17

22 Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data, 2018–19

to work more closely and collaboratively with psychiatrist, clinical psychologists, registered psychologists, occupational therapists, and appropriately trained social workers to support patients.

The three tables below highlight the increase in Medicare-subsidised mental health-specific services from 2015-2016 to 2019-20 on the Gold Coast. This increase in general practitioner, clinical psychologists, and other allied health providers Medicare-subsidised mental health-specific services is above the Gold Coast population growth rate and employment rate for clinical psychologists and medical practitioners.

- During this time, the Gold Coast population increased by 10.3% (575,629 in 2015 to 635,191 in 2020)[23].
- Number of medical practitioners on the Gold Coast increased by 23.3% (2,070 in 2015 to 2,552 in 2020).
- Number on clinical psychologists on the Gold Coast increased by 23.2% (514 in 2015 to 633 in 2020)[24].

[23] Queensland Government Population Projections, 2018 edition (medium series)
[24] Sources: Department of Health 2020; ABS 2018

Table 4. Number of Medicare-subsidised mental health-specific services, Gold Coast, 2015-16 to 2019-20

Provider type	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Psychiatrists	82,241	84,033	84,162	85,276	87,138	6.0%
General practitioners	93,462	102,199	110,186	120,163	122,516	31.1%
Clinical psychologists	65,549	69,438	75,266	80,405	85,333	30.2%
Other psychologists	95,942	92,091	100,336	105,059	106,073	10.6%
Other allied health providers	5,790	7,422	7,675	7,484	8,501	46.8%
All providers	342,984	355,183	377,625	398,387	409,561	19.4%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

The number of general practitioner Medicare-subsidised mental health-specific services (Mental Health Treatment items, review of a GP Mental Health Treatment Plan, and GP Mental Health Treatment Consultation) have increased 31.1% from 2015-16 to 2019-20 on the Gold Coast. Table 5 shows that Robina had the largest percentage with 42.6% (7,720 in 2015-16 to 10,295 in 2019-20). Ormeau-Oxenford had the greatest number of general practitioner Medicare-subsidised mental health-specific services with 28,221 in 2019-20.

Table 5. Number of General Practitioner Medicare-subsidised mental health health-specific services, Gold Coast Statistical Area Level 3 regions, 2015-16 to 2019-20

	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Broadbeach - Burleigh	10,026	10,828	11,489	12,686	13,232	32.0%
Coolangatta	9,829	10,403	11,229	11,530	11,424	16.2%
Gold Coast - North	11,562	12,276	13,082	14,102	14,559	25.9%
Gold Coast Hinterland	3,449	3,538	3,874	4,349	4,302	24.7%
Mudgeeraba - Tallebudgera	4,998	5,388	5,967	6,643	6,869	37.4%
Nerang	10,008	11,350	11,676	12,700	13,028	30.2%
Ormeau - Oxenford	20,416	23,149	25,135	27,788	28,221	38.2%
Robina	7,220	8,243	8,865	9,991	10,295	42.6%
Southport	10,248	11,031	12,350	13,173	13,154	28.4%
Surfers Paradise	5,726	6,012	6,544	7,227	7,457	30.2%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

The number of Medicare-subsidised services by clinical psychologists on the Gold Coast have increased by 30.2% from 2015-16 to 2019-20. Table 6 shows that Broadbeach-Burleigh had the largest increase with 47% (7,830 in 2015-16 to 11,508 in 2019-20), and Ormeau-Oxenford had the greatest number of clinical psychologists' services with 15,872 in 2019-20.

Table 6. Number of Clinical Psychologists Medicare-subsidised services, Gold Coast SA3 regions, 2015-16 to 2019-20

	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Broadbeach - Burleigh	7,830	8,987	9,832	10,616	11,508	47.0%
Coolangatta	7,836	7,943	8,318	8,982	9,422	20.2%
Gold Coast - North	7,346	7,678	8,286	8,390	9,061	23.3%
Gold Coast Hinterland	2,114	2,287	2,393	2,442	2,438	15.4%
Mudgeeraba - Tallebudgera	3,892	4,066	4,481	5,009	5,386	38.4%
Nerang	7,975	8,109	7,841	8,990	9,342	17.1%
Ormeau - Oxenford	11,652	12,222	14,912	14,922	15,872	36.2%
Robina	5,956	5,971	6,495	7,452	8,011	34.5%
Southport	7,038	7,664	8,379	8,445	8,780	24.8%
Surfers Paradise	3,926	4,525	4,349	5,177	5,531	40.9%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

COVID-19

As part of the Australian Government's COVID-19 response, changes were made to the Better Access initiative including:

- an increase from 10 to 20 in Medicare subsisded individual psychological services each calendar year,
- expanded eligibility to include residents of aged care facilities,
- expanded access to telehealth.

Early data suggest utilisation of MBS funded psychological services remained high during 2020-21 on the Gold Coast.

Local stakeholders report that the changes to Better Access have impacted on the workforce and consequently, timely access to services for people seeking mental health support. NGOs service providers report increased wait times for their services due to difficulty in recruiting staff as many private practitioners are choosing to work from home and see patients through Better Access. This is particularly an issue in the northern corridor of the Gold Coast as there is already a limited workforce and high demand in the area.

System Navigation

Consultation throughout the 2020 Gold Coast Joint Regional Plan between Gold Coast Health and Gold Coast Primary Health Network identified that there is a high demand for system navigation support and to support people to assess and determine suitable options. There are two elements to services navigation that have been identified:

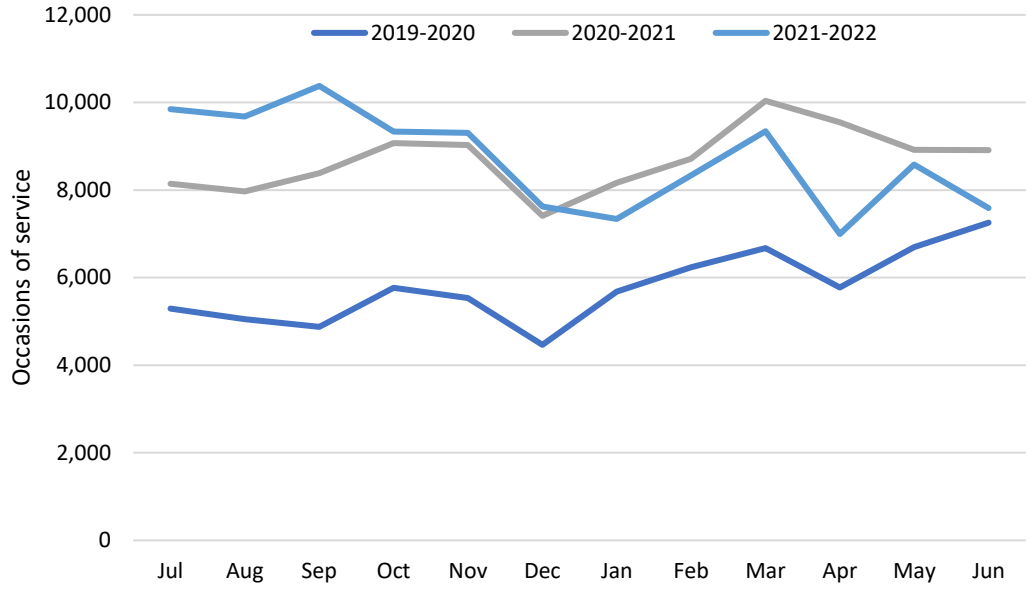
1) Uncoordinated and inconsistent approach to assessment, referrals, and intake:
    - Most services operate an assessment and intake component for their service meaning individuals and referrers often have to share their story at each transition point or when ascertaining eligibility. When people are not matched to the right service initially, they have to retake the intake process, which can be a system inefficiency and can contribute to a poor experience and poor outcomes. Additionally, the frustrating experience of trying to find the right fit can result in disengagement and opportunities for early intervention may be lost with people presenting to the system later in crisis.
    - An inconsistent approach to assessment (e.g various tools) leads to inconsistent assigned levels of care, resulting in discrepancies in the type of care provided across providers and regions, for similar clinical presentations.
    - Referrals to services are often inappropriate, resulting in people being under or over serviced.
2) Limited awareness/understanding of service infrastructure, including availability and capability of services:
    - Referrals to services are often inappropriate, resulting in people being under or over serviced.
    - There are many pathways to mental health, AOD and suicide prevention and support services. Community members and service providers perceive that the local service system changes frequently due to funding changes, resulting in providers and people being unclear about available services and the pathways to access these services. There is a need for timely and accurate information and easily identifiable access points for individuals seeking care, so that they can be matched with the service which optimally meets their needs.

Increasing demand management across the Stepped care approach

In 2020-21, GCPHN funded providers saw over 8,000 unique clients access the Stepped Care programs. The rate of referrals to PHN funded services across low intensity, psychological therapy and clinical care coordination continued to rise in Q4 (October, November, December) as compared to Q3 (July, August, September). These high referral rates are placing significant pressure on all services.

Data extracted through Primary Sense™, GCPHN data extraction and population health management clinical audit tool, shows that demand on services as evidenced by presentations to general practice for anxiety and depression significantly increased from 2019-2020 to 2020-2021 (Figure 5). This presents a challenge as some GCPHN Psychological Service providers (PSP) have very high waiting times for appointments. Psychological Services have continued to express their preference to take MBS clients over PSP clients as the administrative burden of the MBS program is less with no reporting, or performance monitoring requirements.

Figure 5. Mental health GP consultations for anxiety/depression, Gold Coast, 3019-20 to 2021-22



Source: Primary Sens. Data is extracted from 159 general practices.

Service system

Services	Number in GCPHN region	Distribution	Capacity discussion
Psychological Services Program (PSP)	18	Organisations are available across the GCPHN region and are evenly spread	• The Psychological Services Program (PSP) is a moderate intensity service that offers short term structured psychological therapies by a range of providers.
Headspace (12-25 years)	2	Upper Coomera and Southport	• An accessible 'one-stop shop' for young people aged 12-25 that helps promote wellbeing: mental health, physical health, work/ study support and alcohol and other drug services. • A multidisciplinary service of consultant psychiatrists, peer workers and clinicians that support young people aged 12-25 at risk of or experiencing a first episode of psychosis. The Early Psychosis team intervene early to improve the lives of young people impacted by psychosis and their families.
E-mental health services	4	headspace, beyondblue, eheadspace, ReachOut	• Online Services. Public awareness knowledge of these services would drive uptake/demand and could bridge gap between services.
Phone Services	2	Beyond Blue Headspace	
Online Counselling	2	beyondblue online chat headspace online chat	
Coaching	Online	Reachout	• Phone coaching for parents and carers of 12 to 18 year olds.
NewAccess (Beyond Blue)	Phone, online or in person	Phone, online or in person	• Coaching low intensity CBT.
Psychologists	633, across all settings and job roles, in labor force	Psychologists generally distributed across the Gold Coast, majority in coastal and central areas.	• Psychologists can be a point of referral for individuals.
General Practice	212	Clinics are distributed across the Gold Coast; majority in coastal and central areas.	• 855 GPs on the Gold Coast.

Consultation

Various consultation activity was undertaken across the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one-to-one interviews, industry presentations, working groups and co-design processes.

Joint regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services

- A range of structured psychological interventions are available in the GCPHN region to support people with or at risk of mild and moderate mental illness. Some of these interventions are also intended to target identified high risk/hard to reach groups.
- Identified gaps include people who may need ongoing support (e.g., personality disorders) but do not meet criteria for care coordination on or supports designed for severe and complex mental illness.
- Review of this infrastructure will help to further refi ne and target these services ensuring they best meet the needs of the GCPHN region.
- There are unmet psychosocial needs for people with severe mental illness who are not eligible for assistance through the NDIS, and who are not receiving psychosocial services through National Psychosocial Support Measure programs.
- The Gold Coast Psychosocial Alliance has been established to coordinate services between Queensland Health, PHN and NDIS providers of psychosocial services.
- People with an existing health concern may be able to function independently in the community with minimal formal supports. However, when services are not well coordinated across the sectors, people may become more vulnerable resulting in exacerbation of issues and higher use of treatment services.
- Supporting people with an existing health concern through the perinatal stage has long term benefits. There is existing investment in this space that can be leveraged to support further developments of perinatal services.

Primary and Community Care Community Advisory Group

Primary needs/gaps identified:

- Crisis accommodation, particularly for domestic violence.
- Domestic violence services to support people to access safety.
- Transport options for homeless. Many of the foodbanks etc require transport. An idea that was raised was transport concession cards for homeless people.
- Advocacy for the homeless particularly in regard to the Council. We are aware the Gold Coast council now has 2 Public Space liaison workers (for the whole Gold Coast). But it is identified that homeless people are being served notice to move on from an area, but then their belongings are confiscated when they're not looking (so to speak) and there doesn't seem to be a pathway to get their belonging back. We identified that this cohort need advocacy to prevent it getting to the point where all their worldly possessions are taken from them.
- Bulk billing psychiatrists.
- Bulk billing psychology.

- Cardiometabolic monitoring – this is interesting because we are developing our cardiometabolic monitoring & deprescribing clinic.

Service provider consultation

- Need to look at service options in northern corridor on the Gold Coast:
    - Most services tend to end around Southport yet there is significant growth in Northern Corridor (Pimpama and Ormeau).
    - Since COVID, single practitioners in the Northern Corridor area are attending to mental health issues for 20-30% of daily practice.
    - Northern corridor community actively seeking after hours options, when crisis happens Southport is too far away, especially for young families. Many of these young families include migrants and FIFO workers, with additional challenges in accessing services.
- GCPHN's Clinical Council provided feedback during consultation session in May 2021 that there is significant strain on GPs in the Coomera, Ormeau and Oxenford area:
    - Number of consultations GPs are having with patients with mental health concerns has significantly increased over the past 2 years (particularly in the past 12 months)
    - GPs report that they deliver increased number of consultations due to significant lack of allied health service availability in the GCPHN region.
    - GPs in this area also report very high levels of work stress due to patients' mental health needs escalating over time, and GPs "holding" a reasonable degree of patient risk whilst the patient/s are waiting to access a service.
- People with intellectual disability, autism and acquired brain Injury are often not able to get psychological support:
    - Some private psychologists do not feel confident or have skills to provide support to these people.
    - These people fall through the gaps as they are not able to access disability services for mental health support, but mental health services won't provide services.

COVID-19 Impacts

The Wesley Mission Queensland COVID-19 Recovery Service was established to provide responsive wellbeing support for people aged 16 years and over living in the GCPHN region whose wellbeing has been impacted by the ongoing effects of COVID-19. Below are some of the common presentations to the service:

- Loneliness and social isolation,
- Suicidal ideation,
- Problems with secure housing,
- Financial barrier's such as loss of employment/struggles to secure adequate ongoing employment,
- Overall anxiety and depressive presentations – low mood and lack of motivation,
- Struggles with accessing services such as Centrelink and NDIS,
- Loss of routine,
- Grief and loss,
- Difficulties in accessing appropriate higher mental health services in a timely manner due to long waitlists.

In addition to the above, very early on in the rollout of this service it became apparent that schools needed support as children's anxiety levels had increased; anecdotally, home-schooling had a massive impact on some students finding it difficult to re-engage in face-to-face learning. Parents were also struggling with how to deal with the impact of COVID-19 on the mental health and wellbeing of their children.

Older people mental health

The Older Person's sector incorporates all services that are delivering services to older people as defined by the relevant funding body, such as Commonwealth and State agencies. While we can quantify the population of older people in the Gold Coast Primary Health Network (GCPHN) region as those aged 65 years or more, it is recognised that Aboriginal and Torres Strait Islander people have a shorter life expectancy than non-Indigenous Australians and may experience the impacts of ageing at a younger age, with the age of this population group often referred to as those 55 years or more. It is acknowledged that multiple government agencies define the older population differently and funding and service access may be determined more by functional capacity and whether they are living in an aged care facility, as opposed to age.

Services are delivered to older people on the Gold Coast by a range of stakeholders including residential aged care facilities, public hospitals, GPs, community-controlled organisations and medical deputising services and not-for-profit organisations. The most used types of publicly funded aged care services include Commonwealth Home, Support Programme (CHSP), Home Care Packages (HCP), Residential Aged Care, including permanent and respite, and Transition Care.

There are strengths and challenges in the provision of services for the older population. The Gold Coast population is increasingly becoming older with the number of older adult residents in the GCPHN region projected to double by 2030. Overall demand for aged care services will therefore increase significantly, and in turn greater demand will be placed on the mental health and dementia specific services. This highlights the pressing need for a greater level of service planning and integration to ensure the GCPHN region has a comprehensive approach to care, particularly between Gold Coast Health, Commonwealth funded programs and primary care providers.

In March 2020, the Australian Government released the Royal Commission into Aged Care Quality and Safety to look at the quality of care provided in residential and home aged care to senior and young Australians. An interim report was published in October 2019, which identified significant failures and flaws of the aged care system including that it:

- Is designed around transactions, not relationships or care.
- minimises the voices of people receiving care and their loved one
- Is hard to navigate and does not provide the information people need to make informed choices about their care
- relies on a regulatory model that does not provide transparency or an incentive to improve
- has a workforce that is under pressure, under-appreciated and lacks key skills

Gold Coast Health and GCPHN acknowledge that some of these systemic problems will need to be resolved at a national level and this will take time.

Local health needs and service issues

- Mental health and aged care related issues (e.g., dementia) are often treated in isolation of each other or as separate disciplines.
- Evolving service system results in General Practitioners being unclear about available services and the pathways to access these services.
- Limited access to assessment and treatment by public sector geriatricians to patients in the community.
- Gaps in clinical resources, knowledge and supports in the community result in people referring to Older Person's Mental Health unit (tertiary service) as a default option or last resort.
- High levels of isolation and loneliness among older people on the Gold Coast.
- System navigation is difficult for General Practitioners and people
- Timely access to services for people seeking mental health support.
- Increasing demand for all mental health services.

Key findings

- Gold Coast has a higher rate of people aged 65+, compared to Queensland.
- Gold Coast rate of General Practitioner mental health services above national rate for people aged 65-79 and 80+.
- Gold Coast rate of clinical psychologists services above national rate for people aged 65-79 and 80+.
- Gold Coast rate of psychiatrists services above national rate for people aged 65-79 and 80+.
- Low rate of people aged 65 and over with a coded mental health diagnoses who had claimed a mental health treatment plan in the last 12 months.

Evidence

Demographics

The population as of the 2021 census data on the Gold Coast aged 65 years and over, referred hereafter as 'older adults' was 114,349 people in 2021.Table 1 provides a breakdown of the older adult population in the GCPHN region by sex and age group based on 2021 Census data.

Table 1. Number and proportion of population by age group, Gold Cost SA3 regions, 2021

Region	65-74		75-84		85 years or more	
	Number	%	Number	%	Number	%
Queensland	503,466		274,997		97,140	
Gold Coast (SA4)	64,273		37,005		13,071	
Broadbeach - Burleigh	7,194	11.19%	4,215	11.39%	1,638	12.53%
Coolangatta	6,506	10.12%	3,548	9.59%	1,599	12.23%
Gold Coast - North	9,735	15.15%	6,398	17.29%	2,187	16.73%
Gold Coast Hinterland	2,587	4.03%	1,273	3.44%	299	2.29%
Mudgeeraba - Tallebudgera	3,182	4.95%	1,564	4.23%	494	3.78%
Nerang	6,493	10.10%	3,737	10.10%	1,209	9.25%
Ormeau - Oxenford	11,571	18.00%	5,603	15.14%	1,519	11.62%
Robina	5,166	8.04%	3,287	8.88%	1,434	10.97%
Southport	6,036	9.39%	4,042	10.92%	1,834	14.03%
Surfers Paradise	5,804	9.03%	3,335	9.01%	849	6.50%

Source: Australian Bureau of Statistics (ABS), 2021 Census of Population and Housing

Prevalence, service usage and other data

It is thought that between 10% and 15% of older people experience depression and about 10% experience anxiety[1]. Rates of depression among people living in residential aged care are believed to be much higher, at around 35%[1].

Applying these rates to the Gold Coast population aged 65 years and over, 15,876 have experienced depression while 10,584 have experience anxiety. As seen in Table 1, the Gold Coast rate of people aged 65 and over (16.6%) is above the Queensland rate (15.7%) and the average annual growth rate on the Gold Coast 2.4% between 2014 and 2019 which was also above the Queensland rate 1.5% the number of older people experiencing mental illness will continue to increase on the Gold Coast[2].

[1] National Ageing Research Institute. (2009). beyondblue depression in older age: a scoping study. Final Report. Melbourne: National Ageing Research Institute.
[2] ABS 3218.0, Regional Population Growth, Australia, various editions

Medicare Benefits Schedule

Patients suffering from poor mental health can see their GP who will assess the patient and what may be of assistance for the patient. This could include:

- making a mental health assessment,
- creating a mental health treatment plan,
- referring the patient to a psychiatrist or other mental health professional,
- giving the patient a prescription for medicines to treat the illness.

These interactions with GPs and mental health workers are captured in Medicare-subsidised data. GP mental health services may include early intervention, assessment, and management of patients with mental disorders. These services include assessments, planning patient care and treatments, referring to other mental health professionals, ongoing management, and review of the patient's progress.

A mental health treatment plan is a support plan for someone who is going through mental health issues. If a doctor agrees that the individual requires additional support, the patient and the doctor will make the plan together.

Gold Coast Primary Health Network (GCPHN) acknowledge that people may not always see a clinical psychologist and may see a general psychologist, counsellors, or social workers for a consultation. General psychologists, counsellors and social workers data is limited in national reports due to psychologists (clinical or other) may also provide some services listed for general psychologist, counsellors, social workers. Implications of this is (psychologists (clinical or other)) cannot be readily separated from other mental health workers and leading to duplication in reporting. Due to this GCPHN will report on GP mental health services, clinical psychologists and psychiatrists MBS services provided and acknowledge data is not included for services delivered by general psychologist, counsellors, or social workers services.

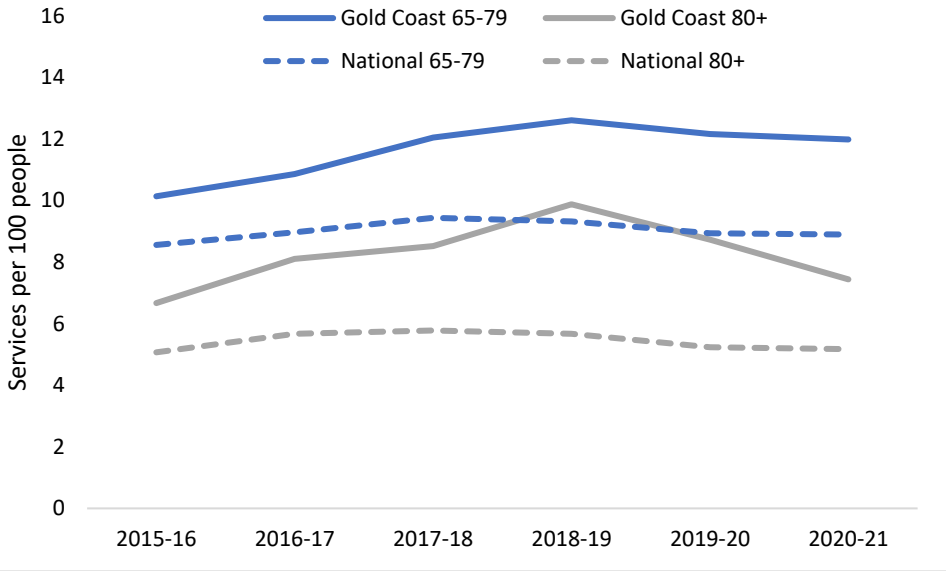
General practitioner

For the purpose of this report, GP metal health includes early intervention, assessment and management of patients with mental disorders by GPs or other medical practitioners (who are not specialists or consultant physicians). These services include assessments, planning patient care and treatments, referring to other mental health professionals, ongoing management, and review of the patient's progress.

The Gold Coast rates for GP mental health services per 100 people in 2020-21 were:

- Aged 65-79; above the national rate (12.0 vs 8.9 per 100 people)
    - 5,639 residents had a mental health consultation with a GP leading to 10,024 consultations.
- Aged 80 years and over; above the national rate (7.4 vs 5.2 per 100 people)
    - 1,150 residents had a metal health consultation with a GP, leading to 2,001 consultations.

Figure 1. General Practitioner mental health services per 100 people, national and Gold Coast, 2015-16 to 2020-21



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population, please note all data is mapped to the patients Medicare residential address

Clinical Psychologists

Psychologists are health professionals who can work in a range of areas such as clinical, neuropsychology, health, community, forensic, organizational and sports and exercise psychology. Clinical psychologists have skills in the following areas:

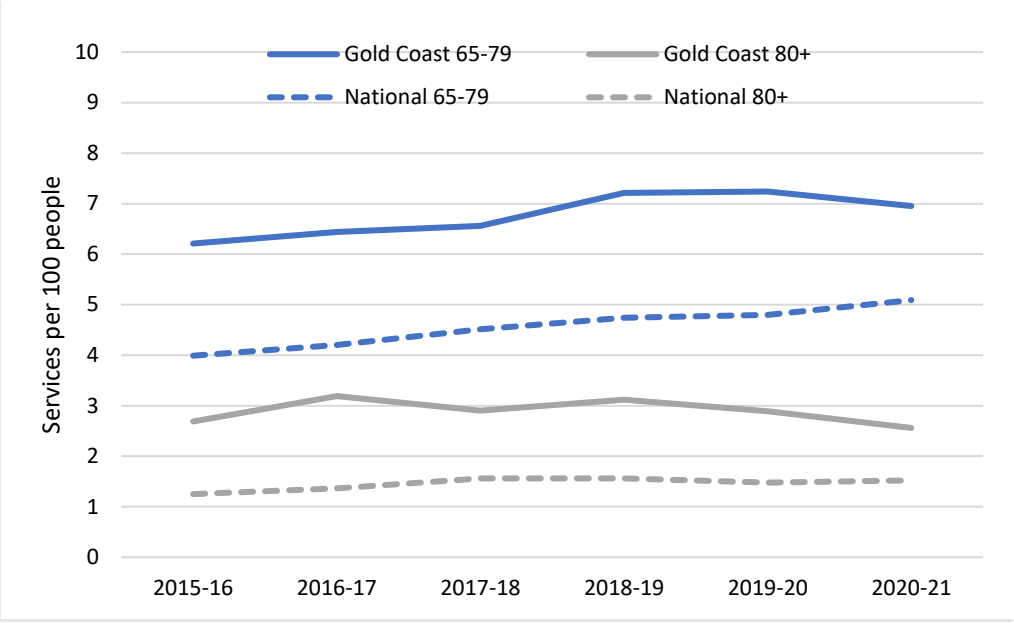
- assessment and diagnosis
- treatment
- learning

For the purpose of this report psychological therapy services provided by eligible clinical psychologists includes individual attendances, group therapy, and telehealth video consultations.

The Gold Coasts rate for clinical psychologists' services per 100 people in 2020-21 were:

- Aged 65-79; above the national rate (7.0 vs 5.1 per 100 people)
    - 1,247 residents had a clinical psychologists consultation, leading to 5,807 consultations.
- Aged 80 years and over; above the national rate (2.6 vs 1.5 per 100 people)
    - 186 residents had a clinical psychologists consultation, leading to 690 consultations.

Figure 2. Clinical Psychologists services per 100 people, national and Gold Coast, 2015-16 to 2020-2021



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population, please note all data is mapped to the patients Medicare residential address

Psychiatrists

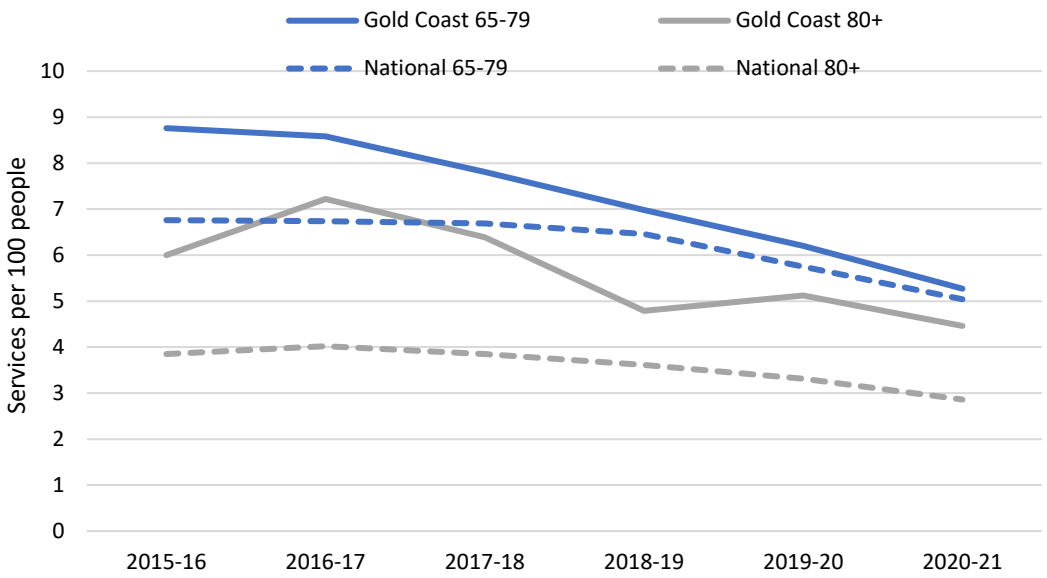
Psychiatrists are doctors who have undergone further training to specialise in the assessment, diagnosis, and treatment of mental health conditions. Psychiatrists can make medical and psychiatric assessments, conduct medical test, provide therapy, and prescribe medication.

For the purpose of this report Medicare-subsidised services provided by a psychiatrist, included patient attendances (or consultations), group psychotherapy, tele-psychiatry, case conferences and electroconvulsive therapy.

The Gold Coasts rate for psychiatrist services per 100 people in 2020-21 were:

- Aged 65-79; above the national rate (5.3 vs 5.0 per 100 people)
    - 1,233 residents had a psychiatry consultation leading to 4,410 consultations.
- Aged 80 years and over: above the national rate (4.5 vs 2.9 per 100 people)
    - 467 residents had a psychiatry consultation leading to 1,201 consultations.

Figure 3. Psychiatrist services per 100 people, national and Gold Coast, 2015-16 to 2020-21



Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population, please note all data is mapped to the patients Medicare residential address

Gold Coast General Practices data

Prevalence

Analysing data extracted from Gold Coast PHN's PATCAT system which captures de-identified patient data submitted by registered general practices throughout the GCPHN region[3]. As of March 2022, of the 119,766 active patients (three visits in the past two years) aged 65 and over, 18.5% (n=22,152) had a coded mental health diagnosis. Table 2 highlights active population with coded mental health diagnoses. Please note an individual may have a coded diagnoses of anxiety and depression.

Table 2. Active population aged 65 and over with a coded mental health diagnosis, Gold Coast, March 2022

	Number	Rate
Active patents 65 year and over	119,766	
Patients aged 65 and over with a coded mental health diagnosis	22,152	18.5%
Patients aged 65 and over with anxiety	13,572	11.3%
Patients aged 65 and over with depression	14,478	12.1%
Patients aged 65 and over with schizophrenia	361	0.3%
Patients aged 65 and over with bipolar	610	0.5%
Patients aged 65 and over with dementia	3,446	2.9%

Source: Gold Coast Primary Health Network PATCAT tool Includes active patients with a coded diagnosis of at least one, anxiety, depression, schizophrenia or bipolar. All results indicate no date ranges was applied

[3] Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

Medication and management

While psychological and social interventions are available for people experiencing mental illness, there are suggestions that too often the first-line treatment is medication. The 1950s marked the introduction of medication as a treatment for mental illness, and in the 1990s this treatment expanded extremely. New classes of antidepressants, the development of second-generation antipsychotic medication, and the use of medication not traditionally regarded as psychiatric, profoundly influenced the treatment of mental illness.

In the past ten years, the use of medication to treat mental illness has increased by 58% in Australia[4], which has the second highest, per capita antidepressant consumption of all OECD countries[5].

In 2018-19, 39 million mental health-related prescriptions (subsidised and under co-payment) were provided. 17.1% of the Australian population or 4.3 million patients received mental health-related prescriptions, an average of 9 prescriptions per patient. The majority (86%) of mental health-related prescriptions were prescribed by GPs, 7.7% prescribed by psychiatrist and 4.5% prescribed by non-psychiatrist specialist in 2018-19. Of the 39 million mental health-related prescriptions, 70.9% were for antidepressants[6].

Data from Primary Sense which 159 general practices in the GCPHN region submits to show that in November 2022, of the 41,436 active patients (three visits in the past two years) aged 65 and over with a coded mental health diagnosis, 13% (n=5,337) had claimed a mental health treatment plan in the last 12 months.

Table 3 highlights active population with coded mental health diagnoses and, mental health treatment plans and BMI record for those with a coded mental health diagnosis.

Table 3. Active population aged 65 and over with a coded mental health diagnoses management, March 2022

Description	Count	Rate
Active patients aged 65+	147,468	
Patients aged 65+ with a mental health diagnosis	41,436	28%
Patients aged 65+ with anxiety	14,986	36%
Patients aged 65+ with depression	21,020	51%
Patients aged 65+ with schizophrenia	593	1%
Patients aged 65+ with bipolar	784	2%
Patients aged 65+ with dementia	4,053	10%
Patients 65+ with coded MHD billed a MHTP	5,337	13%
Patients 65+ with mental health diagnosis with BMI recorded	13,433	32%
BMI recorded as underweight	293	2%
BMI recorded as healthy	3,735	28%
BMI recorded as overweight	5,020	37%
BMI recorded as obese	3,904	29%
BMI recorded as morbid	481	4%

Source, Primary sense

[4] Roughead L. Presentation to Safety and Quality Partnership Standing Committee. 11 July 2014. (As cited in National Mental Health Commission (2014): The National Review of Mental Health Programmes and Services. Sydney: National Mental Health Commission).
[5] OECD (2011). Health at a Glance 2011: OECD Indicators, OECD Publishing. http://dx.doi.org/10.1787/health_glance2011-en
[6] Mental health services in Australia, Australian Institute of Health and Welfare, 2021

Mental health services in Residential Aged Care Facilities

There is evidence that RACF residents have very high rates of mental illness. It is estimated that approximately 39% of all permanent aged care residents are living with mild to moderate depression[7].

One of the biggest issues facing residents is difficulty adjusting to the changes that a move into aged care can bring. Many people experience a great sense of loss because of this. If untreated, this can lead to more serious mental health issues, so we like to connect with residents right from the beginning.

GCPHN has commissioned a service to provide the psychological services in RACFs, which is now currently available in 43 aged care facilities. The service objective is to build capacity of RACF and their staff through education, training, and liaison to enable:

- Early identification, response, and referral
- Support to attend therapy, undertake self-help and follow interventions
- Provide an environment and lifestyle options to support mental wellbeing
-

From July 2020 to March 2021 there was slightly over 400 unique residents who had been referred or accessing psychological services on the Gold Coast leading to over 1,500 service contacts.

There has been an increase in referrals for social isolation and loneliness to the psychological services program in RACFs in 2020-21. There have been recent cases where residents have been referred for hopelessness and depression. Upon investigation causes for hopelessness by the psychologists found they are related mainly to:

- enduring power of attorney issues
- public guardians being unresponsive
- family members misappropriating finances
- slow response from advocacy groups
- access to social workers, ADA and other advocacy groups can take time. This places practitioners in a difficult position

For this initiative, the definition of mental illness is consistent with that applied to MBS Better Access items. This means that dementia and delirium are not regarded as mental illness. This is because these conditions require medical and/or other specialised support which is not within scope of this initiative. People with dementia are not excluded from treatment if they also have a comorbid mental illness such as anxiety or depression. Delirium may present with symptoms similar to those associated with a mental illness although it will not respond to psychological therapies and requires urgent medical assessment.

Care needs of older people with mental disorders

The mental health of older people may be affected by losing the ability to live independently due to frailty, reduced mobility and/or disability, or pre-existing or recent onset of a chronic physical condition[8].

Individuals who are physically independent but isolated by the loss of a partner or relocation, may need housing in a community where they can develop new relationships and be close to social support facilities. Those with physical disabilities may need greater access to medical facilities, and assistance with daily

[7] Australian Institute of Health and Welfare 2015. Australia's welfare 2015. Australia's welfare series no. 12. Cat. no. AUS 189. Canberra: AIHW
[8] Rickwood D 2005. Pathways of recovery: preventing further episodes of mental illness. Canberra: National Mental Health Promotion and Prevention Working Party.

activities like shopping or other domestic household tasks. Those who are very ill and/or frail may need a much higher level of support, including 24-hour care.

Social isolation and loneliness

Social isolation and loneliness can be damaging to both mental and physical health. They are considered significant health and wellbeing issues in Australia because of the impact they have on people lives. Both concepts do not necessarily co-exist—a person may be socially isolated but not lonely, or socially connected but feel lonely[9].

- social isolation: state of having minimal contact with others
- loneliness: subjective state of negative feeling about having a lower level of social contact than desired[10]

One in three Australians reported an episode of loneliness between 2001 and 2009, with 40% of these people experiencing more than one episode[11].

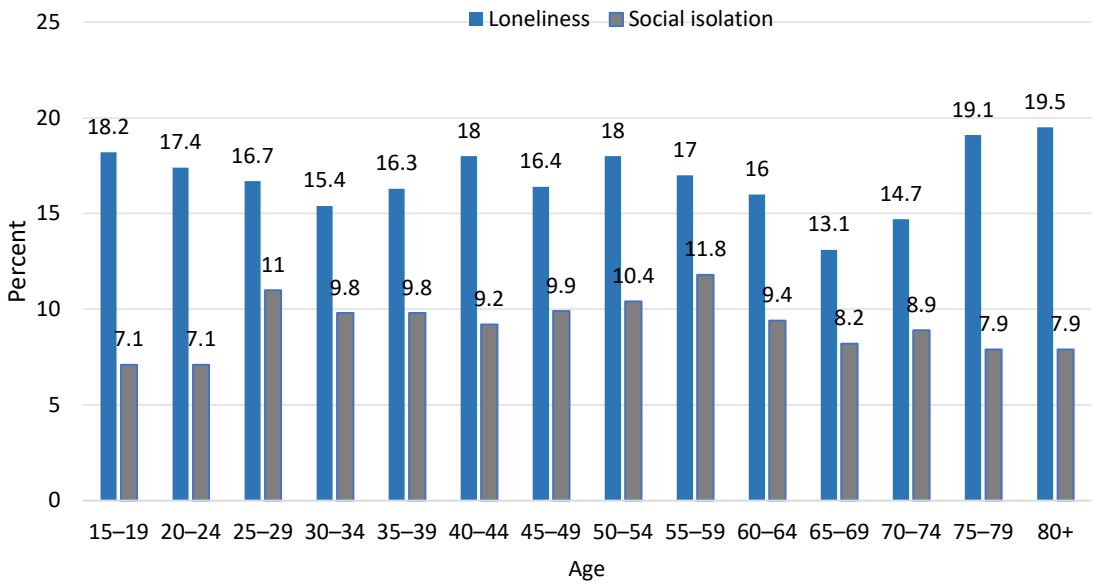
- one in ten Australians aged 15 and over report lacking social support[12]
- one in four report they are currently experiencing an episode of loneliness[13]
- one in two report they feel lonely for at least one day each week

Social distancing during the pandemic was never meant to prevent social connections, but many family members, friends and neighbours of older adults were staying away to avoid exposing their loved ones to the virus.

Loneliness and social isolation have been linked to mental illness, emotional distress, suicide, and development of dementia[14]. Part of the challenge in reporting on social isolation and loneliness comes from no universally agreed upon definitions. Figure 4 shows how social isolation and loneliness vary across age groups.

[9] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS.
[10] Peplau L & Perlman D 1982. Perspectives on loneliness. In: Peplau L & Perlman D (eds). Loneliness: A sourcebook of current theory, research, and therapy. New York: Wiley.
[11] Baker D 2012. All the lonely people: loneliness in Australia, 2001–2009. Canberra: The Australia Institute.
[12] Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey. Canberra: Relationships Australia.
[13] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS
[14] Hawthorne G 2006. Measuring social isolation in older adults: development and initial validation of the friendship scale. Social Indicators Research 77:521–48

Figure 4. Proportion of people experiencing social isolation and loneliness, by age groups, Australia, 2018



Source: Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labor Dynamics of Australia Survey. Canberra: Relationships Australia.

Neuropsychological assessment

Neuropsychological assessment is a performance-based method to assess cognitive functioning. This method is used to examine the cognitive consequences of brain damage, brain disease, and severe mental illness. Some clients in Residential Aged Care Facilities require these assessments to determine capacity and develop management plans for Residential Aged Care Facility staff. If these assessments are not completed there is a risk of the client may need to be hospitalised for ongoing treatment and support.

Elder abuse

Elder abuse takes a myriad of forms, including psychological abuse, financial abuse, physical abuse, and sexual abuse, and often a combination of these. Like family violence, elder abuse is about one person having power and control over another person.

The percentage of people aged 65 and over on the Gold Coast (17.0%) or 110,532 people in 2020 was slightly above the Queensland rate (16.1%). Australia has an ageing population rate of people aged 65 and over is expected to rise to 19.6% of the population by 2055[15].

In Australia, the available evidence suggest that prevalence varies across abuse types, with psychological and financial abuse being the most common. A population-based study to identify the prevalence of elder abuse (women only) is the Australian Longitudinal Study of Women's Health 2014[16].

This study is based on a random sample of women with the oldest cohort (n = 5,561) being born between 1921 and 1926. When this cohort was surveyed in 2011 (at age 85-90), the findings suggested that 8% had experienced being exposed to abuse, with name calling and put-downs being the most common forms. A similar level of prevalence was evident for this cohort in a preceding wave, conducted in 2008 (age 82-87),

[15] Source: ABS 3235.0, Population by Age and Sex, Regions of Australia

[16] Australian Longitudinal Study on Women's Health. (2014). 1921-26 cohort: Summary 1996-2013. Callaghan, NSW & Herston, Qld: University of Newcastle and the University of Queensland.

and slightly lower prevalence levels were found at younger ages (70-81 years). Measures the researchers used to assess neglect indicate a relatively stable prevalence rate of about 20% across waves, from ages 70-75 and 85-90 years.

In Queensland, calls to the Elder Abuse Prevention Unit (EAPU) have increased over the past years that it has been operating from just over 200 in 2000-01 to nearly 1,300 in 2014-15[17]. The calls were mostly in relation to female victims (68% female, 31% male and 1% unknown). Perpetrators were male in 50% of calls and female in 45% (unknown 5%). Children were the largest groups of perpetrators reported (31% sons, 29% daughters). Otherwise, 10% were "other relatives".

In 2014-15, the most reported type of abuse to the EAPU helpline was financial abuse, accounting for 40% of reports, compared to 35% for psychological abuse which was the most common type in 2012-13.

It has been highlighted the importance of allowing a person (the patient) privacy to talk about their safety and not always assuming that the carer is the safe person of the relationship (carer can be partner or paid carer).

Underserviced Groups

Many underserviced groups have higher rates of psychological distress and may not access services due to numerous determinants including location, cost, culturally appropriateness of the service provider and language barrier.

These characteristics may make it difficult for people to participate, especially if the ways in which they are expected to contribute do not make allowances for the barriers they may face. Some of the key factors that can impact people's ability to access and successfully engage in services include language, age, gender identity, geographic location, income, ethnicity, education, residential status, sexual orientation, health, and religion. As a result, careful consideration of services to best meet their needs are required.

A current barrier for underserviced population groups accessing the Medicare Benefits Schedule Better Access initiative is the out-of-pocket cost for the patient. Australian Bureau of Statistics survey identified that high out-of-pocket cost prevent people with log-term or chronic conditions from seeking healthcare and place financial strain on low-income consumers[18]. An increasing number of people delay visits to GPs and psychologists because of cost consideration[19].

In 2016-17, 43.1% of Gold Coast residents out an out-of-pocket cost for a non-hospital Medicare service. For these patients with a cost, the median amount spent in the year was $145 per patient. This means that half of patients with cost spent more than $145, and half spent less[20].

In 2018-19, was the total fees charged by the clinical psychologists were $12,148,391, comprising the benefits paid by Medicare and patients' out-of-pocket cost with 80,083 services being claimed[21].

Data, research and consultation with service users, service providers, community members and Clinical Council identified the following groups as potentially underserviced and people in distress (including those who do not have a current mental health diagnosis and maybe at increased risk of suicide on the Gold Coast:

[17] Spike, C. (2015). The EAPU helpline: Results of an investigation of five years of call data. Report for the International Association of Gerontology and Geriatrics Asia & Oceania Regional Congress 2015. Chermside Central, Qld: Elder Abuse Prevention Unit, UnitingCare Community.
[18] Patient Experiences in Australia, Summary of Findings, Australia Bureau of Statistics, 2020
[19] Patient Experiences in Australia: Summary of Findings, 2011-12, Australian Bureau of Statistics
[20] Australian Institute of Health and Welfare analysis of Department of Health, Medicare Benefits claims data, 2016–17
[21] Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data, 2018–19

- Aboriginal and Torres Strait Islanders
- Culturally and Linguistically Diverse
- LGBTIQAP
- perinatal – have had a baby in the last 12 months
- children up to 12 years old
- children in out of home care (up to 12 years old)
- experiencing or at risk of homelessness
- people who have attempted, or are at risk of suicide or self-harm
- veterans
- youth justice
- older adults (aged 65 and over)
- children with autism
- children in care
- people with a dual diagnosis
- complex families
- people with an eating disorder
- men linked to family court
- victims of family and/or domestic violence

MBS changes and workforce issues

The Better Access initiative aims to improve treatment and management for people who have mild to moderate mental health conditions through Medicare rebates for people accessing care. GPs are encouraged to work more closely and collaboratively with psychiatrist, clinical psychologists, registered psychologists, occupational therapists, and appropriately trained social workers to support patients.

The three tables below highlight the increase in Medicare-subsidised mental health-specific services from 2015-2016 to 2019-20 on the Gold Coast. This increase in GP, clinical psychologists, and other allied health providers Medicare-subsidised mental health-specific services is above the Gold Coast population growth rate and employment rate for clinical psychologists and medical practitioners.

- During this time, Gold Coast population increased by 10.3% (575,629 in 2015 to 635,191 in 2020)[22].
- Number of medical practitioners (working in all settings) employed on the Gold Coast working as a medical practitioner increased by 23.3% (2,070 in 2015 to 2,552 in 2020).
- Number on clinical psychologists (working in all settings) employed on the Gold Coast working as a clinical psychologist increased by 23.2% (514 in 2015 to 633 in 2020)[23].

Table 4. Medicare-subsidised mental health services, Gold Coast, 2015-16 to 2019-20

Provider type	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Psychiatrists	82,241	84,033	84,162	85,276	87,138	6.0%
General practitioners	93,462	102,199	110,186	120,163	122,516	31.1%
Clinical psychologists	65,549	69,438	75,266	80,405	85,333	30.2%
Other psychologists	95,942	92,091	100,336	105,059	106,073	10.6%
Other allied health providers	5,790	7,422	7,675	7,484	8,501	46.8%
All providers	342,984	355,183	377,625	398,387	409,561	19.4%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

[22] Queensland Government Population Projections, 2018 edition (medium series)

[23] Sources: Department of Health 2020; ABS 2018

The number of GP Medicare-subsidised mental health-specific services (Mental Health Treatment items, review of a GP Mental Health Treatment Plan, and GP Mental Health Treatment Consultation) have increased 31.1% from 2015-16 to 2019-20 on the Gold Coast. Table 5 shows that Robina had the largest percentage with 42.6% (7,720 in 2015-16 to 10,295 in 2019-20). Ormeau-Oxenford had the greatest number of GP Medicare-subsidised mental health-specific services with 28,221 in 2019-20.

Table 5. General Practitioner Medicare-subsidised mental health services, Gold Coast SA3 regions, 2015-16 to 2019-20

	2015–16	2016–17	2017–18	2018–19	2019–20	Rate change from 2015-16 to 2019-20
Broadbeach - Burleigh	10,026	10,828	11,489	12,686	13,232	32.0%
Coolangatta	9,829	10,403	11,229	11,530	11,424	16.2%
Gold Coast - North	11,562	12,276	13,082	14,102	14,559	25.9%
Gold Coast Hinterland	3,449	3,538	3,874	4,349	4,302	24.7%
Mudgeeraba - Tallebudgera	4,998	5,388	5,967	6,643	6,869	37.4%
Nerang	10,008	11,350	11,676	12,700	13,028	30.2%
Ormeau - Oxenford	20,416	23,149	25,135	27,788	28,221	38.2%
Robina	7,220	8,243	8,865	9,991	10,295	42.6%
Southport	10,248	11,031	12,350	13,173	13,154	28.4%
Surfers Paradise	5,726	6,012	6,544	7,227	7,457	30.2%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

The number of clinical psychologists Medicare-subsidised services have increased 30.2% from 2015-16 to 2019-20 on the Gold Coast. Table 6 shows that Broadbeach-Burleigh had the largest percentage increase with 47% (7,830 in 2015-16 to 11,508 in 2019-20). Ormeau-Oxenford had the greatest number of clinical psychologists' services with 15,872 in 2019-20.

Table 6. Clinical Psychologists Medicare-subsidised services, Gold Coast SA3 regions, 2015-16 to 2019-20

	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Broadbeach - Burleigh	7,830	8,987	9,832	10,616	11,508	47.0%
Coolangatta	7,836	7,943	8,318	8,982	9,422	20.2%
Gold Coast - North	7,346	7,678	8,286	8,390	9,061	23.3%
Gold Coast Hinterland	2,114	2,287	2,393	2,442	2,438	15.4%
Mudgeeraba - Tallebudgera	3,892	4,066	4,481	5,009	5,386	38.4%
Nerang	7,975	8,109	7,841	8,990	9,342	17.1%
Ormeau - Oxenford	11,652	12,222	14,912	14,922	15,872	36.2%
Robina	5,956	5,971	6,495	7,452	8,011	34.5%
Southport	7,038	7,664	8,379	8,445	8,780	24.8%
Surfers Paradise	3,926	4,525	4,349	5,177	5,531	40.9%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

COVID-19

As part of the Australian Government's COVID-19 response, changes were made to the Better Access initiative including:

- an increase from 10 to 20 in Medicare subsisded individual psychological services each calendar year
- expanded eligibility to include residents of aged care facilities
- expanded access to telehealth

Early data suggest utilisation of MBS funded psychological services remained high during 2020-21 on the Gold Coast.

Local stakeholders report that the changes to Better Access have impacted on the workforce and consequently, timely access to services for people seeking mental health support. NGOs service providers report increased wait times for their services due to difficulty in recruiting staff as many private practitioners are choosing to work from home and see patients through Better Access. This is particularly an issue in the northern corridor of the Gold Coast as there is already a limited workforce and high demand in the area.

System Navigation

Consultation throughout the 2020 Gold Coast Joint Regional Plan between Gold Coast Health and Gold Coast Primary Health Network identified that there is a high demand for system navigation support and to support people to assess and determine suitable options. There are two elements to services navigation that have been identified:

1) Uncoordinated and inconsistent approach to assessment, referrals, and intake.
    - Most services operate an assessment and intake component for their service meaning individuals and referrers often have to share their story at each transition point or when ascertaining eligibility. When people are not matched to the right service initially, they have to retake the intake process, which can be a system inefficiency and can contribute to a poor

experience and poor outcomes. Additionally, the frustrating experience of trying to find the right fit can result in disengagement and opportunities for early intervention may be lost with people presenting to the system later in crisis.

- An inconsistent approach to assessment (e.g various tools) leads to inconsistent assigned levels of care, resulting in discrepancies in the type of care provided across providers and regions, for similar clinical presentations.
- Referrals to services are often inappropriate, resulting in people being under or over serviced.

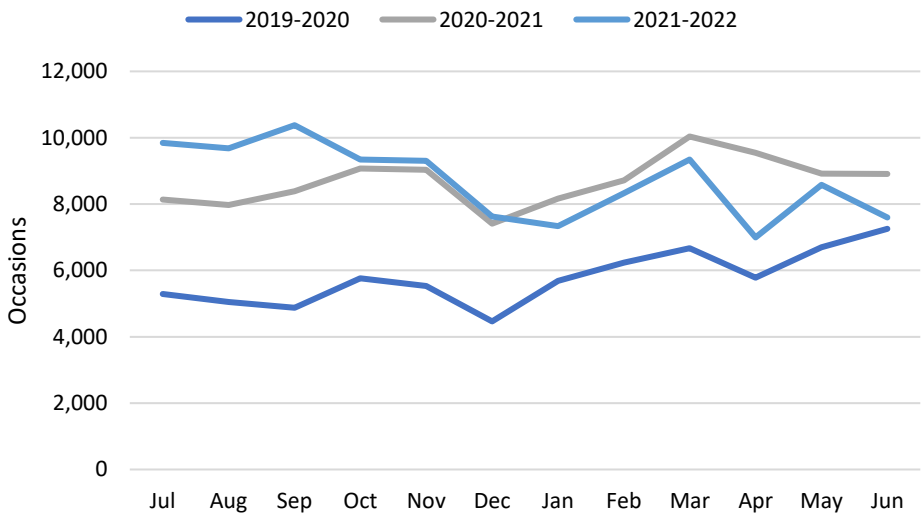
2) Limited awareness/understanding of service infrastructure, including availability and capability of services.
    - Referrals to services are often inappropriate, resulting in people being under or over serviced.
    - There are many pathways to mental health, AOD and suicide prevention and support services. Community members and service providers perceive that the local service system changes frequently due to funding changes, resulting in providers and people being unclear about available services and the pathways to access these services. There is a need for timely and accurate information and easily identifiable access points for individuals seeking care, so that they can be matched with the service which optimally meets their needs.

Increasing demand management across the Stepped care approach

In 2020-21, GCPHN funded providers saw over 8,000 unique clients access the Stepped Care programs. The rate of referrals to PHN funded services across low intensity, psychological therapy and clinical care coordination continued to rise in Q4 (October, November, December) as compared to Q3 (July, August, September). These high referral rates are placing significant pressure on all services.

Data extracted through Primary Sense, GCPHN data extraction and population health management clinical audit tool, shows that demand on services as evidenced by presentations to general practice for anxiety and depression, which flow onto community mental health services, significantly increased from 2019-2020 to 2020-2021 (Figure 5). This presents a challenge as some GCPHN Psychological Service providers (PSP) have very high waiting times for appointments. Psychological Services have continued to express their preference to take MBS clients over PSP clients as the administrative burden of the MBS program is less with no reporting, or performance monitoring requirements.

Figure 5. Mental health consultations for anxiety/depression, Gold Coast, 2019-20 to 2021-22



Source: Primary Sense. Data from 159 general practices.

Service system

Services	Number in GCPHN region	Distribution	Capacity discussion
Psychological Services in Residential Aged Care Facilities (RACFs)	1	Change Future's attend in person at each RACF	• The Psychological Services in RACF program offers structured psychological therapies that support people with mental health needs living in residential aged care.
Psychological Services Program (PSP)	18	Organisations are available across the region and are evenly spread	• The Psychological Services Program (PSP) is a moderate intensity service that offers short term structured psychological therapies delivered by a range of providers.
Plus Social service funded by GCPHN	1 which offers psychosocial support, after hour's safe space, as well as clinical care coordination.	Mermaid Beach	• Plus Social is a comprehensive clinical support service for people who experience the impact of severe mental illness. The program supports individuals who are finding it difficult to maintain their regular day to day activities using clinical care coordination. The program includes structured, recovery and goal-oriented services focused on creating significant improvements in quality of life, health, and wellbeing.
Aboriginal and Torres Strait Islander: Kalwun Social Health Clinical Care Coordination	3	Miami, Bilinga, Coomera	• Identify as an Aboriginal and/or Torres Strait Islander person. • Parent/carer/partner of an Aboriginal and/or Torres Strait Islander person. • This low to high intensity service offers

			comprehensive support for Aboriginal and Torres Strait Islander people who are struggling with their mental health or for those with alcohol and other drug needs.
E-mental health services	4	headspace, beyondblue, eheadspace, ReachOut	• Online Services. Public awareness knowledge of these services would drive uptake/demand and could bridge gap between services.
Phone Services	2	Beyond Blue Headspace	
Online Counselling	2	beyondblue online chat headspace online chat	
NewAccess (Beyond Blue)	Online	Phone, online or in person	• Coaching low intensity CBT.
Psychologists	633, across all settings and job roles, in labor force	Psychologists generally distributed across the Gold Coast, with the majority located in coastal and central areas	• Psychologists can be a point of referral for individuals.
General Practice	212	Clinics are generally distributed across the Gold Coast, with the majority located in coastal and central areas.	• 855 GPs on the Gold Coast.

Consultation

Various consultation activity was undertaken across the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one-to-one interviews, industry presentations, working groups and co-design processes.

Joint regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services

- Mental health and aged care related issues (e.g., dementia) are often treated in isolation of each other or as separate disciplines.
- Limited access to assessment and treatment by public sector geriatricians to patients in the community.
- Gaps in clinical resources, knowledge and supports in the community result in people referring to Older Person's Mental Health unit (tertiary service) as a default option or last resort.
- Isolation and loneliness can have a significant impact on people's mental and physical health. The growing and changing population on of the Gold Coast has resulted in loss of connection and sense of community that can be natural or informal support systems. The Gold Coast has more older adults living alone than in other South East Queensland regions. This combined with high levels of older people moving to the Gold Coast in their later years, who may lack informal care and support networks, raises concerns of social isolation on among older people and potentially limited ability to access services without support.
- Proactive engagement can prevent further social isolation and loneliness, however activities in the community that support inclusion/connection on may not be targeted or inclusive of older people and their needs.

Service provider consultation

- Needs to be a greater focus on early intervention, care coordination and helping isolated older people.
- We have seen evidence of older people being very confused about what services they can access and how to access them which results in a delay or complete barrier to care.
- High rate (40%) of referrals received in the first three months have needed assistance with coordination of medical appointments.
- People have needed assistance with both their Physical and Mental health, understanding their medications and help accessing broader services such as financial services, housing, and Centrelink.
- The sector seems fragmented, resulting in confusion for older people trying to access services and this leads to a decline in their overall physical and mental wellbeing.
- Through the COVID recovery service our data indicates that a high percentage of Older People living in the Gold Coast are feeling lonely or socially isolated.
- Clients not knowing how to navigate the My Aged Care System and access services that they are eligible for (for example, some clients have been approved for home maintenance support to get help with their lawns, however they don't know what to do next or who to get the support from).
- Many clients need more in-home care services than what they are receiving but are assessed incorrectly.

- Long wait-times for My Aged Care assessments leaving vulnerable people without the support they need.
- Need to look at service options in northern corridor on the Gold Coast:
    - Most services tend to end around Southport yet there is significant growth in Northern Corridor (Pimpama and Ormeau).
    - Since COVID, single practitioners in the Northern Corridor area are attending to mental health issues for 20-30% of daily practice.
    - Northern corridor community actively seeking after hours options, when crisis happens Southport is too far away, especially for young families. Many of these young families include migrants and FIFO workers, with additional challenges in accessing services.

GCPHN Clinical Council (May 2021):

- There is significant strain on GPs in the Coomera, Ormeau and Oxenford area:
    - Number of consultations GPs are having with patients with mental health concerns has significantly increased over the past 2 years (particularly in the past 12 months).
    - GPs report that they deliver increased number of consultations due to significant lack of allied health service availability in the region.
    - GPs in this area also report very high levels of work stress due to patients' mental health needs escalating over time, and GPs "holding" a reasonable degree of patient risk whilst the patient/s are waiting to access a service.
- People with intellectual disability, autism and acquired brain Injury are often not able to get psychological support
    - Some private psychologists do not feel confident or have skills to provide support to these people.
    - These people fall through the gaps as they are not able to access disability services for mental health support, but mental health services won't provide services.

Primary and Community Care Community Advisory Group

Primary needs/gaps identified:

- Crisis accommodation, particularly for domestic violence.
- Domestic violence services to support people to access safety.
- Transport options for homeless. Many of the foodbanks etc require transport. An idea that was raised was transport concession cards for homeless people.
- Advocacy for the homeless particularly in regards to the Council. We are aware the Gold Coast council now has 2 Public Space liaison workers (for the whole Gold Coast). But it is identified that homeless people are being served notice to move on from an area, but then their belongings are confiscated when they're not looking (so to speak) and there doesn't seem to be a pathway to get their belonging back. We identified that this cohort need advocacy to prevent it getting to the point where all their worldly possessions are taken from them.
- Bulk billing psychiatrists
- Bulk billing psychology
- Cardiometabolic monitoring – this is interesting because we are developing our cardiometabolic monitoring & deprescribing clinic.

COVID-19 Impacts

The Wesley Mission Queensland COVID-19 Recovery Service was established to provide responsive wellbeing support for people aged 16 years and over living in the Gold Coast region whose wellbeing has been impacted by the ongoing effects of COVID-19. Below are some of the common presentations to the service:

- loneliness and social isolation,
- suicidal ideation,
- problems with secure housing,
- financial barriers such as loss of employment/struggles to secure adequate ongoing employment,
- overall anxiety and depressive presentations – low mood and lack of motivation,
- struggles with accessing services such as Centrelink and NDIS,
- loss of routine,
- grief and loss,
- difficulties in accessing appropriate higher mental health services in a timely manner due to long waitlists.

In addition to the above, very early on in the rollout of this service it became apparent that schools needed support as children's anxiety levels had increased; anecdotally home-schooling had a massive impact on some students finding it difficult to re-engage in face-to-face learning. Parents were also struggling with how to deal with the impact of COVID-19 on the mental health and wellbeing of their children.

Mental health – underserviced population groups

Local health needs and service issues

Access and awareness of appropriate services is limited for underserviced groups, for psychosocial and psychological concerns. This includes primary health care and mental health services for people within the mild to moderate range. While there is limited data specifically on underserviced groups/individuals for mental health services, data, research and consultation with service users, service providers and community members identified a broad range of groups that were potentially underserviced:

- People who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+),
- People who are currently homeless or are at risk of homelessness,
- Children (aged 0-12) who have, or are at risk of developing a mental, childhood behavioral or emotional disorder (including children in care),
- People in situational distress (including people who self-harm and those who do not have a current mental health diagnosis and maybe at increased risk of suicide),
- People who self-harm or who are at increased risk of suicide,
- Aboriginal and Torres Strait Islander people, and
- Culturally and Linguistically Diverse people (CALD).

In 2022, GCPHN undertook co-design process to support underserviced populations and the following sub-groups were particularly prioritised:

- Indigenous children in care (0 – 19 years) with a mental illness,
- Youth (12 – 24 years) and adults within the LGBTIQAP+ community with a mental illness and who require culturally specific support,
- Adults (16+ years) with a mental illness and who present with other situational factors such as: homelessness or at risk of homelessness, domestic violence issues, current legal issues, financial hardship.

Key findings

- Many underserviced groups are not comfortable accessing mainstream services. The competence of staff affects access to services for underserviced groups.
- Access and awareness of appropriate services is limited for underserviced groups, for psychosocial and psychological concerns. This includes primary health care and mental health services for people within the mild to moderate range.
- Evolving service system results in GPs being unclear about available services and the pathways to access these services.
- There is low uptake of free translation services by Gold Coast general practitioners, specialists, pharmacy, and nurse practitioners. A broad range of languages are spoken in the Gold Coast Primary Health Network (GCPHN) region, including growing numbers from countries where trauma and torture issues can impact an individual's ability to access appropriate services.

- Use of interpreter services can be difficult, particularly telephone-based services, as interpreters may have limited understanding of mental health issues and cultural sensitivity coupled with the limited capacity of existing CALD services to support mental health clients.
- Stigma, privacy concerns and cultural issues present barriers to people accessing services.
- Flexibility of service provision, such as outreach, is necessary to engage homeless people and those at risk of becoming homeless. There is a high number of homeless people in Southport, Surfers Paradise and Coolangatta, and a high number of socio-economically disadvantaged people in Southport and Gold Coast North.
- Training and education are required for services to ensure safe and appropriate service provision for LGBTIQAP+ people. LGBTIQAP+ organisations are time limited and must facilitate communication with broader health services.
- Children aged 0 to 12, particularly children in care, have high needs (see Mental Health – Children and Young People Needs Assessment Summary).
- Perinatal depression a considerable proportion of women, but they may not seek services due to stigma. Use of GCPHN funded services is low.

Prevalence and utilisation of health services

Overall, the Gold Coast has good service coverage and relatively unimpeded access to health services. However, there are people in the community who are vulnerable and/or experience circumstances that can prevent those accessing services without additional support.

These characteristics may make it difficult for people to participate, especially if the ways in which they are expected to contribute do not make allowances for the barriers they may face. Some of the key factors that can impact people's ability to access and successfully engage in services include language, age, gender identity, geographic location, income, ethnicity, education, residential status, sexual orientation, health and religion. As a result, careful consideration of services to best meet their needs are required.

The Psychological Services Program provides short term psychological interventions for financially disadvantage people with non-crisis, non-chronic, moderate mental health conditions or for people who have attempted, or at risk of suicide or self-harm. This program particularly targets several priority groups including children. From the 1st of July 2021 to 30th June 2022, PSP had:

- 1,056 referrals, and
- 6,999 sessions delivered.

Table 1. Psychological Services Program referrals and sessions, GCPHN, 1st July 2021 to 30th June 2022

	Number of referrals	% of all referrals	Sessions	Sessions as % of referrals
Adult Suicide Prevention	1,056	65%	4,909	70%
Children	235	15%	849	12%
Aboriginal and Torres Strait Islander	111	7%	383	5%
Homeless	55	3%	197	3%
CALD	47	3%	248	4%
Perinatal	68	4%	215	3%
LGBTIQAP+	48	3%	197	3%
General (COVID19 Response)	0	0	1	0
TOTAL	1,620		6,999	

Source: PIR-FIXUS

Suicide prevention is by far the most common cause for referral to PSP program.

The Royal Commission into Victoria's Mental Health System interim report found that a disproportionate number of people with mental health issues have a low income. The commission findings revealed that this, combined with the high cost of mental health services, represents a major barrier to people accessing the care they require.

Availability of psychology appointments and out-of-pocket cost are the two key issues that may impact a person with a mental healthcare plan (MHCP) engaging in clinical services. There is no requirement to bulk bill sessions under a MHCP and when a gap fee is charged patients may be unable to afford to access the service. Currently there are higher than average wait times for MBS supported services due to an increase in referral numbers.

Further distress can be felt by the individual when they are not unwell enough for hospital services yet cannot afford to pay the out-of-pocket cost for mental healthcare through Medicare-subsidised psychological sessions. They may access free telephone counselling (Beyond Blue, Kids Help Line) and/or digital e-mental health services to manage their mental health but the level of care they receive may not match the care they require.

People who are at risk of homelessness

Quantifying the prevalence of mental illness among homeless populations is difficult, and estimates have varied considerably. A 2020 Australian Institute of Health and Welfare report on mental health services in Australia identified the prevalence of mental health issues among homelessness people accessing specialist homelessness services which assistance is provided by a specialist homelessness agency to a client aimed at responding to or preventing homelessness.

This report identified 88,338 (about 1 in 3) of the 241,966 specialist homelessness services clients aged 10 years and over in 2017-18 had a current mental health issue. The national rate of specialist homelessness with a current mental health issue has increased each year from 2012-12 to 2019-20[1]. In total, 28,000 (about 1 in 10) of specialist homelessness services clients aged 10 years and over reported problematic alcohol and/or drug use.

The Journeys Home project (a longitudinal survey of Australians) found that of those people who had experienced housing instability or homelessness, risky use of substances was also reported (57%), illicit drug use (39%) and the injection of drugs (14%) in the previous 6 to 12 months[2] .

A 2016 study by Australian Institute of Health and Welfare highlights the complexity of people in this group finding that over the 3-year period 2011-2013, more than 1 in every 5 alcohol and drug treatment clients also accessed homelessness assistance, while about 1 in 12 of all homelessness clients received alcohol and drug treatment[3]. The report's analysis further reveals that over three-quarters (77%) of the study population, in addition to their housing and drug and alcohol issues, experienced an additional vulnerability, including mental health problems or domestic and family violence issues.

In 2016, there were 1,723 homeless people on the Gold Coast, a rate of 29.4 per 10,000[4]. This was lower than the Queensland rate of 45.6 per 10,000. However, within the Gold Coast, Southport exceeded the state rate of homelessness with 71.5 persons per 10,000. Two other GCPHN regions had rates above that of the broader Gold Coast were Surfers Paradise (41.9 per 10,000) and Coolangatta (35.8 per 10,000). Service providers report that this is likely to be an under-representation of the true numbers.

The 2014 Home for Good study found that of the 382 homeless Gold Coasters that participated, 53% reported experiencing physical, emotional, or sexual abuse and trauma that they had not sought help for, or that had caused their homelessness[5] .

Socio-Economic Indexes for Areas (SEIFA) is a summary measure of the social and economic conditions of geographic areas across Australia. SEIFA comprises several indexes, generated by the ABS from the Census of Population and Housing. People in the most disadvantaged quintiles are at greater risk of homelessness.

[1] Australian Institute of Health and Welfare, Mental Health Services in Australia

[2] Scutella R, Chigavazra, A Killackey E, Herault N, Johnson G, Moschion J et al. 2014. Journeys home research report no. 4. Melbourne: University of Melbourne.

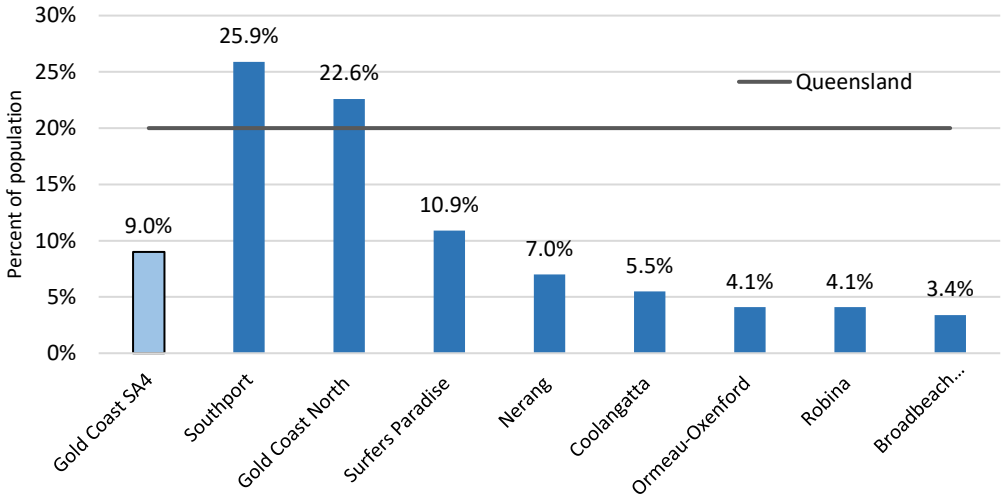
[3] Australian Institute of Health and Welfare. 2016. Exploring drug treatment and homelessness in Australia: 1 July 2011 to 30 June 2014. Cat. no. CSI 23. Canberra: AIHW

[4] ABS. 2011. Census. Gold Coast (SA4). Quick Stats.

[5] Queensland Council of Social Services. 2014. Home for Good. Gold Coast Registry Week Report.

Overall, the Gold Coast had 9.0% of people in the most disadvantaged quintile. Southport (25.9%) and Gold Coast North (22.6%) exceeded both the broader Gold Coast and Queensland figures, as shown in Figure 1.

Figure 1. Percentage of population by SEIFA quintile 1 (most disadvantaged), Gold Coast SA3 regions, 2016



Source: ABS 2033.0.55.001, Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia - Data only, 2016, (Queensland Treasury derived) Please note, Gold Coast Hinterland and Mudgeeraba-Tallebudgera were not included in this figure as their rate was not included in the source.

Specialist Homelessness Services

The Specialist Homelessness Services Collection (SHSC) collects information about people who are referred to, or seek assistance from, specialist homelessness services (SHS) agencies. Data shown below is extract from Queensland December 2021. Of the 13,367 clients who received homelessness services, 59% were females while 41% were males. Age groups did vary of people using Specialist Homelessness Services in December 2021 as can be seen below in Table 2.

Table 2. Specialist Homelessness Services, by age group and sex, Queensland, December 2021

Age	Females	Males	Total
0–4 years	8%	13%	10%
5–9 years	7%	13%	10%
10–14 years	7%	10%	8%
15–17 years	6%	6%	6%
18–19 years	5%	4%	4%
20–24 years	12%	8%	10%
25–29 years	10%	5%	8%
30–34 years	10%	6%	8%
35–39 years	10%	7%	9%
40–44 years	8%	7%	8%
45–49 years	6%	7%	7%
50–54 years	4%	6%	5%
55–59 years	3%	4%	3%
60–64 years	2%	2%	2%
65+ years	2%	3%	2%

Source: Australian Institute of Health and Welfare, Specialist Homelessness Services Collection, December 2021.

In December 2021, Specialist Homelessness Services Collection had a total of 13,367 Queensland-based clients. Of those, 37% identified as Aboriginal and/or Torres Strait Islanders, and 27% have experienced family and domestic violence. Table 3 shows Queensland clients disaggregated by sex.

Table 3. Specialist Homelessness Services, Queensland, December 2021

Sex	Client Group	Number	% of all presentations
Female	Indigenous Clients	2,996	22%
Female	Clients who have experienced family and domestic violence	2,701	20%
Female	Clients with a current mental health issue	2,082	16%
Female	Clients with problematic drug or alcohol issues	403	3%
Female	Clients who are homeless	3,986	30%
Female	Clients who are at risk of homelessness	3,758	28%
Male	Indigenous Clients	1,956	15%
Male	Clients who have experienced family and domestic violence	962	7%
Male	Clients with a current mental health issue	1,162	9%
Male	Clients with problematic drug or alcohol issues	401	3%
Male	Clients who are homeless	3,091	23%
Male	Clients who are at risk of homelessness	2,280	17%
Total	Indigenous Clients	4,952	37%
Total	Clients who have experienced family and domestic violence	3,663	27%
Total	Clients with a current mental health issue	3,244	24%
Total	Clients with problematic drug or alcohol issues	804	6%
Total	Clients who are homeless	7,077	53%
Total	Clients who are at risk of homelessness	6,038	45%

Source: Australian Institute of Health and Welfare, Specialist Homelessness Services Collection, December 2021

Of the 13,367 clients, 60% identified that accommodation was the reason they were seeking assistance from the Specialist Homelessness Services. Among health issues for seeking services from QLD clients:

- 21% (n=2,762) stated health
- 14% (n=1,849) stated mental health issues
- 9% (n=1,204) stated medical issues
- 3% (n=454) stated problematic drug or substance use
- 2% (n=275) problematic alcohol use

People from culturally and linguistically diverse (CALD) backgrounds

The prevalence of mental health and wellbeing issues among people born in Australia is higher (19.5% for males and 24% for females) than in people born overseas (17.7% for males and 19.9% for females)[6]. While the reasons are not clear it may relate to the fact that people who successfully migrate to Australia are

[6] ABS. 2007. National Survey of Mental Health and Wellbeing: Summary of Results 2007

required to complete rigorous health checks and testing which means they are more likely to be physically healthier than the remainder of the population. This may also be true for mental health issues.

For immigrants from some countries, especially refugees, migration can be a source of trauma and refugees have been found to have high rates of mental health issues[7]. Rates of post-traumatic stress disorder, depression and anxiety were 3-4 times higher among Tamil asylum seekers than other immigrants[8] . Iraqi and sub-Saharan African refugees in Australia were found to have lower levels of mental health literacy compared with the general Australian population, indicating that targeted mental health promotion would benefit these refugee populations.

Gold Coast is an identified area of settlement by the Department of Home Affairs for humanitarian entrants and it has migrants and international students residing in the area who may require additional support. Additional support is required to address the language and cultural barriers experienced by these population to enable greater participation in patient centered care.

Migrants often have disadvantages on several social and cultural determinants of health and mental health. Including language barriers, lower socio-economic status, lower education and lower levels of mental health literacy which are factors that relate to an increased risk of mental illness.

Australia's Refugee and Humanitarian Program helps people in humanitarian need who are:

- Outside Australia (offshore) and need to resettle to Australia when they do not have any other durable solution available.
- Already in Australia (onshore) and who want to seek protection after arriving in Australia.

From 2000 to August 2016, Australia has allocated 199,009 applications to the refugee and humanitarian program of which 0.5% were located to Gold Coast[9].

Most permanent residents entering Gold Coast under the offshore humanitarian program are residing in Gold Coast-North and Southport (see Table 4), which are the two lowest socioeconomic status regions on the Gold Coast. It is well established that low socioeconomic households have higher number of people with mental and behavioural problems, higher rates of overnight hospitalisations for mental healthcare and intentional self-harm hospitalisations [10,11].

Only a small proportion of refugees are settled within the GCPHN region. In terms of overall migration (inclusive of humanitarian, family and skilled migration) – Gold Coast is the second largest local government area in Queensland where migrants are settling[12].

[7] Shawyer F, Enticott JC, Block AA, Cheng I-H & Meadows GN. The mental health status of refugees and asylum seekers attending a refugee health clinic including comparisons with a matched sample of Australian-born residents. BMC Psychiatry 17:76

[8] Minas H, Kakuma R, Too LS, Vayani H, Orapeleng S, Prasad-Ildes R, Turner G, Procter N & Oehm D 2013. Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. International Journal of Mental Health Systems 20137:23.

[9] Compiled by PHIDU based on the ABS Census of Population and Housing, August 2016

[10] PHIDU, Social Health Atlas, http://phidu.torrens.edu.au/social-health-atlases/data

[11] AIHW (2019-2020), National Hospital Morbidity Database Intentional Self-harm hospitalisations

[12] ABS, Census of Population and Housing, 2016, General Community Profile - G41

Table 4. Permanent migrants entering Gold Coast under the Offshore Humanitarian Program, August 2016

	Number	Percent
Gold Coast (SA4)	993	
Broadbeach-Burleigh	6	0.6%
Coolangatta	0	0.0%
Gold Coast-North	414	41.7%
Gold Coast Hinterland	5	0.5%
Mudgeeraba-Tallebudgera	0	0.0%
Nerang	44	4.4%
Ormeau-Oxenford	114	11.5%
Robina	46	4.6%
Southport	301	30.3%
Surfers Paradise	63	6.3%

Source: Compiled by PHIDU based on the ABS Census of Population and Housing, August 2016

In 2016, 28% of the Gold Coast population were born overseas, with 12% of those migrating from a non-English speaking country. On the Gold Coast, 12% speak a language at home other than English. Within the Gold Coast, Southport, Surfers Paradise, Gold Coast north, and Robina have the greatest number of people who do not speak English well or at all. The most common non-English languages spoken at home for the Gold Coast were Chinese (2.3%), Japanese (1%) and Indo Aryan languages (0.9%).

Language barriers may hinder an individual's access to health services. It can also have an impact on employment, which has broader socioeconomic implications. Gold Coast Health data indicates an increase in the number of requests for interpreter services across the health service from 2016 to 2017 with interpreter bookings for mental health almost doubling[13].

Working with a qualified interpreter is essential to ensure all patients can access healthcare regardless of their English language skills. Engaging an interpreter helps the health professional to communicate effectively with the non-English speaking patient, protect from professional risk and is consistent with best practice ethical and professional standards.

Analysing data from Gold Coast Health from November 2020 to April 2021 on specifics around what languages / cultural groups are presenting to Gold Coast health facilities, the top ten languages requested included:

- Mandarin
- Auslan/ASL
- Korean
- Japanese
- Cantonese
- Spanish
- Vietnamese
- Thai
- Serbian
- Hindi

[13] Internal Gold Coast Health Data

The below departments at Gold Coast health facilities are using interpreters regularly:

- OPS Surgical, Anaesthetics and Procedural Services
    - general surgery
    - preadmissions/Perioperative
    - oral health
- OPS Women's, Newborn & Children's Services
    - gynaecology
    - antenatal
- OPS Diagnostic and Subspecialty Services
    - oncology
- OPS Allied Health
    - physiotherapy

Specific challenges identified to impact CALD communities on the Gold Coast include availability, access of on-site Auslan and ASL interpreters.

The Translating and Interpreting service (TIS) is an interpreting service provided by the Department of Home Affairs for people who do not speak English and for agencies and business that need to communicate with their non-English speaking clients. The interpreting service aims to provide equitable access to key services for people with limited or no English language proficiency.

Medical Practitioners (defined as general practitioners, nurse practitioners and approved medical specialist) are eligible for the free interpreting service and access to the medical practitioner line when providing services that are:

- Medicare-rebatable,
- delivered in private practice,
- provided to non-English speakers who are eligible for Medicare.

Pharmacies dispense medications that can be dangerous if taken incorrectly and information about medications can be complex. It is essential that people can communicate effectively with staff in pharmacies about the medications they are taking, how to take them correctly and any risk or side effects that may be associated. Using interpreters can also protect pharmacists from professional risk.

2019-20 data from TIS shows there was a total of 1,007 translation services completed by GPs, specialist, pharmacy, and nurse practitioners on the Gold Coast. Of those, 85% (n=858) were completed by phone while 15% (149) were completed on site.

GPs had the largest usage by phone with 86% (n=742), followed by specialists with 12% (n=104). For onsite services, specialist had the largest usage (54%, n=80), followed by general practitioners with 46 % (n=69).

Data from the 2021 census identified that there were 10,361 people living on the Gold Coast who did not speak English at home well or not at all[14]. Of the 1,007 TIS translation services that were delivered on the Gold Coast in 2019/20, 10.8% of people who did not speak English at home well or not at all received translation services offered by TIS (note, one patient may use TIS services multiple times).

[14] ABS, Census of Population and Housing, 2016, General Community Profile - G13

Particular GCPHN regions had high usage of TIS translation services including postcodes 4215 and 4207 while some regions on the Gold Coast with a high number of people who did not speak English at home well or not at all had low uptake of TIS services including postcode 4217 and 4226. Mandarin was the most common language that a service was booked for followed by Tigrinya.

LGBTIQAP+ community

Research has demonstrated that a disproportionate number LGBTIQAP+ people experience poorer mental health outcomes and have higher risk of suicidal behaviours than their peers. These health outcomes are directly related to experiences of stigma, prejudice, discrimination and abuse on the basis of being LGBTIQAP+.

While Australian and international research provide evidence that raises significant concern about mental health outcomes and suicidal behaviours among these groups, it is vital to note that significant knowledge gaps remain. This is due to lack of inclusion of sexual orientation, gender identity and intersex status in population research and data collection by mental health and mainstream services. As data informs evidence-based policy, this exclusion has led to inaccuracy in reporting and significant underestimates that has left this group relatively invisible in mental health and suicide prevention policies, strategies and targeted programs.

Consequently, Australian evidence on the health and wellbeing of the LGBTIQAP+ population nationally relies on a growing but limited number of smaller studies that target the LGBTIQAP+ populations, or part thereof. While uniquely valuable, these can have methodological issues relating to representative data collection and limited ability to provide a comprehensive data analysis that is therefore unable to represent a holistic picture of LGBTIQAP+ people.

When considering data provided in this document it is important to note that this is not a comprehensive literature review, and we urge the reader to consider this broader context where adequately estimating the mental health outcomes and suicidal behaviours for the LGBTIQAP+ populations remain highly challenging.

According to the 2016 Census, there are approximately 47,000 same-sex couples in Australia, an increase of 42% since 2011. This may be an underrepresentation as it is known that people identifying as lesbian, gay, bisexual, transgender, intersex, or queer (LGBTIQAP+) may hide their sexuality or gender due to discrimination, harassment or hostility[15].

LGBTIQAP+ Australians are far more likely to be psychologically distressed than non-LGBTIQAP+ Australians. One study of 3,835 LGBTIQAP+ Australians found that they scored noticeably higher than the national average on the K10 scale, with a score of 19.6 versus 14.5[16]. The K10 is a widely recommended as a simple measure of psychological distress and as a measure of outcomes following treatment for common mental health disorders.

19.2% homosexual/bisexual Australians aged 16 to 85 have experienced an affective disorder in the last 12 months. This is more than triple the rate of adult heterosexual Australians (6%)[17]. Among homosexual/bisexual Australians aged 16 to 85, 31.5% have experienced an anxiety disorder in the last 12 months, which was more than double the rate of heterosexual Australians (14.1%)[17].

There is a lack of publicly available and comprehensive data examining the use of alcohol and other drugs by people identifying as LGBTIQAP+. The AIHW's National Drug Strategy Household Survey (NDSHS) is the only

[15] Australian Human Rights Commission 2014. Face the facts: lesbian, gay, bisexual, trans and intersex people. Sydney: AHRC

[16] Private Lives 2, The second national survey of the health and wellbeing of GLBT Australians 2012 p VII

[17] ABS National Survey of Mental Health and Wellbeing: Summary of Results 2007 p 32

national data source that specifically disaggregates by sexual identity and provides comprehensive estimates. However, the NDSHS does not include estimates for people identifying as transgender, intersex or queer.

Since 2010, the NDSHS has consistently shown high rates of substance use among people who identify as gay, lesbian, or bisexual relative to the heterosexual Australian population. After adjusting for differences in age, people who were homosexual or bisexual were still far more likely than others to smoke daily, consume alcohol in risky quantities, use illicit drugs and misuse pharmaceuticals[18]. Suicide and self-harm have a disproportionate impact among the LGBTIQAP+ community and are covered in further detail in the 'Suicide Prevention Summary'.

Feedback through consultation has indicated that there are many LGBTIQAP+ people on the Gold Coast living in isolation. Young gender-diverse and gender-questioning individuals have little support and it's hard for their parents and themselves to find support services of any kind.

Women experiencing perinatal depression

The perinatal period is a highly volatile time and addressing the complex needs of the mother and baby both as individuals and as a dyad is essential to ensure the best possible outcomes. Recognising symptoms early and seeking help minimises the risk of potentially devastating outcomes for new parents and their baby:

- 1 in 5 women will experience postnatal depression[19]
- 1 in 5 women will experience postnatal anxiety[20]
- 1 in 5 women will experience both postnatal anxiety and depression[21]
- 1 in 10 fathers experience postnatal depression[22]

Most mothers suffering from perinatal depression seek treatment from their GP and support from family and friends. Perinatal depression was more commonly reported among mothers who[23]:

- were younger (aged under 25)
- were smokers
- came from lower income households
- spoke English at home
- were overweight or obese
- had an emergency caesarean section

Veterans

While information specific to the GCPHN region is not available, a population group that may be at higher risk of suicide in the GCPHN region is ex-serving men aged under 30 years. This group was identified as an underserviced group through consultation with GCPHN Clinical Council.

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[18] Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW

[19] Bryson, H., Perlen, S., Price, A., Mensah, F., Gold, L., Dakin, P., & Goldfeld, S. (2021). Patterns of maternal depression, anxiety, and stress symptoms from pregnancy to 5 years postpartum in an Australian cohort experiencing adversity. Archives of Women's Mental Health, 24(6)

[20] Leach, L. S., Poyser, C., & Fairweather-Schmidt, K. (2017). Maternal perinatal anxiety: A review of prevalence and correlates. Clinical Psychologist, 21(1), 4-19.

[21] Falah-Hassani, K., Shiri, R., & Dennis, C. L. (2017). The prevalence of antenatal and postnatal co-morbid anxiety and depression: a meta-analysis. Psychological Medicine, 47(12)

[22] Paulson JF, Bazemore SD. (2010), Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. Jama. May 19;303(19):1961-9.

[23] Australian Institute of Health and Welfare 2012, Perinatal depression: data from the 2010 Australian National Infant Feeding Survey, AIHW, Canberra

- Ex-serving males who discharged from service on medical grounds have higher rates of suicide than Australian males.
- From 2002-2019, the age-specific rate of suicide (per 100,000 population) in ex-serving men aged under 30 years was higher than an age-matched non-serving population[24].
- Ex-serving men aged under 30 had a suicide rate 2.2-times that of Australian men the same age[25].
- From 2002-2019, for reserve, and ex-serving ADF males, and males in the Australian population aged 16–29, the leading cause of death was suicide[25].

Youth justice

Young people involved in the justice system are a vulnerable group, with significant and complex health needs. Compounding this is the over-representation of other already vulnerable groups, such as Indigenous Australians, within this population[i]. This group was identified as an underserviced group through consultation with GCPHN Clinical Council.

- Mental illness often appears for the first-time during adolescence and those involved in the youth justice system are a population at increased risk for developing serious and chronic mental illness[26].
- Risk factors for the development of mental health problems among young offenders include parental incarceration or death; a history of abuse or neglect; being in out-of-home care; social isolation; and living with someone with physical National data on the health of justice-involved young people: A feasibility study 5 or mental disabilities[27].
- The rate of Youth Justice clients who have clinical mental health needs:
    - In the 2019 state-wide census for Youth Justice over 40% of youth justice clients were identified as having a diagnosed or suspected mental health disorder.
    - Anecdotally for Gold Coast Youth Justice, most of the clients have experienced significant trauma in their childhood and would benefit from mental health treatment. The poor mental health presentations are vast, including suicidal ideation/self-harm, depression, anxiety, symptoms of psychosis (auditory and visual hallucinations), problematic substance misuse, emerging personality traits, ADD, ADHD, cognitive impairments, and mood disorders (emerging bi-polar, major depressive disorder).
- What services/providers they access for mental health support:
    - Key services Youth Justice refer to include Child and Youth Mental Health Service, Forensic CYMHS, Headspace, Bond University Psychology clinic (when appropriate) and a range of private psychologists.
- Access issues they encounter:
    - Young people often have wavering motivation to participate in mental health treatment. Young people can find their case closed after one or two missed appointments and then make the decision to not attempt to attend any further appointments. Given the time for rapport to develop, a service that proactively seeks out the young people may have improved retention of clients (like the AMIYOS model).

[24] Australian Institute of Health and Welfare, Health of Veterans – web report, 2022, Supplementary data tables, Table S9, extracted from, https://www.aihw.gov.au/

[25] AIHW, National suicide monitoring of serving and ex-serving Australian Defence Force personnel: 2018 update

[26] Casswell M, French P & Rogers A 2012. Distress, defiance or adaptation? A review paper of at-risk mental health states in young offenders. Early Intervention in Psychiatry 6(3):219–28.

[27] Kenny DT 2014. Mental health concerns and behavioural problems in young offenders in the criminal justice system. Judicial Officers' Bulletin 26(4):29–32.

- Being assessed as too acute for the services available, or the nature of their offences meaning the service assesses the young person as unsuitable for their service.
- Transport – getting to the appointments at a specific place/time can be a challenge for this disadvantaged cohort – often not having parental support, financial considerations, their age and at times rural address have significant impacts for young peoples' capacity to attend appointments (particularly, on time attendance to appointments).
- Meeting too many people – young people have given consistent feedback that they do not wish to "tell their story" To multiple people however some service models require an appointment with GP and/or an intake person prior to meeting the treating mental health practitioner – leading to disengagement.

Older adults (aged 65 years and over)

While limited data exist at a local level for the mental health of older adults, it is very likely that subgroups of older adults may be at an increased risk of poor mental health.

- While the prevalence of mental health concerns tends to decline in older age, within this age group, there are sub-groups that are at a higher risk of mental health concerns. These include adults in hospital, supported accommodation, people living with dementia, and older carers[28].
- Many people aged over 65 feel there is stigma attached to anxiety and depression viewing them as weaknesses or character flaws and not as health condition[28].
- High levels of isolation and loneliness on the Gold Coast among older people in the GCPHN region.
- Older adults in RACFs are at increased risk of loneliness and social isolation with the COVID-19 pandemic due to visitor restrictions and lack of access to appropriate technology required to keep connection[29].
- Mental health and aged care related issues (e.g., dementia) are often treated in isolation of each other or as separate disciplines.

Children with autism

Limited data exist at a local level for the mental health of children with autism, reports highlight that it is very likely that children with autism experience mental health conditions. This group was identified as an underserviced group through consultation with GCPHN Clinical Council.

- Current evidence reports that around 50–70% of people with autism also experience mental health conditions[30].
- Autistic children and teenagers can experience anxiety more intensely and more often than other children.

Children in care

Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex needs. This group was identified as an underserviced group through consultation with GCPHN Clinical Council.

[28] Beyond Blue Older People
[29] Inquiry into social isolation and loneliness in Queensland 2021
[30] Amaze, Autism and mental health

- Children in care do not have a dedicated healthcare coordinator and their health needs are not being met at the right time and with the right practitioner. This contributes to care arrangement failure, further traumatisation, service fatigue & disengagement,
- Children in care (children subject to Child Safety orders) are likely to have poorer mental health as well as physical and developmental health, than their peers, with only 3% of young people in care without health problems:
    - more than half (54%) have emotional or behavioral problems
    - 14% have abnormal growth
    - 45% aged 10-17 years have moderate or high health risks associated with substance use
    - 24% have incomplete vaccinations.
    - up to 63% have an eating disorder or obesity
    - 20% have abnormal vision screening
    - 28% have an abnormal hearing test
    - 30% have dental problems

People with a dual diagnosis

Dual diagnosis is a term used to describe when a person is experiencing both mental health problems and drug and alcohol misuse. It is also commonly referred to as co-morbidity and co-occurring mental-health and substance use. Approximately 50% of people experiencing a mental illness also have a substance use problem and vice versa[31].

Mental health problems and drug use both have a significant impact on people's lives and the lives of those around them. When they exist together, other issues may develop such as[31,32]:

- a person with a mental illness using alcohol or other drugs to help cope with the symptoms of their illness,
- difficulties with diagnosis and establishing whether the issues the person is experiencing are due mainly to the drugs, the mental illness, or a combination of both,
- difficulties engaging a person into treatment and completing the treatment,
- the relapse of one condition may increase the risk of relapse in the other condition,
- there may be a risk of one problem increasing the risk of the other, or an existing disorder becoming more problematic with the other present,
- interactions between prescribed medication and alcohol or other drugs can result in unwanted side-effects and can increase the risk of overdose,
- people with a dual diagnosis experience higher rates of homelessness and social isolation, infections and physical health problems, suicidal behaviour, violence, antisocial behaviour, and incarceration,
- people with a dual diagnosis was often discussed as an underserviced group through consultation in developing the Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services in the GCPHN region.

[31] Australian Drug Foundation (2021). What is Dual Diagnosis (internal document) Melbourne: ADF
[32] VicHealth (2017). Dual diagnosis. Melbourne: Victoria State Government

Complex families

The term 'complex needs' refers to families who experience numerous, chronic and interrelated problems[33]. Limited data exist at a local level for complex families. This group was identified as an underserviced group through consultation with GCPHN Clinical Council.

- Families with complex needs frequently experience problems that span social, economic and health domains (mental health difficulties, physical health problems, disability, substance abuse, domestic and family violence, social exclusion, poverty, unemployment, and homelessness)[34].
- Families can face many challenges in accessing services, including lack of knowledge of the services available to them, inadequate transport to attend services, feelings of intimidation due to inexperience with services, and a history of negative experiences with services[35].

People with an eating disorder

People experiencing eating disorders may experience mental health concerns more frequently (and to a greater severity).

- In 2015-16, 95% of Australian hospitalisations with a principal diagnosis of an eating disorder were for females. Females aged 15-24 made up the largest proportion of these hospitalisations (57%)[36].
- Estimated prevalence of eating disorders in the Gold Coast PHN is consistent with the national prevalence.

Men linked to family court

Separation and divorce are among life's most traumatic experiences, for adults there are increased rates of depression, substance abuse, suicidal behaviour, and anxiety.

- People accessing the Family Law Courts often experience stress, despair, anxiety, depression, and other forms of mental illness, along with anger and frustration, and frequently a sense of powerlessness.

Victims of family and/or domestic violence

Domestic and family violence is associated with a variety of poor health outcomes, both immediate and long-term. Rate of Breach of Domestic Violence Protection Orders in the Gold Coast Police District notably increased between 2015 to 2019. High rates of domestic violence (private and by police) in Southport and Surfers Paradise SA3 region which may indicate a higher prevalence of domestic and family violence in these locations.

- Breach of Domestic Violence orders number increased by 75% from 2015 (n=1,528) to 2019 (n=2,676)[37].
- In 2019, the rate for domestic violence applications made by police in Surfers Paradise above the Queensland rate (541 vs 402 per 100,000 people)[37].

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[33] Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L.,.Wegner, L. M. (2012). The lifelong effects of early childhood adversity and toxic stress. Paediatrics, 129(1), e232-e246

[34] Bromfield, L., Sutherland, K., & Parker, R. (2012). Families with multiple and complex needs: Best interests case practice model. Retrieved from Melbourne: Victorian Government Department of Human Resources in collaboration with the Australian Institute of Family Studies.

[35] McDonald, M. (2010). Are disadvantaged families "hard to reach"? Engaging disadvantaged families in child and family services (CAFCA Practice Sheet). Melbourne: Australian Institute of Family Studies

[36] Australian Institute of Health and Welfare 2018. Australia's health 2018

[37] Queensland Police Service

- Ormeau-Oxenford region had the highest number of domestic violence charges in 2019.
- GCPHN region had a higher rate of strangulations in a domestic setting than the Queensland average. Queensland rate of strangulation in a domestic setting decreased 5.7% from 2018 to 2019, while Gold Coast SA4 increased 16.9% in the same period.
- Domestic and family violence was a common priority area identified by Clinical Council, Community Advisory Council and GCPHN Board.

MBS changes and workforce issues

The Better Access initiative aims to improve treatment and management for people who have mild to moderate mental health conditions through Medicare rebates for people accessing care. General practitioners are encouraged to work more closely and collaboratively with psychiatrist, clinical psychologists, registered psychologists, occupational therapists, and appropriately trained social workers to support patients.

The three tables below highlight the increase in Medicare-subsidised mental health-specific services from 2015-2016 to 2019-20 on the Gold Coast. This increase in general practitioner, clinical psychologists, and other allied health providers Medicare-subsidised mental health-specific services is above the Gold Coast population growth rate and employment rate for clinical psychologists and medical practitioners.

- During the same period, the Gold Coast population increased by 10.3% (575,629 in 2015 to 635,191 in 2020)[38].
- Number of medical practitioners employed on the Gold Coast increased by 23.3% (2,070 in 2015 to 2,552 in 2020).
- Number on clinical psychologists employed on the Gold Coast increased by 23.2% (514 in 2015 to 633 in 2020)[39].

[38] Queensland Government Population Projections, 2018 edition (medium series)

[39] Sources: Department of Health 2020; ABS 2018

Table 5. Number of Medicare-subsidised mental health-specific services on the Gold Coast from 2015-16 to 2019-20

Provider type	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Psychiatrists	82,241	84,033	84,162	85,276	87,138	6.0%
General practitioners	93,462	102,199	110,186	120,163	122,516	31.1%
Clinical psychologists	65,549	69,438	75,266	80,405	85,333	30.2%
Other psychologists	95,942	92,091	100,336	105,059	106,073	10.6%
Other allied health providers	5,790	7,422	7,675	7,484	8,501	46.8%
All providers	342,984	355,183	377,625	398,387	409,561	19.4%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

The number of general practitioner Medicare-subsidised mental health-specific services (Mental Health Treatment items, review of a GP Mental Health Treatment Plan, and GP Mental Health Treatment Consultation) have increased by 31.1% from 2015-16 to 2019-20 on the Gold Coast. Table 6 shows that Robina had the largest increase with 42.6%, while Ormeau-Oxenford had the greatest number of GP mental health-specific services with 28,221 in 2019-20.

Table 6. Number of General Practitioner Medicare-subsidised mental health health-specific services, Gold Coast SA3 regions, 2015-16 to 2019-20

	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Broadbeach - Burleigh	10,026	10,828	11,489	12,686	13,232	32.0%
Coolangatta	9,829	10,403	11,229	11,530	11,424	16.2%
Gold Coast - North	11,562	12,276	13,082	14,102	14,559	25.9%
Gold Coast Hinterland	3,449	3,538	3,874	4,349	4,302	24.7%
Mudgeeraba - Tallebudgera	4,998	5,388	5,967	6,643	6,869	37.4%
Nerang	10,008	11,350	11,676	12,700	13,028	30.2%
Ormeau - Oxenford	20,416	23,149	25,135	27,788	28,221	38.2%
Robina	7,220	8,243	8,865	9,991	10,295	42.6%
Southport	10,248	11,031	12,350	13,173	13,154	28.4%
Surfers Paradise	5,726	6,012	6,544	7,227	7,457	30.2%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

The number of clinical psychologists Medicare-subsidised services have increased 30.2% from 2015-16 to 2019-20 on the Gold Coast. Table 7 shows that Broadbeach-Burleigh had the largest percentage increase with 47% (7,830 in 2015-16 to 11,508 in 2019-20). Ormeau-Oxenford had the greatest number of clinical psychologists' services with 15,872 in 2019-20.

Table 7. Number of Clinical Psychologists Medicare-subsidised services, Gold Coast SA3 regions, 2015-16 to 2019-20

	2015–16	2016–17	2017–18	2018–19	2019–20	Change from 2015-16 to 2019-20
Broadbeach-Burleigh	7,830	8,987	9,832	10,616	11,508	47.0%
Coolangatta	7,836	7,943	8,318	8,982	9,422	20.2%
Gold Coast-North	7,346	7,678	8,286	8,390	9,061	23.3%
Gold Coast Hinterland	2,114	2,287	2,393	2,442	2,438	15.4%
Mudgeeraba-Tallebudgera	3,892	4,066	4,481	5,009	5,386	38.4%
Nerang	7,975	8,109	7,841	8,990	9,342	17.1%
Ormeau-Oxenford	11,652	12,222	14,912	14,922	15,872	36.2%
Robina	5,956	5,971	6,495	7,452	8,011	34.5%
Southport	7,038	7,664	8,379	8,445	8,780	24.8%
Surfers Paradise	3,926	4,525	4,349	5,177	5,531	40.9%

Source: AIHW analysis of MBS data maintained by the Australian Government Department of Health.

COVID-19

As part of the Australian Government's COVID-19 response, changes were made to the Better Access initiative including:

- an increase from 10 to 20 in Medicare subsided individual psychological services per calendar year
- expanded eligibility to include residents of aged care facilities
- expanded access to telehealth

Early data suggest utilisation of MBS funded psychological services remained high during 2020-21 on the Gold Coast.

Local stakeholders report that the changes to Better Access have impacted on the workforce and consequently, timely access to services for people seeking mental health support. NGOs service providers report increased wait times for their services due to difficulty in recruiting staff as many private practitioners are choosing to work from home and see patients through Better Access. This is particularly an issue in the northern corridor of the Gold Coast as there is already a limited workforce and high demand in the area.

System Navigation

Consultation throughout the 2020 Gold Coast Joint Regional Plan between Gold Coast Health and Gold Coast Primary Health Network identified that there is a high demand for system navigation support and to support people to assess and determine suitable options. There are two elements to services navigation that have been identified:

1) Uncoordinated and inconsistent approach to assessment, referrals, and intake:

- Most services operate an assessment and intake component for their service meaning individuals and referrers often have to share their story at each transition point or when ascertaining eligibility. When people are not matched to the right service initially, they have to retake the intake process, which can be a system inefficiency and can contribute to a poor experience and poor outcomes. Additionally, the frustrating experience of trying to find the right fit can result in disengagement and opportunities for early intervention may be lost with people presenting to the system later in crisis.
- An inconsistent approach to assessment (e.g various tools) leads to inconsistent assigned levels of care, resulting in discrepancies in the type of care provided across providers and regions, for similar clinical presentations.

2) Limited awareness/understanding of service infrastructure, including availability and capability of services:
   - Referrals to services are often inappropriate, resulting in people being under or over serviced.
   - There are many pathways to mental health, AOD and suicide prevention and support services. Community members and service providers perceive that the local service system changes frequently due to funding changes, resulting in providers and people being unclear about available services and the pathways to access these services. There is a need for timely and accurate information and easily identifiable access points for individuals seeking care, so that they can be matched with the service which optimally meets their needs.

Service system

Priority groups	Services	Number in GCPHN region	Distribution	Capacity discussion
Children (Ages 0-12) particularly children in care	See summary for 'Mental Health, Youth including children'			
People who are or are at risk of Homelessness	Gold Coast Health Community Services - Specifically, for homeless persons or those at risk.	1 (Homeless Health Outreach Team).	Outreach, whole of GCPHN region.	There is one service on the Gold Coast that specifically provides mental health and AOD support to homeless people or those at risk of homelessness. While not specifically mental health or AOD services themselves, many homeless support services refer their clients to appropriate providers due to high need among this group.
	Community NGO services, (predominantly accommodation, crisis support and case management).	9 NGO providers who provide specific homeless services or refer into mental health services.	5 in Southport, 2 in Bilinga, 1 in Robina, 1 in Miami.	
Culturally and linguistically diverse (CALD) backgrounds	GCPHN funded Psychological Services Program (PSP)	Of the 20 PSP contracted organisations, 18 are contracted to provide services to culturally and linguistically diverse backgrounds	Providers are distributed across the GCPHN region	There is one program specifically providing mild to moderate support to CALD people, however eligibility is narrow.
	Pharmacies	13 of the 148 Queensland pharmacies registered with the National Translating and Interpreting Services (TIS) are on the Gold Coast	They are clustered in the central coastal region, the most Southern in mermaid, most northern in Hope Island and most western in Carrara/ Arundel.	
	GCPHN funded Community	1 NGO	Operates in the GCPHN region	

	Pathway Connector Program			
LGBTIQAP+	Community NGO LGBTI service - support group and information service for young people Ages 12-25.	1 service for youth providing support groups and Information.	Southport	There is one service in Southport providing support for LGBTIQ youth (12-25). Information and resources on health, specifically suicide prevention.
	Online health services and information targeted at LGBTI mental Health.	4 (Qlife, LGBTIQ Alliance, Queensland AIDS Council, Minus 18).	Online Services. Public knowledge of these services would drive uptake/ Demand.	
	GCPHN funded Psychosocial Services Program (PSP) LGTIQAP+	20 contracted organisations	Providers are distributed across the GCPHN region	

Consultation

Various consultation activity was undertaken across the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one-to-one interviews, industry presentations, working groups and co-design processes.

Service provider consultation

- Need to look at service options in northern corridor on the Gold Coast
    - Most services tend to end around Southport yet there is significant growth in Northern Corridor (Pimpama and Ormeau).
    - Since COVID, some practitioners in the Northern Corridor area are attending to mental health issues for 20-30% of daily practice.
    - Northern corridor community actively seeking after hours options, when crisis happens Southport is too far away, especially for young families. Many of these young families include migrants and FIFO workers, with additional challenges in accessing services.
- GC PHN's Clinical Council provided feedback during consultation session in May 2021 that there is significant strain on GPs in the Coomera, Ormeau and Oxenford area:
    - Number of consultations GPs are having with patients with mental health concerns has significantly increased over the past 2 years (particularly in the past 12 months).
    - GPs report that they deliver increased number of consultations due to significant lack of allied health service availability in the region.
    - GPs in this area also report very high levels of work stress due to patients' mental health needs escalating over time, and GPs "holding" a reasonable degree of patient risk whilst the patient/s are waiting to access a service.

COVID-19 Impacts

The Wesley Mission Queensland COVID-19 Recovery Service was established to provide responsive wellbeing support for people aged 16 years and over living in the GCPHN region whose wellbeing has been impacted by the ongoing effects of COVID-19. Below are some of the common presentations to the service:

- loneliness and social isolation
- suicidal ideation
- problems with secure housing
- financial barrier's such as loss of employment/struggles to secure adequate ongoing employment
- overall anxiety and depressive presentations – low mood and lack of motivation
- struggles with accessing services such as Centrelink and NDIS
- loss of routine
- grief and Loss
- difficulties in accessing appropriate higher mental health services in a timely manner due to long waitlists

In addition to the above, very early on in the rollout of this service it became apparent that schools needed support as children's anxiety levels had increased; anecdotally home-schooling had a massive impact on some students finding it difficult to re-engage in face-to-face learning. Parents were also struggling with how to deal with the impact of COVID-19 on the mental health and wellbeing of their children.

People who are or are at risk of homelessness

Service provider consultation

- Some community-based organisations provide a soft entry point to cater for the homeless and provide an initial point of contact through which to identify and deliver healthcare.
- Homelessness is on the rise and that it becomes more problematic in winter as the weather which drew people to the Gold Coast in the first instance turns colder.
- The homeless population do not present to mainstream services yet have physical health issues that require regular primary care.
- Domestic violence is often a significant reason behind homelessness and on the Gold Coast, women are more likely to have unstable accommodation due to this problem.
- Service providers identify that it takes considerable time and consistency of staff to develop trust and relationships with this group as many are suspicious of service providers due to past negative experiences.
- Once trust has been established, engagement with services to provide mental healthcare is more likely and effective.
- Flexibility on behalf of the service provider was also identified as critical, as keeping appointment times can be challenging for people who are homeless.

Service user consultation

- Consumer journey mapping indicated that for people with mental health conditions who were homeless, often contact with a trusted staff member was the thing that put them on a trajectory to recovery in addition to finding accommodation and taking the step of seeking treatment.

- As similarly identified by the service providers, engagement of this group into services often occurred when the service provider had an informal presence where the homeless population visits, such as the food vans and emergency accommodation.

People from culturally and linguistically diverse (CALD) backgrounds

Service provider consultation

- Consultation identified many services for people of CALD backgrounds are concentrated in Brisbane and only limited ones on the Gold Coast.
- Providers indicated providing psychological services to the CALD population was identified as important along with the need to ensure appropriately trained interpreters. Engagements of CALD clients with mental health problems is better if the interpreter has a mental health background or mental health training
- There are very real gaps in equity due to limited health provider support to find resources, referral pathways, communicate effectively people with a refugee / asylum seeker background.
- Staff unaware of who to ask for help.
- Interpreter/language services are still hindering service access across the sector.
- Long wait list for gender affirming support.
- Lack of parent support groups.
- Need for more social safe spaces (across weekends).
- More consultation with community/services on the gold coast to ascertain needs.

Service user consultation

- Service users identified that the lived experience of mental health issues of the CALD worker helps relationship building.
- The Community Briefing also revealed that where cross cultural relationships exist and not well accepted, having mental health needs further disenfranchises the individual from their community and the positive effect of a family and friendship network in their recovery.
- Additionally, sections of the CALD community can be affected by myths and falsehoods linked to mental health issues, resulting in stigma
- Concern about accessing culturally sensitive interpreters and a further concern about privacy may be compromised in smaller communities.
- Manty Asylum seekers have no Medicare card or have fluid access to Medicare
- People with no Medicare access will delay access to primary care because of the cost, they then present to emergency department
- Continued presentation of situations of a more complex nature, requiring a longer and more coordinated response. Care coordination for this setting would enhance opportunity to engage in a multidisciplinary way and over a longer period of time.

LGBTIQAP+ community

- Lack of local services that specifically focus on service delivery for this group across all ages.
- Mainstream services often do not have the specific skill set, confidence or knowledge to work with this group.

- Administration / intake processes can create a barrier or cause a traumatic experience hindering access e.g., male, or female options only on forms.
- Nursing staff are often “too scared to ask the questions” limiting appropriate referral and service options for clients.
- Access to web-based support required phone, phone credit and access to data/WIFI – this can be a barrier for some people, particularly young people. All support offered via phone/internet including groups – however access to suitable devices, data etc. may be a barrier for some participants as public WIFIs at cafes are now closed due to COVID.
- There are a range of issues that contribute to the health needs of LGBTIQAP+ young people and children in the Gold Coast:
    - health education,
    - specialist medical Care (access and costs),
    - lack of referral pathways,
    - cultural competencies within health and mental health services,
    - access/location/transport options to health facilities (also the risk and safety associated with this especially for the trans community),
    - access to support services for Families of LGBTIQAP+ young people/children, and
    - increase in ASD Diagnosis for those accessing low level support services (skill level and expertise is needed in this area along with other barriers associated with things like legal name & gender changes.

Service user consultation

- Service users state from a lived experience perspective that there are limited local services that meet their needs.
- Staff including reception, intake and administration at mainstream services do not always respond appropriately leading to reluctance to engage with services.
- Staff are embarrassed and lack knowledge of how to diffuse conflict and provide a service that the LGBTIQAP+ person requires at the point of patient registration.
- A consumer journey for this group was captured from a client who had experienced the full spectrum of experiences from service providers from poor to excellent. Useful interventions were when key people such as guidance counsellors and school nurses reached out to new LGBTIQAP+ students to provide support.

Women experiencing perinatal depression

Service provider and consumer consultation

- Consultation indicates the stigma of not being a good mother and limited outreach options prevents some from accessing support.
- Barriers exist for women to access mainstream mental health services in circumstances where they are caring for other children, are isolated due to no transport (for example in Upper Coomera) or are too unwell.

Primary and Community Care Community Advisory Group

Primary needs/gaps identified:

- Crisis accommodation, particularly for domestic violence,
- Domestic violence services to support people to access safety,
- Transport options for homeless. Many of the foodbanks etc require transport. An idea that was raised was transport concession cards for homeless people.
- Advocacy for the homeless particularly in regard to the Council. We are aware the Gold Coast council now has 2 Public Space liaison workers (for the whole Gold Coast). But it is identified that homeless people are being served notice to move on from an area, but then their belongings are confiscated when they're not looking (so to speak) and there doesn't seem to be a pathway to get their belonging back. We identified that this cohort need advocacy to prevent it getting to the point where all their worldly possessions are taken from them.
- Bulk billing psychiatrists,
- Bulk billing psychology, and
- Cardiometabolic monitoring - this is interesting because we are developing our cardiometabolic monitoring & deprescribing clinic.

Crisis support and suicide prevention

Local health needs and service issues

- Suicidal people often visit primary care providers in the weeks or days before suicide but often their suicide risk is not identified.
- Limited supports are available for people in distress who end up in Emergency Department by default or on a mental health trajectory.
- Carers are at the frontline of suicide prevention and many sit daily with this risk and responsibility but may not having any training or skills to equip them for this.
- When challenges occur during a crisis, it is often at the points of intersection between different sectors.
- Service providers do not always know what the best evidence-based treatments are for people experiencing suicidal thoughts and behaviours or how to access local services and supports.
- Organisations can be very risk averse due to a culture of blame. People in suicidal crisis can be passed back and forth between organisations without receiving the care they need.
- Many mental health clinicians do not have specific training in suicide prevention or know what the best evidence-based treatments are for people experiencing suicidal thoughts and behaviours.
- Many people in the community lack the confidence and skills to address people in suicidal distress or crisis.
- People with a lived experience of suicide have the potential, to inform, influence and enhance local suicide prevention solutions but may lack the confidence, skills and readiness to participate.
- Confidentiality and legal concerns along with lack of formal arrangements limit information sharing between providers.

Key findings

- Gold Coast Primary Health Network (GCPHN) suicide rate is consistent with the state rate, while greater than the national rate.
- The Gold Coast has one of the busiest Emergency Departments in Queensland, and a large percentage of these are people presenting with mental health issues.
- Males accounted for 65% of suspected deaths by suicide on the Gold Coast in 2017-2019, compared to 35% for females in the same period.
- Mental illness, including depression, and trauma are associated with a large portion of suicide attempts.
- Suicide prevention is the most common cause for referral by General Practitioners (GP) to the Psychological Services Program.
- National data indicates the lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others communities, Aboriginal and Torres Strait Islanders, and culturally and linguistically diverse community is particularly vulnerable.
- Services that support people struggling with relationship and family breakdowns, financial problems and bereavement are essential elements of the suicide prevention system.

- A mental health crisis is not synonymous with mental illness. A prolonged mental health crisis can however lead to a mental illness.

Prevalence, service usage and other data

Deaths by suicide

Suicide was the leading cause of death for young Queenslanders in 2020 with 126 deaths among people aged 15-24 years[1] . It was also the leading cause of death for people aged 25-34 years with 139 deaths and 35-44-year-olds with 149 deaths in Queensland.

In the 2020 calendar year, there were 759 suspected suicides of Queensland residents. This is just under 15 suspected suicides for every 100,000 people. The number of male suspected suicides increased by 28 from 570 in 2019 to 598 in 2020. Female suspected suicides decreased by 26, from 187 in 2019 to 161 in 2020. Strangulation or suffocation and poisoning were the most common methods of suicide in Queensland.

Suspected suicide rates of Queensland residents have decreased since 2017 with a 2.8% decrease from 2018 to 2019 in Queensland. Male suspected suicide rates in 2020 in increased from 22.9 to 24.0 per 100,000 males. For females the number decreased with 7.3 per 100,000 in 2019 to 6.6 per 100,000 in 2020. Suspected suicide numbers and rates for 2020 were highest in males aged 75 to 79 and females aged 30-34. These age cohorts differ from the age cohorts with the highest rates in 2019 of males 40-49 and females aged 45-49[2].

During the period 2017-2019, there were 278 suicides in the Gold Coast Primary Health Network catchment area, representing an age-standardised suicide rate of 14.5 per 100,000 people[2].

Table 1. Suspected suicides and suicide rates per 100,000 people, Primary Health Network, Queensland, 2017–19

PHN	Suspected Suicides	Age-standardised rate per 100,000
Northern Queensland	423	20.6
Western Queensland	35	20.0
Darling Downs and West Moreton	303	18.3
Central Queensland, Wide Bay, Sunshine Coast	424	16.8
Gold Coast	278	14.5
Brisbane North	407	13.1
Brisbane South	545	12.9

Source: Leske, S., Adam,G., Schrader, l., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. Brisbane, Australia.

The release of the 2015-2019 leading cause of death in Australia by Australian Institute of Health and Welfare indicated suicide was the 11th leading cause of death in this period with 15,743 deaths (12.7) per 100,000)

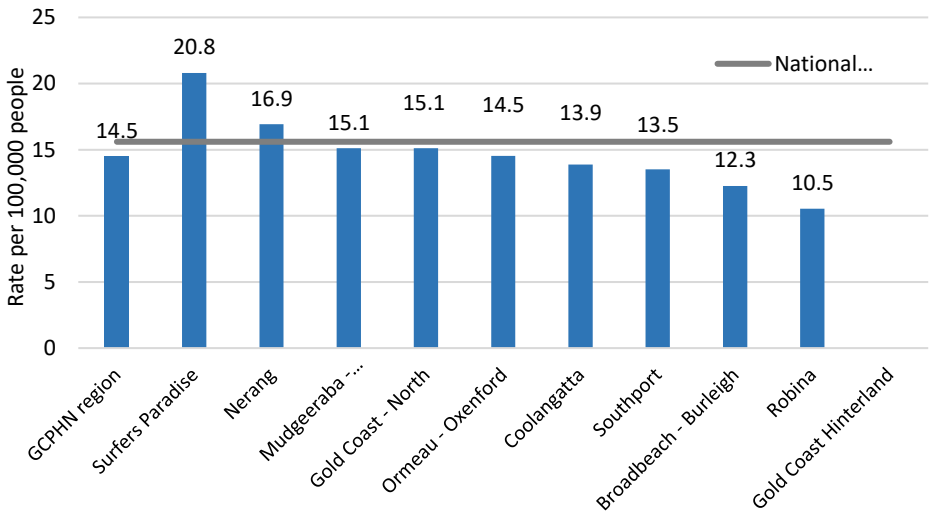
[1] Australian Bureau of Statistics, 3303.0-Cause of Death.

[2] s S Leske, I Schrader, G Adam, A Catakovic, B Weir and K Kõlves, Suicide in Queensland: annual report 2021

in Australia. Suicide was the 8th leading cause of death on the Gold Coast in the same reporting period with 447 deaths (14.5 per 100,000)[3].

As can be seen in Figure 1, the Gold Coast rate of deaths by suicide from 2015 to 2019 was above the national rate while Surfers Paradise had the largest rate of deaths by suicide with 19.2. Although the age-standardised rate of deaths by suicide identified that Ormeau-Oxenford had the second lowest rate the GCPHN region, the region did have the highest total number of deaths by suicide from 2014 to 2018 (Table 2).

Figure 1. Age-standardised rate per 100,000 people of deaths by suicide, Gold Coast SA3 regions, 2015-19



Source: Deaths in Australia/Grim MORT Books, Australian Institute of Health and Welfare, 2020

Table 2 shows the number of deaths by suicide across Gold Coast SA3 regions between 2015 and 2019, identifying the northern corridor of the Gold Coast as having the highest number of suspected suicides.

[3] AIHW (Australian Institute of Health and Welfare) 2021. MORT (Mortality Over Regions and Time) books: Primary Health Network (PHN), 2015–2019. Canberra: AIHW.

Table 2. Suicides in Gold Coast PHN including SA3 regions, 2015–19

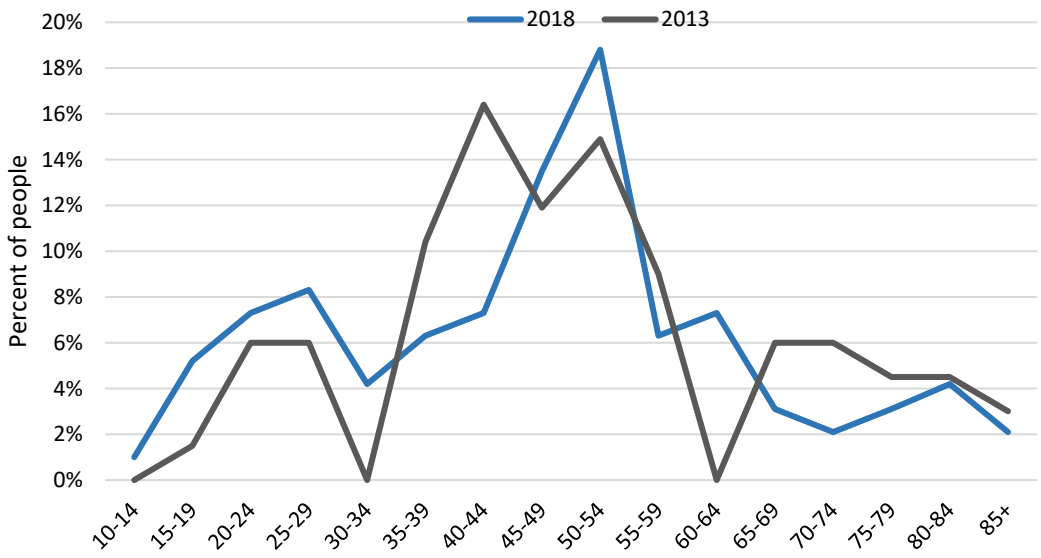
	Number of deaths
Gold Coast SA4	447
Ormeau - Oxenford	88
Nerang	61
Gold Coast - North	54
Surfers Paradise	51
Southport	45
Broadbeach - Burleigh	43
Coolangatta	39
Robina	27
Mudgeeraba - Tallebudgera	27
Gold Coast Hinterland	12

Source: AIHW (Australian Institute of Health and Welfare) 2021. MORT (Mortality Over Regions and Time) books: Statistical Area Level 3 (SA3), 2015–2019. Canberra: AIHW.

Suicide rates by age and gender

In 2018, the age group of 50-54 had the highest number people dying of suicide in the Gold Coast Hospital and Health Service compared to 2013, which the age group of 40-44 had the highest number of people dying by suicide as can be seen in Figure 2.

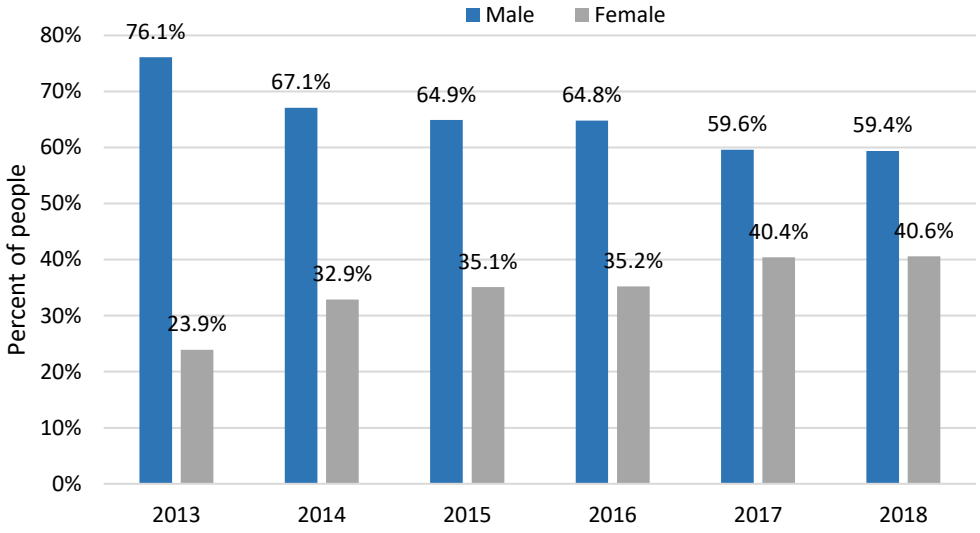
Figure 2. Deaths by suicide, by age groups, Gold Coast and Hospital and Health Service, 2013 and 2018



Source: Leske, S., Crompton, D., & Kõlves, K. (2019). Suicide in Queensland: Annual Report 2019. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith University

The male rate of deaths by suicide has been decreasing on the Gold Coast in recent years while the female rate has been increasing. Males accounted for 59.4% of deaths by suicide on the Gold Coast in 2018 compared to 76.1% in 2013. In 2018, the female rate of deaths by suicide was 40.6% which has increased from 23.9% in 2013.

Figure 3. Deaths by suicide, by sex, Gold Coast and Hospital and Health Service, 2013 to 2018



Source: Leske, S., Crompton, D., & Kõlves, K. (2019). Suicide in Queensland: Annual Report 2019. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith University

Aboriginal and Torres Strait Islander peoples

The suicide rate in Queensland Aboriginal and Torres Strait Islander peoples is twice that of the non-Indigenous population, and suicide occurs at a much younger age. Intentional self-harm is the fifth highest cause of death for Indigenous people, with males representing the vast majority (83%) of suicide deaths[4].

Of the 757 suicides reported in 2019 in Queensland. Aboriginal and Torres Strait Islander females living in Queensland accounted (11.9%) of all female suicides while males accounted for 8.3% of all male suicides[5]. The age group of 20-24 had the highest number of suspected suicides by Aboriginal and Torres Strait Islander Queenslanders.

True suicide mortality figures in Aboriginal and Torres Strait Islander populations remain poorly understood due to incomplete data collection processes and inaccurate classification systems (see Mental Health & Suicide Aboriginal & Torres Strait Islander needs assessment).

[4] Australian Bureau of Statistics (2018). Catalogue 3303.0—Causes of Death. Canberra. Australia

[5] Leske, S., Adam, G., Schrader, l., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith

Lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual, and other (LGBTIQAP+)

LGBTIQAP+ are far more likely to attempt suicide than heterosexual people. LGBTIQAP+ people are between 3.5 and 14-times more likely to try and die by suicide compared to heterosexual people[6] .

Of the 757 suicides reported in 2019 in Queensland, 36 (1.5% of all) suspected suicides by persons identifies as LGBTIQAP+[5]. Australian Bureau of Statistics data indicates a heightened risk of poor mental health that may lead to suicidal behaviour in LGBTIQAP+ communities[7] . This increased risk of poor mental health and suicidality among LGBTIQAP+ people are not attributable to sexuality, sex, or gender identity, but rather due to experiences of discrimination and exclusion[8].

One in six young LGBTIQAP+ people have attempted suicide and one third have harmed themselves. 16% of LGBTIQAP+ Australians aged between 16 and 27 have attempted suicide and 33% have self-harmed[9] . Looking at transgender young people, around 3 in every 4 transgender young people have experienced anxiety or depression, 4 out of 5 transgender young people have ever engaged in self-harm and almost 1 in 2 (48%) have attempted suicide[10].

Culturally and linguistically diverse (CALD) populations

Australia's CALD communities have diverse views of suicide and suicidal thinking, and vary in the way that their community, family, and friends respond to suicide. Multicultural differences, past trauma and experiences of discrimination are acknowledged and related to effective suicide prevention strategy. Limited data is available on this group although stigma around mental health and the topic of suicide, as well as language barriers and the difficulty of maintaining privacy and confidentiality can affect people in CALD communities.

Prevalence of life events

There are multiple factors recognised as contributing to suicidal behaviour or someone being at risk of suicide. These include personal hardship, difficult life events, poor physical and mental health such as depression and trauma, harmful substance use and previous self-harm or suicide attempts. It is important to understand these factors when considering suicide prevention.

Data from the Australian Institute for Suicide Research and Prevention identified the prevalence of life events among people who died by suicide (2013-2015). Relationship separation was the most frequently recorded life event (32.5%) among all ages and for both women and men. This was followed by financial problems (27.3%), recent or pending unemployment (19.5%).

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[6] Suicide Prevention Australia Position Statement, Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities 2009

[7] Skerrett, D., Kolves, K., De Leo, D (2015). Are LGBT Populations at a Higher Risk for Suicidal Behaviors in Australia? Research Findings and Implications. Journal of Homosexuality. Vol. 62. Issue 7.

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Table 3. Life events reportedly experienced by those dying by suicide in Gold Coast Hospital and Health Service, 2013 to 2015

Life event		2013	2014	2015
Relationship problems	Conflict	17.9%	14.1%	18.2%
	Separation	22.4%	29.4%	32.5%
Bereavement	Spouse	9.0%	3.5%	3.9%
	Family	6.0%	7.1%	5.2%
	Other	1.5%	1.2%	3.9%
	Multiple	1.5%	0.0%	0.0%
Conflict	Familial	6.0%	8.2%	10.4%
	Interpersonal	7.5%	3.5%	7.8%
Other	Pending legal matters	4.5%	8.2%	5.2%
	Financial problems	14.9%	20.0%	27.3%
	Recent/pending unemployment	9.0%	8.2%	19.5%
	Work/school problems	4.5%	7.1%	5.2%
	Child custody dispute	6.0%	4.7%	6.5%
	Childhood trauma	6.0%	0.0%	3.9%
	Sexual abuse	1.5%	0.0%	2.6%

Source: Leske, S., Crompton, D., & Kõlves, K. (2019). Suicide in Queensland: Annual Report 2019. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith University.

ED Presentations

EDs are frequent places for people in mental health crisis to present, with 69,585 presentations in 2019/20 by Gold Coast residents. Of these presentations, 59% the emergency service episode is completed and discharged, 19% are admitted, 16% are admitted to short stay unit, 4% transferred to another hospital, 2% left at own risk after treatment commenced and 1% did not wait.

In general people presenting with mental health issues wait longer to be seen initially in EDs than other consumers with a similar severity of physical illness and of concern, they were twice as likely as other ED presentations to leave before their treatment and care was complete. Crisis responses do not respond well to the needs of individuals and emergency mental healthcare is frequently compared unfavorably to emergency physical care, raising issues of lack of equality.

Presentations to Gold Coast University Hospital and Robina Hospital Emergency Department for suicidal ideation between June 2019 to July 2020 was slightly above 2,000 presentations. Of these, 49% were males and 51% were females. 7% of presentations were by people identifying as Aboriginal and or Torres Strait Islanders. People aged between 20 to 29 years old had the largest rate of presentation of people for suicidal ideation with 29%, followed by people aged 7 to 19 (23%).

Intentional self-harm

Intentional self-harm is often defined as deliberately injuring or hurting oneself, with or without the intention of dying. Intentional self-harm comes in many forms, and affects people from different backgrounds, ages and lifestyles. The reasons for self-harm are different for each person and are often complex. Most people who self-harm does not go on to end their lives- but previous self-harm is a strong risk factor for suicide. Therefore, monitoring of intentional self-harm is key to suicide prevention.

As can be seen in Table 4, the GCPHN region was below the Queensland rate per 100,000 people for all intentional self-harm for all age cohorts except males aged 0-24 and females aged 65 years and over in 2019-20.

Table 4. Number and rate of intentional self-harm hospitalisations, Gold Coast and Queensland, 2019-20

		Gold Coast	Queensland	Gold Coast	Queensland
		Number		Rate per 100,000 people	
Male	0-24	103	946	102.9	112.1
	25-44	134	1,328	158.9	194.5
	45-64	83	737	110.3	120.4
	65+	24	203	48.3	53.4
	All ages	344		3,214	
Female	0-24	219	2,467	305.3	293.6
	25-44	173	1,723	243.9	251.6
	45-64	119	1,018	158.7	167.4
	65+	38	214	51.0	48.8
	All ages	549		5,422	

Source: Data tables: 2019–20 National Hospital Morbidity Database—Intentional self-harm hospitalisations

Psychological Services Program

The Psychological Services Program (PSP) provides short term psychological interventions for financially disadvantaged people with non-crisis, non-chronic, moderate mental health conditions or for people who have attempted, or at risk of suicide or self-harm. This program targets seven underserviced and priority groups, including children, people at risk of homelessness and suicide prevention.

From the 1st of July 2021 to 30th June 2022 there were 1,056 referrals to the Adult Suicide Prevention Psychological Services Program (PSP) stream, leading to 4,909 sessions. Suicide prevention is by far the most common cause for referral by GPs and services users include a range of people in distress. Of those referred to the adult suicide prevention stream, 16% came from clients located in Coomera, Pimpama, and Upper Coomera followed by 15% from Labrador and Southport.

Table 5. Number of persons accessing Psychological Services Program on the Gold Coast, 2021-22

	Referrals	% of all referrals	Sessions	Sessions as % of referrals
Adult Suicide Prevention	1056	65.2%	4909	70.1%
Children	235	14.5%	849	12.1%
Aboriginal and Torres Strait Islander	111	6.9%	383	5.5%
Homeless	55	3.4%	197	2.8%
CALD	47	2.9%	248	3.5%
Perinatal	68	4.2%	215	3.1%
LGBTIQAP+	48	3.0%	197	2.8%
General (COVID19 Response)	0	0.0%	1	0.01%
Total	1,620		6,999	

Source: PIR-FIXUS

The Way Back Support Service

People who have attempted suicide or experienced a suicidal crisis often experience severe distress in the days and weeks immediately afterwards, and they are at high risk of attempting again within 12 months from being discharged. Beyond Blue developed The Way Back Service Support Service to support them through this critical risk period. The Way Back provides non-clinical, tailored support for up to three months following discharge from hospital after a suicide attempt.

The Gold Coast Way Back Service receives the largest number of referrals compared to other PHN regions. Between 1st July to 30th March 2021, 432 people accessed the service which exceeds the expected number of people accessing the service of 261 (166% of target).

Suicide Prevention Pathway

The Gold Coast Mental Health and Specialist Services Suicide Prevention Pathway assists patient's recovery from suicidal thoughts and behaviors. Between January and November 2019, there was a total of 1,681 placements on the Suicide Prevention Pathway (on average, 153 placements per month). This represented a total of 1,498 persons (average of 136 / month). Of these people, 84.2% were aged 18 years and over.

COVID-19 Impacts

There is much uncertainty around the medium- and long-term impacts of the COVID-19 pandemic on suicide mortality in Australia. Duration and intensity of restrictions, timeframe of economic recovering and the impact of state and federal government interventions to reduce the economic and social effects will all affect suicide mortality. As the Gold Coast is a region dependent on tourism this may have more of an impact on the Gold Coast compared to other regions depending on ongoing social distancing practices.

As previously mentioned, suicide is not influenced or caused by one factor but results from complex interaction between multiple risk factors, consequently it is difficult to understand the impact COVID-19 on suspected suicides. As can be seen in Table 6, the year-to-date comparisons for suicides from January to July in 2020 is comparable to 2019.

Table 6. Year to date comparisons for suicides from January to July, by sex, Queensland, 2015-2020

Year	Males	Females
2015	315	106
2016	290	92
2017	340	116
2018	341	89
2019	343	102
2020	352	102

Source: Leske, S., Adam, G., Schrader, l., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith University

The Wesley Mission Queensland COVID-19 Recovery Service was established to provide responsive wellbeing support for people aged 16 years and over living in the GCPHN region whose wellbeing has been impacted by the ongoing effects of COVID-19. Below are some of the common presentations to the service:

- loneliness and social isolation,
- suicidal ideation,
- problems with secure housing,
- financial barrier's such as loss of employment/struggles to secure adequate ongoing employment,
- overall anxiety and depressive presentations – low mood and lack of motivation,
- struggles with accessing services such as Centrelink and NDIS,
- loss of routine,
- grief and loss,
- difficulties in accessing appropriate services in a timely manner due to long waitlists.

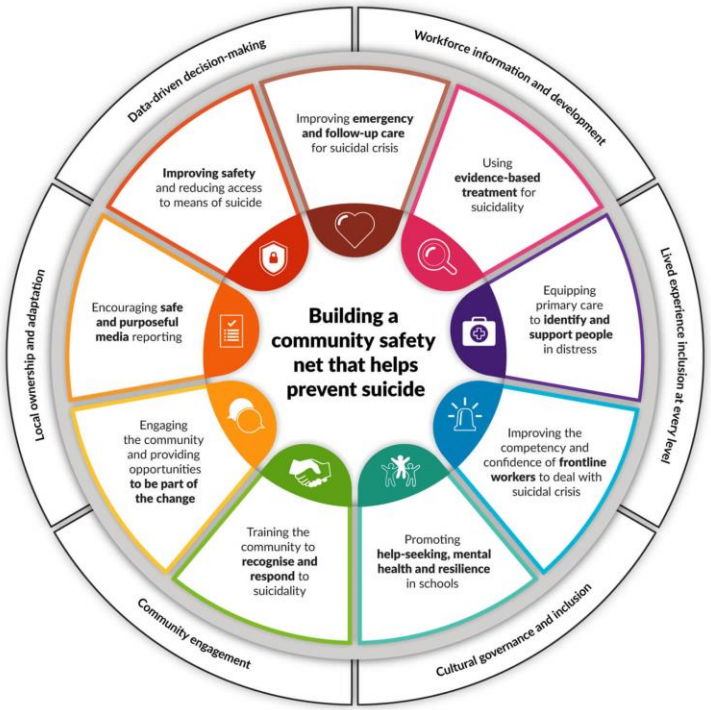
In addition to the above, very early on in the rollout of this service it became apparent that schools needed support as children's anxiety levels had increased; anecdotally home-schooling had a massive impact on some students finding it difficult to re-engage in face-to-face learning. Parents were also struggling with how to deal with the impact of COVID-19 on the mental health and wellbeing of their children.

Community approach to suicide prevention

Reducing the rate and impact of suicide in the Gold Coast community is not something any single agency or level of government can do alone. The health system plays a vital role in suicide prevention, particularly through the delivery of specialised mental healthcare. However, equally important roles are played by a wide range of social and human services, law enforcement agencies, industry bodies, education providers, private and non-government service providers, community services and workplaces. Community events can also provide people with clear opportunities to be actively involved in suicide prevention.

Recognising the need for a community approach to suicide prevention, as part of the Joint Regional Planning process a Suicide Prevention Leadership Group was formed in August 2019. This group advised on the suicide prevention components of the Joint Regional Plan and developed a more in-depth Community Action Plan for Suicide Prevention using the LifeSpan framework developed by Black Dog Institute. This framework includes nine evidence-based strategies and six overarching principles and when implemented together, this approach is predicted to reduce suicide death by 20% and suicide attempts by 30%.

Figure 4. LifeSpan: Integrated Suicide Prevention



Source: The LifeSpan lived experience framework, Australian National University

Through the development of the Suicide Prevention Community Action Plan, the following issues were identified, in alignment with the nine LifeSpan strategies:

1) Improving emergency and follow up care for suicidal crisis:
   - A suicide attempt is the strongest risk factor for subsequent suicide.
   - People who present in emergency department in crisis or for suicidal thinking or attempts often do not receive the care and support they need. This may be related to staff experience and skills to deal with suicide and crisis.
   - The emergency department environment can be fast paced and traumatising environment.
   - Police and ambulance may not have the level of experience/skills or time to deal with mental health related call outs effectively.
   - Current resource material to support crisis and suicide is outdated to changes in the sector.

2) Using evidence-based treatment for suicidality:
   - Mental illness, including depression, and trauma are associated with a large portion of suicide attempts.
   - Currently it is unclear what evidence-based treatments are being delivered, by whom or what the quality of these services is.
   - Mental health professionals are not aware of the latest evidence and best practice care and treatment options for suicide.
   - The Gold Coast has some of the highest use of MBS billings in the country for the private sector, but it is not clear who is accessing these services, what services are available and the quality of these services.

- There is a lack of urgency for evidence-based treatment options to address suicide within the mental health sector.

3) Equipping primary care to identify and support people in distress:
   - Primary care providers are often visited by suicidal persons in the weeks or days before suicide but due to fear, stigma or time pressures, do not receive the care they need.
   - GPs encounter numerous barriers and competing priorities which impacts GP uptake and access to suicide prevention training.
   - Traditional GP training does not necessarily equip GPs with the skills and confidence to address mental health concerns and suicidal ideation.
   - Many GPs are unaware of referral points and current best practice care and treatment.
   - Issues with GPs being able to access forms for referral pathways other than Mental healthcare Plan e.g., Psychological Service Providers.

4) Improving the competency and confidence of frontline workers to deal with suicidal crisis:
   - Frontline workers can play a key role in de-escalating a crisis and improving safety.
   - Existing training for frontline workers (mental health services, police, paramedics, and hospital staff) may not include specific suicide prevention skills.
   - Barriers to training such as funding, time of day, endorsement and approval by workplaces can limit uptake and participation in training.

5) Promoting help-seeking, mental health and resilience in schools:
   - Schools are overwhelmed with options and pressure from multiple bodies/sectors to include additional content in their curriculum and programs.
   - Schools are keen to support their students but often do not know how to choose quality programs or integrate programs with other student wellbeing activities and referral pathways.
   - A focus on preventing or intervening early in the progression of mental health difficulties not only benefits infants and children, but also creates a solid foundation for health outcomes later in life.
   - Training initiatives are often fragmented, parents, teachers, and young people may all receive different training, resources and information about how to respond to mental health issues and suicidal crisis resulting in fragmentation and diffusion of responsibility.
   - Currently the communication between hospitals and schools to is not being optimised to support young people post discharge and in the recovery process or to help children and youth remain engaged with school.
   - Clinicians in schools often operate in silos and at the discretion of school principals. Involvement in the planning of school activities could facilitate and enhance coordination of activities.
   - Organisations can be very risk averse due to a culture of blame. People in suicidal crisis can be passed back and forth between organisations without getting the care they need.

6) Training the community to respond to suicidality/Gatekeeper training:
   - Many people who are experiencing suicidal thoughts communicate distress through their words or actions, but these warning signs may be missed or misinterpreted.

- Suicide prevention efforts are often fragmented and have not always been strategically planned or coordinated.
- Inconsistent approaches to increasing Mental Health and Suicide Prevention literacy across the community through workplaces.
- Many gatekeepers are in roles that might encounter people in suicidal crisis, however since this is not their primary role, they may lack skills and confidence to respond to suicidality.
- There is a lot of training available, but people are not always aware of what is available and relevant to them, this may result in duplication and inefficiency.
- There are limited evidence around which programs are most effective and relevant to local stakeholders.

7) Engaging the community and providing opportunities to be a part of change:
   - Suicide prevention activity is frequently fragmented. There are opportunities to improve awareness of how we can work together better.
   - Suicide prevention services and approaches need to be more culturally inclusive and responsive to diversity.
   - Service eligibility criteria/thresholds often limits access to services. In addition, many services do not provide afterhours support.
   - Stigma associated with suicide and help-seeking is a significant barrier to prevention. Greater acknowledgment and recognition of community suicide prevention activity is required to raise the profile of suicide prevention and postvention in a positive way.
   - There is often stigma attached to mental health and suicide. Some people don't identify with these labels and will not access support for conditions that they don't relate to.
   - Safe communication about suicide actively promotes help-seeking, reduces stigma and encourages collaboration.
   - People do not know how to be actively involved in suicide prevention and are not always aware of opportunities or ways they can contribute.

8) Encouraging safe and purposeful media reporting:
   - Representations of suicide in the media can be sensationalised/or stigmatised and unsafe leading to copycat behaviour.
   - The graphic nature of news can be traumatising and cause fear and anxiety.
   - People with a lived experience of suicide are often not empowered or provided with opportunities to become agents of system change or to share messages of hope and recovery with others.
   - Suicide prevention activities and campaigns could be better coordinated to maximise impact.

9) Improve safety and the means of suicide:
   - Currently timely (up to date) regional data is not available which limits our ability to use data to drive decision making.
   - Safety plans are held by providers and individuals have to develop new safety plans with multiple providers.
   - Carers are often not aware of/informed of details of safety plans and how they can support people to implement their safety plans.

Mental Health Crisis Reform

Gold Coast Health commenced the Mental Health Crisis Reform initiative in the second half of 2019 with a consideration of the Crisis Now framework[11], which emphasises a number of care elements including: regional or state-wide crisis call centres coordinating in real time: centrally deployed, 24/7 mobile crisis teams; short-term, "sub-acute" residential crisis stabilization programs; and essential crisis care principles and practices including recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

Feedback was obtained through a range of stakeholder meetings held on the Gold Coast across the second half of 2019 and through 2020. There was a very positive response to the core elements as outlined in the Crisis Now framework. However, it was felt by many stakeholders that it was important to emphasise other aspects of the system and go beyond those presented within Crisis Now. There was strong feedback that any plans around crisis reform on the Gold Coast needed to have due consideration of the whole continuum of care, and to be well integrated into the community, and recovery focused. The Gold Coast Crisis Reform Framework has been developed[12] in response to the following issues identified by local stakeholders:

- There is a need for health services (physical health, mental health, alcohol and other drugs services), social services and emergency response services (e.g., police and ambulance) to work together on coordinated and strategic approaches to transforming mental health crisis care across the GCPHN region. When challenges occur during a crisis, it is often at the points of intersection of these agencies. These entities have their own points of entry, and staff with significant variation in skills, training, and experience in mental health crisis. There are complex questions regarding who takes the lead for certain situations and how does integration and communication occur.
- While principles related to best practice crisis care have been driving reform at a regional level for many years, there is a need to continue to embed these principles in our service and system, both existing and new initiatives:
    - trauma-informed care
    - lived experience and involvement of families central to all models of care
    - adopting a Journey to Zero Seclusion and Restraint
    - integrated mental health, alcohol and other drug and physical healthcare
    - culturally safe, responding to diversity
- A narrow focus on how we respond once a significant crisis has developed will not meet the needs of our community, nor will it align with a growing evidence base internationally. Only with an adequate continuum of service will we be able to prevent crises from developing or reduce likelihood of re-presentations in the future. A comprehensive system needs to include social and housing support to enable recovery and prevent a cycle of repeated crises.
- There is a need for real-time displays of data to inform rapid decision making and tracking of consumers during their crises.

[11] *Crisis Now: Transforming Services is Within our Reach* (National Action Alliance for Suicide Prevention: Crisis Services Task Force, 2016)

[12] Gold Coast Crisis Reform: A Strategic Approach to Transforming Mental Health Crisis Care
Published by the State of Queensland (Queensland Health), December 2020

- There is a need to develop a data-driven quality improvement approach to inform clinical, cultural and system changes that will lead to improved outcomes for people in crisis on the Gold Coast.
- There is a need to add to the local evidence base through research and evaluation of crisis reform initiatives.
- New models of service to respond to mental health crisis will require training and support to ensure success.
- With lived experience workers a central component of the crisis service models, there are specific needs to ensure enough peer workers and appropriate support systems are in place.
- Opportunities for shared training across organizations can assist in achieving a consistent approach and shared language, attitudes and beliefs which will be important in an integrated network of care and include:
    - training developed to support all underlying principles and new models of service
    - opportunities to enhance connections of networks of services through shared training
    - lived experience workforce training
    - all staff receive training on crisis intervention, trauma-informed care, lived experience principles.

Service system

Services	Number in GCPHN region	Distribution	Capacity discussion
GCPHN funded Psychological Services Program (PSP) suicide prevention	Of the 20 contracted organisations, 16 are contracted to provide suicide prevention services	Providers are distributed across the region	Dedicated suicide prevention services on the Gold Coast appear to be limited; however, some mental health services provide information and referral advice on suicide prevention. A 2018 review of clients accessing Psychological Services Program (PSP) suicide prevention service stream indicates strong use but those using the service tend to be females and younger people, which are not the most at risk cohorts in the region. Crisis services on the Gold Coast are available through the public health system in the form of hospital emergency departments and specific crisis support (Acute Care Treatment team, 24hr phone line). There are numerous well-known national suicide prevention and crisis services that are likely to be accessed by the Gold Coast community. For example, Lifeline (phone and online), Suicide call back service (phone and online) and Beyond blue (phone and online).
Gold Coast Health crisis helpline	1 phone hotline (13 MH CALL) for the Acute Care Treatment (ACT) Team	ACT team telephone service available 24hrs	
Emergency Departments (ED)	5	Southport and Robina (public) Southport, Benowa and Tugun (private)	
Support and Transition Program - Suicide Prevention (coordination support for those at-risk of suicide, recently attempted or are recently discharged	1	Accessible via contact with public hospitals in Robina and Southport	
Crisis helplines	4 national (Lifeline, Suicide Call Back Service, Mensline, Kids Helpline)	24-hour, 7-day telephone services. Public knowledge of these services would drive uptake/demand.	
Counselling helplines and websites	12 national help lines (Mensline, Kids Helpline, Open Arms formerly Veterans and Veterans Families Counselling Service, QLife, Carers Australia, eheadspace, 1800 Respect, Relationships Australia, SANE Australia, ReachOut, BeyondBlue, Counselling Online, Child abuse prevention service)	Online and telephone services.	

			There are no specialised suicide prevention or crisis services for Aboriginal and Torres Strait Islander people on the Gold Coast although the Acute Care Team does employ an Aboriginal and Torres Strait Islander Mental Health Worker.

Consultation

GCPHN and Gold Coast Health have been working collaboratively over the past two years through the development of three separate but complementary regional strategies: Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drugs Services (JRP), Crisis Reform Strategy (CRS), and the Suicide Prevention Community Action Plan (SP CAP). While there are different drivers for each of these strategies, many of the underlying issues and longer-term outcomes are similar resulting in the interrelated nature of the three strategies and their contributing activities.

A range of consultation activities have occurred over the past two years to support the development of these strategies as well as the needs assessment process, service design, implementation and evaluation. Community members, clinicians and service providers have been engaged through various mechanisms including workshops, advisory groups, consumer journey mapping, one-to-one interviews, sector presentations, working groups and co-design processes. In addition to the findings mentioned above aligned to the LifeSpan framework, the following insights have emerged from consultation activities:

Service provider consultation

- People presenting to hospital feeling at risk of self-harm but whose mental health issues are not seen as serious enough for admission with limited follow up provided.
- Training and skills development for school staff will support early identification, intervention and referrals.
- Need for enhancing the skills of mainstream services, GPs, and clinicians to work with at risk and vulnerable populations.
- Limited community support systems and services available for those that have attempted suicide
- Early identification of at-risk people who identify as LGBTIQAP+ is key to suicide prevention.
- Lotus staff have described emerging impacts of COVID-19 on service delivery. This includes increased number of people requiring supports and connections to Centrelink and additional time required to support clients in the use of technology to facilitate connections and access to other services and supports during this time.
- The Social and Economic fallout of COVID-19 is anticipated to have significant impacts on service demand and need.

- Responses for 45-56-year age demographic remains a definite gap. People are left highly vulnerable due to unplanned/unforeseen circumstances with little support from the community.
- Access to Domestic Violence services have been an issue especially with carers and violence orders, gaps evident and challenges with this sector.
- GPs refer to the PSP program on “need”, usually distress rather than personal attributes (such as being LGBTIQAP+ or CALD).
- The GCPHN region would benefit greatly from a Safe Space/Safe Haven Service located within walking distance to one of the major hospitals such as Robina.
- The current After Hours Model is limited in its reach (location wise) and capacity to focus around crisis intervention/ED presentation reduction rather than a broader catchment model which includes much of homelessness supports/drop ins.

Service user consultation

- Inadequate response for individuals presenting to hospital feeling unsafe/at risk of self-harm but who are not admitted as their immediate health issues are not seen as serious or acute enough.
- Limited community support systems or services for those that have attempted suicide.
- People who have survived suicide attempts want more support, particularly with non-health related issues such as financial support, relationships and housing.
- Individuals being discharged feel excluded from the hospital discharge planning process.
- Due to high numbers of persons presenting with high mental health needs and/or risk of suicide there are periods of increased length of response times from the Acute Care Team.
- When describing their experience of care, consumers frequently express a lack of empathy and compassion from primary care providers.

Alcohol and other drugs

Local health needs and service issues

- Individual needs are often not matched with the appropriate intensity of treatment.
- Flexible delivery of Alcohol and Other Drugs (AOD) services outside of usual business hours is a factor in successful completion of AODs treatment.
- Limited availability of withdrawal management which impacts an individual's ability to access residential rehabilitation support.
- High demand and limited alcohol and other drugs service options in the northern Gold Coast.
- Variability in formal education, practical experience, and resources in relation to alcohol and other drugs limits capacity of General Practitioners (GPs) to identify alcohol and other drugs issues and have conversations with patients related to alcohol and other drugs use.
- Evolving service system results in GPs and service providers being unclear about available services and the pathways to access services.
- Inefficient transitions between services, particularly from inpatient services to community-based services.
- Limited availability of suitable service options specifically designed to support older population.
- Barriers exists to accessing residential rehabilitation due to upfront financial costs, childcare responsibilities, and funds to cover housing costs while in rehabilitation.
- Alcohol and other drugs services report challenges in recruiting workers that identify as Aboriginal and Torres Strait Islander.
- It can be difficult for service providers to know what capacity services have, particularly for withdrawal and rehabilitation bed availability.
- An inconsistent approach to assessment (e.g., various tools) leads to inconsistent assigned levels of care, resulting in discrepancies in the type of care provided across providers for similar clinical presentations.

Key findings

- Alcohol, cannabis, and amphetamines are the most common drugs of concern in the Gold Coast Primary Health Network (GCPHN) region, with ice reported by service providers to be emerging as a concern across the sector and community.
- There is a strong correlation between mental health issues and alcohol and other drug use.
- Gold Coast has a particularly high rate of young people seeking treatment for alcohol and drugs with 21.8% of all clients seeking treatment in the 10-19-year-old age cohorts.
- 60% of clients accessing treatment for alcohol and drugs were males, and 40% were females.
- When compared to other jurisdictions, the GCPHN region has a range of treatment options including counselling, information and education, support and case management, withdrawal management, rehabilitation and pharmacotherapy.
- There is perception that AOD withdrawal can only occur in a bed-based facility. Knowledge and delivery of in-home and outpatient withdrawal management is lacking in the GCPHN Region. Enhancement of access to such treatment could assist services access to other forms of treatment

such as residential AOD treatment. AOD presentations to ED are a regular and resource intensive issue. Local AODs Services that provide flexible hours of delivery are finding good success especially for people with work, carer of family commitments.

- There are a significant number of stable opioid replacement therapy patients that are unable to be discharged back into the community due to lack of privately “qualified” e-medical prescribers and also due challenges in accessing bulk-billing services. This impacts on capacity services in the community, such as General Practitioners and other AOD services to manage more complex patients. to support more complex patients.
- There is strong correlation between accommodation arrangements and engagement in treatment, whereby people with unstable housing often periodically and more frequently disengage from services
- Service providers actively engage in workforce development and training for their staff but rarely collaborate around learning or learning opportunities. This results in a lack of consistency in knowledge-base, clinical decision making, and service delivery provided to consumers.

Prevalence and utilisation of services

The AOD services sector on the Gold Coast is a mix of public, private and non-government organisations who provide specialist treatment across a broad range of service types for people using drugs, and for their families and friends. The AOD sector operates within a harm minimization or abstinence framework. Harm minimization approaches aim to reduce drug related problems through gradual reduction in AOD use. Abstinence approaches aim to support people ceasing use immediately, often with some added medical treatment and review to ensure client safety. It's important to note that some people use substances without experiencing any significant short or long-term harm. However, there is a proportion of the population who require treatment, care and support to reduce harms from their alcohol, tobacco, prescribed medication and illicit drug use.

Alcohol

Alcohol plays a significant role in Australian culture and is widely accepted in society. The lifetime risk of harm increases with the amount of alcohol consumed. Lifetime risk is defined as people consuming more than 2 standard drinks per day on average over a 12-month period[1]. While consumption at levels of lifetime risk have trended downward for Australia since 2016, Gold Coast had higher proportions of people consuming alcohol at lifetime risky levels than the national figure in 2019 (Table 1).

Local treatment data for the Gold Coast indicates that 64% of people undertaking treatment are men. The proportion of women being treated (36%) was above the Queensland average (34%)[2] .

Table 1. Lifetime risky alcohol consumption, Queensland Primary Health Networks, 2016 and 2019

Primary Health Networks	2016	2019
National	17.2%	16.8%
Brisbane North	19.6%	20.9%
Brisbane South	16.4%	15.6%
Gold Coast	21.7%	21.7%
Darling Downs and West Moreton	16.2%	20.3%
Western Queensland	n.p	n.p
Central Queensland, Wide Bay and Sunshine Coast	22.0%	23.1%
Northern Queensland	22.5%	21.2%

Source: Australian Institute of Health and Welfare 2020, National Drug Strategy Household Survey 2019. Drug Statistics Series According to 2009 NHMRC guideline 1: On average, had more than 2 standard drinks per day. Note – n.p, non-publishable

As can be seen in Table 1, the GCPHN region had a higher percentage of people who reported on average, had more than two standard drinks per day compared to the national rate. While the national rate has decreased from 2016 to 2019 of risky alcohol consumption, the Gold Coast percentage has remained the same.

[1] National Health and Medical Research Council

[2] National Drug Strategy Household Survey (NDSHS) 2016 preliminary findings

Gold Coast PHN's PATCAT system captures de-identified patient data submitted by registered general practices throughout the GCPHN region[3]. Analysis of this general practice data indicates that as of March 2022 of the 486,761 active patients (three visits in the past two years) aged 18 years and over, 13% (n=65,646) of people had indicated that they were a high-risk alcohol drinker (two or more drinks on a regular occasion or more than four drinks on one occasion).

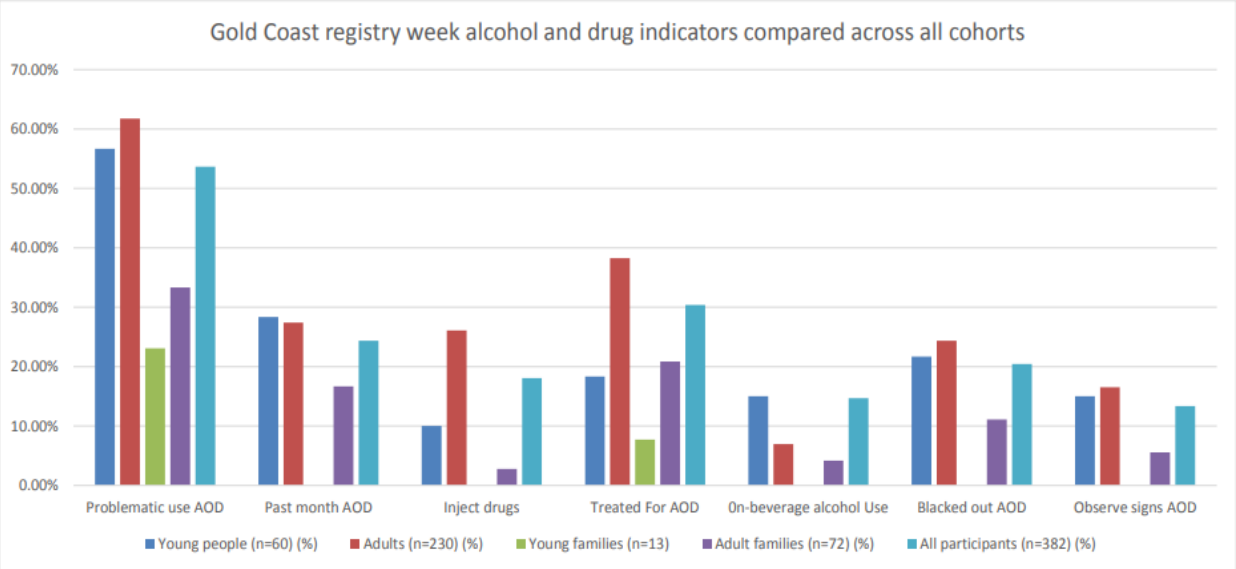
The impact of alcohol on broader health and wellbeing can be both short and long term. In 2011, 70% of the disease burden associated with alcohol was attributed to alcohol dependence and harmful use: 38% of hospitalisations due to alcohol, falls (12%) and other unintentional injuries (14%), coronary heart disease (4%) and suicide and self-harm (4%)[4].

Alcohol and people who experience homelessness

People who experience homelessness are particularly vulnerable to mental health and drug and alcohol issues, and they are also less likely to seek assistance or access services than the general population. Results of the 2014 "Home for good registry week" survey conducted by Queensland Council of Social Services found just over 50% (215 people) of participants reported problematic use of alcohol with a higher prevalence among adults (61.7%) and young people (56.7%) (Figure 1).

Despite having the second highest self-identification of problematic alcohol and or other drug use (53.7%), only 30.4% of young people were treated for these issues. On average, people experiencing homelessness on the Gold Coast were aged 28.5 years and were younger than the general population. This reflects the broader national picture of young people being overrepresented in the homeless population (Mission Australia, 2016).

Figure 1. Percentage of alcohol and drug indicators among homeless people, Queensland, 2014



Source: Queensland Council of Social Services. Home for Good registry week results – Gold Coast, 2014.

Alcohol use across the life span

Older people make up a considerable proportion of the Gold Coast population. In 2019, 105,846 (16.6%) people were aged 65 and over on the Gold Coast which was above the Queensland rate of 15.7% of people

[3] Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

[4] Queensland Health. The Health of Queenslanders 2016. Report of the Chief Officer Queensland. Queensland Government. Brisbane 2016

aged 65 and over[5], additionally, the proportion of older Australians is expected to grow. Data from the 2019 National Drug Strategy Household Survey identified that older people are the most likely to drink alcohol daily, with the highest rates seen among people aged over 70 (12.6%). Comparatively, 1.2% of people aged 20–29 drank daily.

Anecdotally, stakeholders report that older people with problematic drinking are less likely to seek treatment. Through consultation, it has been suggested that often older people are admitted to hospital or have an ambulance called due to 'falls' or other accidents, where drinking was a factor. This is not reported back to the individual's GP and the individual does not disclose this information to their GP either.

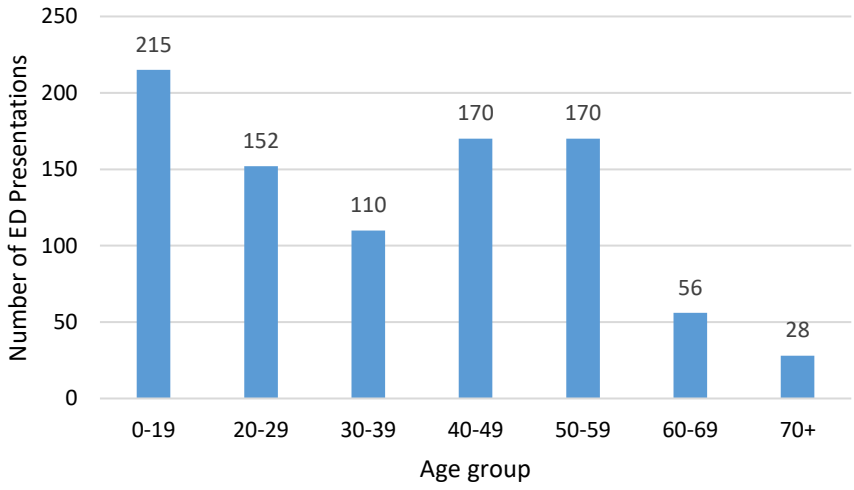
Younger people are now more likely to abstain from alcohol than they were 18 years ago. The proportion of people in their 20s abstaining from alcohol increased from 8.9% in 2001 to 22% in 2019[6].

Single occasion risky drinking was most likely to be exceeded at least monthly by people aged 18-24 (41% in 2019 compared to 42% in 2016 and 25-29 (36%, the same as 2016). However, 27% of people in their 50s surpassed the single occasion guideline at least monthly and increase from 25% in 2016. The rate of people aged 70 and over drinking this amount also increased from 7.2% to 8.8%.

Alcohol and hospitalisations

In 2019-20 there was a total of 901 ED presentations at Gold Coast Public Hospitals for 'mental and behavioural disorders due to use of alcohol, acute intoxication'. The largest number of episodes of care occurring in 0-19 age group followed by 40-49 and 50-59 age group. The large number of presentations in the 0-19 age group may be due to a large number of presentations in November when school leavers attended celebrations on the Gold Coast. The regions which had the largest representation of presentations included Southport, Labrador, and Surfers Paradise.

Figure 2. Alcohol related episodes of care, Gold Coast Emergency Department, by age groups, 2019-20



Source: Gold Coast health

The rate of hospitalisations for drug and alcohol use per 100,000 people on the Gold Coast was below the national figure in 2014-2015. However, within the GCPHN region there were five areas with rates above the

[5] ABS 3235.0, Population by Age and Sex, Regions of Australia
[6] Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW

broader Gold Coast rate, three of these areas had rates above the national figure, with the highest recorded in Coolangatta (245) (Table 2).

Table 2. Drug and alcohol hospitalisations per 100,000 people (age standardised), Gold Coast SA3, 2014-15

Region	Hospitalisations per 100,000 people (2014-15)
National	180
Gold Coast SA4	163
Coolangatta	245
Gold Coast - North	213
Southport	200
Surfers Paradise	199
Broadbeach-Burleigh	170
Robina	159
Nerang	146
Gold Coast Hinterland	124
Mudgeeraba-Tallebudgera	122
Ormeau-Oxenford	101

Source: Australian Institute of Health and Welfare analysis of the National Hospital Morbidity Database 2014–15; and Australian Bureau of Statistics Estimated Resident Population 30 June 2014.

Pharmaceuticals

In 2016, approximately one in 20 Australians aged 14 or older had misused pharmaceuticals in the last year, with painkillers/opiates being the most common[7]. Pharmaceutical misuse includes the non-medical use or abuse of a drug available from a pharmacy, by prescription such as opioid-based pain relief, or over the counter such as codeine. Three quarters of recent users reported misusing over the counter codeine. Codeine is an opioid in the same family of compounds as opioids such as morphine, methadone and heroin. In 2013 in Queensland, painkillers/analgesics were the second most commonly used illicit drug (3.3%)[8].

Pharmaceutical opioids are responsible for far more deaths and poisoning hospitalisations in Australia than illegal opioids such as heroin. Every day in Australia, nearly 150 hospitalisations and 14 ED admissions involve opioid harm[9]. With the figures being so high, the Australian Government asked the Therapeutic Goods Administration to assist in tackling the problem. As a result of this work:

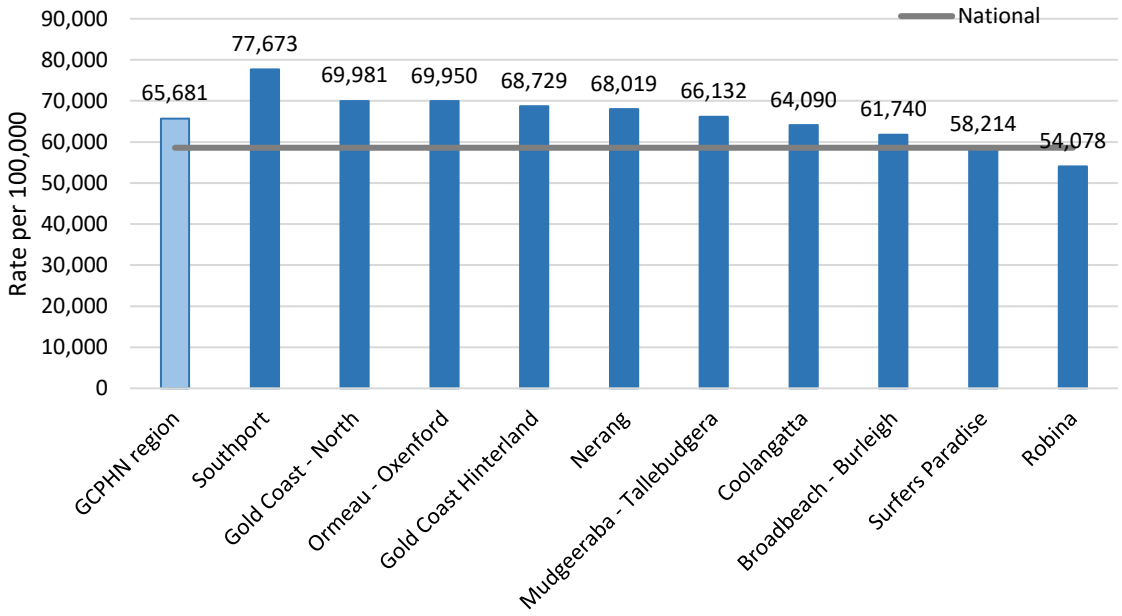
- Smaller pack sizes will be available for immediate-release prescription opioid products, people requiring an additional supply for short-term pain will generally need to visit the doctor again (as opposed to receiving a repeat prescription)
- New restrictions for patients starting on high-strength opioids for chronic pain, such as morphine and fentanyl. A person with chronic pain will need to try other types of pain relief, including lower-strength opioids, before being eligible for high-strength opioids.

[7] Australian Institute of Health and Welfare. National Drug Strategy Household Survey (NDSHS) 2016 preliminary findings
[8] Turning Point Alcohol and Drug Centre. Over the counter codeine dependence. 2010.
[9] Australian Institute of Health and Welfare, Opioid harm in Australia and comparisons between Australia and Canada

Where opioid use exceeds, or is expected to exceed, 12 months the patient will need to seek a second opinion to approve ongoing prescriptions.

The number of opioids dispensed through the Pharmaceutical Benefits Scheme (PBS) increased fifteen-fold over the twenty years from 1992, reaching 7.5 million in 2012. Almost half the prescriptions for opioids from general practice are to treat chronic pain[10], however, evidence does not support using opioids for this condition[11]. In 2016-17, the Australian rate for opioid dispensing was 58,595 per 100,000 people, the Gold Coast rates exceeded this at 65,681 (Figure 3). Within the Gold Coast, Southport had the highest rate of 77,673 per 100,000 people. It is important to consider that these figures do not include over the counter medicines and are therefore an underestimate of the use of opioid medicines in the community.

Figure 3. Rate of PBS prescriptions dispensed for opioid medicines per 100,000 people, Gold Coast SA3 regions, 2016-17



Source: Australian Atlas of Healthcare Variation, 2018

Gold Coast Health provides an Opioid Replacement Therapy service, a pharmacotherapy treatment designed to replace drug dependence with a legally prescribed substitute. Reportedly, this service has significant number of stable opioid replacement therapy patients that are unable to be discharged back into the community due to lack of private prescribers and also due to financial reasons, including lack of bulk-billing services. This impacts on capacity of tertiary services to support more complex patients.

Illicit drugs

Harms from illicit drugs affect all Australians communities, families and individuals, either directly or indirectly. These include illness, injures, mental health, trauma, healthcare and other financial cost. Illicit drug use is considered:

- Use of illegal drugs (such as meth/amphetamines and cocaine),

[10] Alcohol and Drug Foundation. Prevention research: is there a pill for that? 2016
[11] Australian Commission on Safety and Quality in Health Care. Australian Atlas of healthcare Variation. Chapter 5 opioid medicines. 2015

- Use of pharmaceuticals for non-medical purposes (for example, using oxycodone or benzodiazepines without a prescription, or in a quantity or purpose for which is not intended,
- Volatile substances used inappropriately (for example, inhalants such as petrol or glue).

In 2016, 22.6% of people reported recent illicit drug use among Gold Coast residents, which was above the national rate of 16.0%. The Gold Coast rate slightly decreased to 22% while the national rate increased to 16.8%.

Table 3. Recent illicit drug use in people aged 14 and over, Queensland Primary Health Networks, 2019

Primary Health Network Regions	2016	2019
National	16.0	16.8
Brisbane North	15.2	20.1
Brisbane South	16.8	15.8
Gold Coast	22.6	22.0
Darling Downs and West Moreton	12.9	12.8
Western Queensland	n.p.	n.p.
Central Queensland, Wide Bay and Sunshine Coast	17.6	17.6
Northern Queensland	18.2	17.3

Source: Australian Institute of Health and Welfare 2020, National Drug Strategy Household Survey 2019. Drug Statistics Series

The National Drug and Strategy Household Survey is the leading survey of illicit drugs in Australia. In 2019, 22,274 people aged 14 years and over gave information on their drug use patterns, attitudes and behaviours[12]. The survey identified:

- Fewer Australians are smoking tobacco,
- Roll-your-own and e-cigarettes use in increasing,
- More Australians are giving up or reducing their alcohol intake, driven by health concerns,
- More than 2 in 5 Australians have used an illicit drug in their lifetime and recent cannabis use has increased,
- Rates of substance use are falling among younger generations,
- Cocaine use is at its highest in almost two decades,
- Non-medical pharmaceutical use is down, driven by a fall in use of painkillers,
- Fewer Indigenous Australians are smoking or drinking at risky levels,
- Smoking rates increase with socioeconomic disadvantage, but illicit drug use highest in the most advantaged areas,
- Smoking and drinking rates are down among gay, lesbian, and bisexual people.

The National Drug Strategy Household Survey 2016 found the proportion of Australians illicitly using drugs has remained relatively stable, however there has been a gradual increase in numbers since 2007 from 2.3 to 3.1 million. Around 15.6% of people aged 14 and over had used an illicit drug in the previous 12 months, with misuse of pharmaceuticals accounting for approximately 3% of this[13].

[12] Australian Institute of Health and Welfare 2020, National Drug Strategy Household Survey 2019. Drug Statistics Series
[13] Australian Institute of Health and Welfare. Alcohol and other drug treatment services in Australia 2016-17 key findings

This survey found that across PHNs there was wide variation in the use of tobacco, alcohol, and illicit drugs in 2019. Gold Coast did feature prominently in the highest five PHN regions for:

- people who exceeded lifetime risk guideline (23.5%),
- people who exceeded single occasion risk guideline (at least monthly) (34.8%),
- people with recent illicit drug use (22.7%).

Table 4. High risk levels of alcohol and drug use, Gold Coast and national, 2019

	Exceeded lifetime alcohol risk guideline [a]	Exceeded single occasion alcohol risk guideline (at least monthly) [b]	Recent illicit drug use [c]
National	16.8%	24.8%	16.4%
Gold Coast	23.5%	34.8%	22.7%

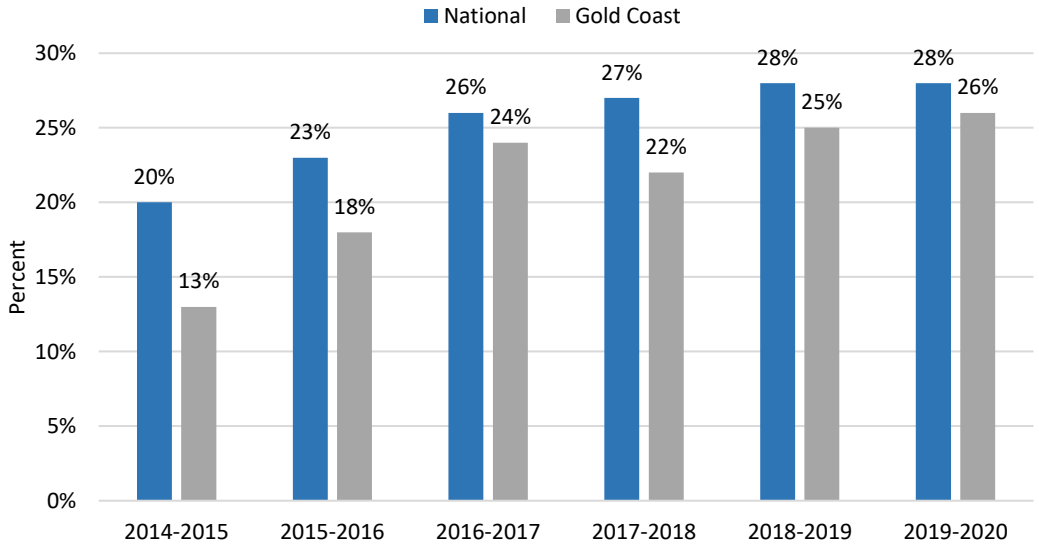
Source: Australian Institute of Health and Welfare 2020, National Drug Strategy Household Survey 2019. Drug Statistics Series. The accumulated risk from drinking either on many drinking occasions, or regularly (for example, daily) over a lifetime (a). The lifetime risk of harm from alcohol-related disease or injury increases with the amount consumed. Single occasion is defined as a sequence of drinks taken without the blood alcohol concentration reaching zero in between (b). The risk of an alcohol-related injury arising from a single occasion of drinking increases with the amount consumed in the previous 12 months.

Methamphetamines

Nationally, declines were seen in use of methamphetamines across the 2013 to 2016 period, reducing from 2.1% to 1.4%. There has been a shift over time to decreasing use of powder and base methamphetamine forms and increasing use of crystal methamphetamine. Study conducted in 2018 highlighted methamphetamine consumers nominated crystal as the main form used (94%), followed by powder (5%).

Gold Coast data confirms an increase in amphetamines as the principal drug of concern among people receiving treatment, increasing from 13.2% (n=562) to 26% (n=1,246) across the 2014-15 to 2019-2020 period (Figure 4).

Figure 4. Percentage of closed treatment episodes for amphetamines, Gold Coast and National, 2014-2015 to 2019-2020



Queensland ED presentations for persons aged 16 and older that related to methamphetamines increased five-fold between 2009-10 and 2014-15, and approximately a third of presentations were admitted. A fifteen-fold increase was observed for methamphetamine related hospitalisations for the same period. Of the presentations recorded in 2014-15, males accounted for 68% and people aged 16-34 accounted for 74%. Similarly, among hospitalisations across the five-year period, 66% were for males and the highest rates were among people aged 16-34.

The Queensland Department of Communities, Child Safety and Disability report that across a one-year period to December 2016, 75% of children (n=1,755) that were admitted to ongoing intervention with the Department had a parent with a current or previous drug and/or alcohol problem. Of these, 1 in 3 children (749) had one or both parents using methamphetamine of which 75% (562 children) were using ice. Findings indicate that in 68% of cases (381 children), parents had only begun using ice in the previous twelve months and not used it prior.

Based on child safety service boundaries, 40% of parental ice use impacting 208 children, was in the two regional corridors of Ipswich North and Brisbane North to Caloundra and Gold Coast, including Beenleigh. When combined with three other child safety regions, these areas account for slightly over half of all children admitted to ongoing intervention for the period of December 2015-16 yet represent almost three-quarters of parental ice use.

Problem drinking of alcohol by parents was less prevalent among those who used ice compared to those who used other substances. However, the rate of co-occurrence of marijuana, amphetamine and heroin was found to be two to three times higher among parents using ice than those using other substances with 69% (n=385) of children whose parents were using ice also using other drugs. This highlights the importance of service providers working with people who use substances being confident in how to refer and support people using ice who may have children and poly-drug use.

The proportion of children impacted by parental use of ice was similar regardless of Aboriginal and Torres Strait Islander status. However, the household characteristics of children whose parents had used ice differed from other children with an ongoing intervention and were more likely to have a parent with a criminal history, a current or previously diagnosed mental illness, experienced domestic and family violence in the past year and been homeless. Sixty percent of children whose parents had used ice were under the age of five, including unborn children (Table 5).

Table 5. Age of child with an ongoing intervention where prenatal ice use was recorded, Queensland, 2015-16

Child age	Number	% of children
Unborn	41	7%
0	89	16%
1	58	10%
2	54	10%
3	48	8%
4	49	9%
5 years or older	223	40%

All children	562	100%

Source: Queensland Government, Department of Communities, Child Safety and Disability, 2016

While the data above relates to a large region, of which the Gold Coast is only one part, this reinforces the critical importance of service providers and government departments committing to work together to support individuals, children and families affected by ice and other drugs.

People with a dual diagnosis

Dual diagnosis is a term used to describe when a person is experiencing both mental health problems and drug and alcohol misuse. It is also commonly referred to as co-morbidity and co-occurring mental-health and substance use. Mental health problems and drug use have a significant impact on people's lives and the lives of those around them[14,15]:

- A person with a mental illness using alcohol or other drugs to help cope with the symptoms of their illness.
- Difficulties with diagnosis and establishing whether the issues the person is experiencing are due mainly to the drugs, the mental illness, or a combination of both.
- Difficulties engaging a person into treatment and completing the treatment.
- The relapse of one condition may increase the risk of relapse in the other condition.
- There may be a risk of one problem increasing the risk of the other, or an existing disorder becoming more problematic with the other present.
- Interactions between prescribed medication and alcohol or other drugs can result in unwanted side-effects and can increase the risk of overdose. Taking prescribed drugs as directed by the doctor can also cause problems.
- People with a dual diagnosis experience higher rates of homelessness and social isolation, infections and physical health problems, suicidal behaviour, violence, antisocial behaviour, and incarceration.
- People with a dual diagnosis was often discussed as an underserviced group through consultation in developing the Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services in the Gold Coast region.

Drug-induced deaths

Drug-induced deaths are defined as those that can be directly attributable to drug use, as determined by toxicology and pathology reports. Australian Institute of Health and Welfare analysis of the national mortality database showed:

- In 2018, there were 1,740 drug-induced deaths (rate of 7.0 per 100,000 population) in Australia. While the number of drug-induced deaths in 2018 was the same as the number recorded in 1999, the rate of drug-induced deaths in 2018 (7.0 deaths per 100,000 population) was 23% lower than in 1999 (9.1 deaths per 100,000 population).

[14] Australian Drug Foundation (2012). What is Dual Diagnosis (internal document) Melbourne: ADF
[15] VicHealth (2017). Dual diagnosis. Melbourne: Victoria State Government

- Opioids were the most common drug class identified in drug-induced deaths over the past 2 decades. Opioids include the use of several drug types, including heroin, opiate based analgesics (such as codeine and oxycodone) and synthetic opioid prescriptions (such as tramadol and fentanyl).
- In 2018, opioids were present in nearly two-thirds of drug-induced deaths (64.5% or 1,123 deaths) — a rate of 4.6 per 100,000 population.
- By single drug type, the most common substance present in drug-induced deaths in 2018 were benzodiazepines, identified in 883 deaths (51%). It is important to note that benzodiazepines may not have been recorded as the underlying cause of death[16].

Violence

The GCPHN region is in line with Queensland per 100,000 people for rate of domestic violence – application made by police. Two Gold Coast Statistical Area Level 3 regions were above the Queensland rate (refer to Family and Domestic Violence chapter of Needs Assessment).

One Australian study has identified the role of illicit drug use in family and domestic violence in Australia. The study identified that drug use within the last 12 months, regardless of drug type used (stimulant or depressant) was associated with three times the odds of reporting past 12-month violence and six times the frequency of violent incidents. The study also identified a stronger association between drug use and family violence, or partner violence compared to other violence[17].

Drug overdose

The number of Gold Coast residents who die from drug-induced deaths each year continues its long-term rise. Over the past 15 years, there have been 725 drug-induced deaths. Drug-induced suicides also exact a substantial toll on the Gold Coast community, with 213 such suicides in the past 15 years and eight in 2019.

The rate of drug induced deaths per 100,000 people in 2015-2019 was 10.2 on the Gold Coast, which was above the national rate of 9.2 per 100,000 people. Surfers Paradise and Southport had the highest rate per 100,000 people for Drug-induced Deaths in 2015-2019 on the Gold Coast while Ormeau-Oxenford had the highest number of drug induced deaths in the same period[18].

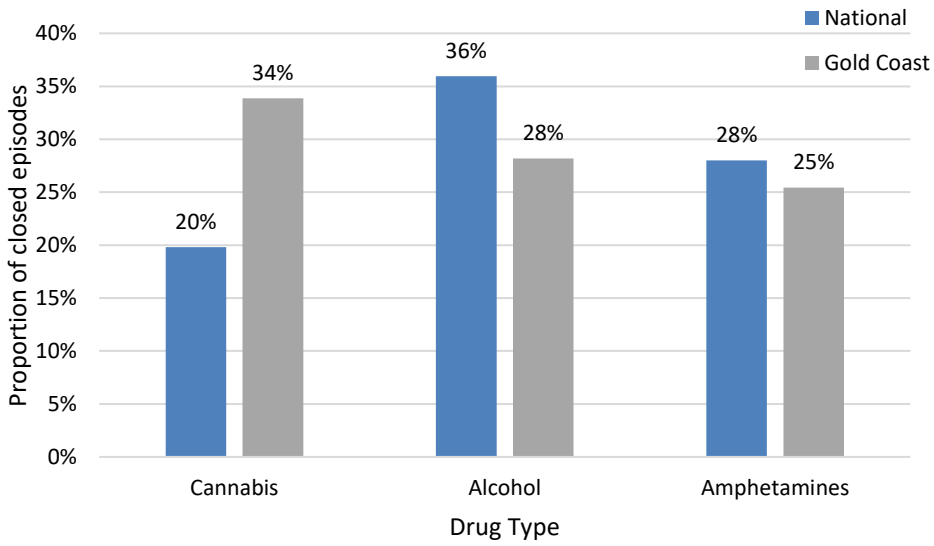
Service usage

Nationally, clients aged 30-39 years old (27.2%) were the most represented in episodes of care for alcohol and drug treatment services. On the Gold Coast, 20-29-year olds were the most represented (28.3%) closely followed by 10-19-year olds (21.8%). This may be due to the availability of a few youth focused AOD treatment programs.

Gold Coast data for 2018-19 confirms cannabis as the most common principal drug of concern among closed treatment episodes at 33.9%, above the national figure of 19.8% (Figure 1)[19]. Data from the 2019 National Drug strategy household survey identified that Gold Coast residents were above the national percentage of people exceeding guideline of no more than 2 standard drinks on average per day. This may suggest that Gold Coast residents are not seeking treatment for alcohol as much as other substances.

[16] Australian Institute of Health and Welfare, National Mortality Database
[17] The role of illicit drug use in family and domestic violence in Australia - Kerri Coomber, Richelle Mayshak, Paul Liknaitzky, Ashlee Curtis, Arlene Walker, Shannon Hyder, Peter Miller, 2019. (2019, April 11). SAGE Journals.
[18] Penington Institute (2021). Australia's Annual Overdose Report 2021. Melbourne: Penington Institute. ISSN: 2652-7790
[19] Australian Institute of Health and Welfare, alcohol and other drug treatment services, 2018/19

Figure 5. Closed treatment episodes for clients who received treatment for drug use, Gold Coast and national, 2018-19



AIHW: Alcohol and other drug treatment services, 2018-19

In 2018-19 on the Gold Coast, 60.2% of clients of alcohol and other drug treatment services were males and 39.7% were females.

System Navigation Consultation throughout the 2020 Gold Coast Joint Regional Plan between Gold Coast Health and Gold Coast Primary Health Network identified that there is a high demand for system navigation support and to support people to assess and determine suitable options. There are two elements to services navigation that have been identified:

1) Uncoordinated and inconsistent approach to assessment, referrals, and intake:
    - Most services operate an assessment and intake component for their service meaning individuals and referrers often have to share their story at each transition point or when ascertaining eligibility. When people are not matched to the right service initially, they have to retake the intake process, which can be a system inefficiency and can contribute to a poor experience and poor outcomes. Additionally, the frustrating experience of trying to find the right fit can result in disengagement and opportunities for early intervention may be lost with people presenting to the system later in crisis.
    - An inconsistent approach to assessment (e.g various tools) leads to inconsistent assigned levels of care, resulting in discrepancies in the type of care provided across providers and regions, for similar clinical presentations
    - Referrals to services are often inappropriate, resulting in people being under or over serviced.
2) Limited awareness/understanding of service infrastructure, including availability and capability of services:
    - Referrals to services are often inappropriate, resulting in people being under or over serviced.
    - There are many pathways to mental health, AOD and suicide prevention and support services. Community members and service providers perceive that the local service system changes frequently due to funding changes, resulting in providers and people being unclear about

available services and the pathways to access these services. There is a need for timely and accurate information and easily identifiable access points for individuals seeking care, so that they can be matched with the service which optimally meets their needs.

Service system

Service	Number in the GCPHN region	Base Location	Capacity discussion
Community based NGO service	2 (education and support, counselling and referral program)	Burleigh, Nerang	• There is recognition from mainstream AOD service providers they need to engage staff that identify as Aboriginal and Torres Strait Islander to effectively meet the needs of more Aboriginal and Torres Strait Islander clients. Some services report that Aboriginal and Torres Strait Islander clients leave AOD programs early due to concerns regarding cultural appropriateness. • There are limited transitional services connected to residential rehab facilities. • Currently, there are no detox services available for young people (under 18 years). • Parents and families have access challenges as few residential services can accommodate their needs. • The Queensland Health 24-hour Alcohol and Drug Information Service provides low intensity AOD services as well as information and referrals to the Gold Coast community. • AOD navigator with Gold Coast Health focusing on frequent presentations.
Private medical detox.	1 (43 beds)	Currumbin	
Private day program provider	1	Currumbin	
Private inpatient rehabilitation unit.	1	Currumbin	
Residential detox facility.	1 (11 beds)	Eagle Heights	
Residential rehabilitation facility.	3 (43 beds, 40 beds and 28 beds)	Eagle Heights, Burleigh, Southport.	
Community withdrawal program (Detox at home)	1	Burleigh	
Needle exchange program	2	Southport, Burleigh	
Gold Coast Health inpatient service - nursing-based intervention	1 (Drug and alcohol brief intervention treatment)	Southport	
Gold Coast Health Community services.	2 clinics (delivering opioid replacement therapy and a mix of programs (5) and support services such as assessment, referral, counselling, hospital liaison and information)	Southport, Palm Beach.	
Low intensity.	6 (Queensland Health AOD info line, cannabis Information helpline, national cannabis prevention and information service, Hello	Online and telephone services. Public knowledge of these services and connectivity capacity would drive uptake/demand.	

	Sunday Morning, Youth substance abuse service, national drug and alcohol services directory).		• Male Aboriginal and Torres Strait Islander clients are accessing these services at a higher rate compared to Aboriginal and Torres Strait Islander females. This has shifted from when the service was first established as the demand was higher for female clients.
Community based NGO services - focus on AOD for youth (aged 12-25).	4 (predominantly a mix of brief intervention, counselling, education and referrals).	3 in Southport, 2 in Burleigh, 1 in Coomera and some outreach (7 listed as one NGO has 4 locations).	
Community based NGO services – focus on AOD needs of pregnant women and new parents.	3 (information & education, support groups, connection with services, relapse prevention, counselling).	3 in Southport, 1 Robina, 1 Burleigh, 3 also provide services through outreach to all of Gold Coast.	
Community based NGO services - focus on AOD for families.	5 (predominantly a mix of brief intervention, group support, counselling, education and referrals).	1 in Burleigh, 3 in Southport, 1 Southport provider conducts outreach between Runaway Bay and Coolangatta.	

Consultation

Over the past two years various consultation activities have been undertaken in the Gold Coast region as part of the needs assessment process, regional planning, service design, implementation and evaluation. Community members, clinicians and service providers have been engaged through various mechanisms including workshops, advisory groups, consumer journey mapping, one-to-one interviews, sector presentations, working groups and co-design processes. Key findings from these consultation activities include:

Joint regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services

- Complex service system means people are unclear about which services are available and what service is the most appropriate fit.
- There is a high demand for service navigation support and working with people to assess and determine suitable options.
- Additionally, many services currently provide intake, triage, and referrals but each are limited in their scope as they are funded to provide specific treatment types, resulting in inefficiencies and gaps and inefficient use of a highly skilled workforce that limits treatment capacity.
- Referrals are often inappropriate, resulting in people being under or over serviced.
- AOD services all fielding information calls from community which could be handled through ADIS.
- For people with alcohol and other drug challenges, timely access to treatment is especially important to capitalise on motivation to change. Clients can often disengage from one service if the service availability does not fit the need. Additionally, providers often have wait times for treatment and at times do not feel they are able to respond quickly enough when people first make contact with the service due to current demand.
- Current capacity of withdrawal management and support, residential rehabilitation and after-hours support limits the provision of flexible support and follow up for clients.
- No bulk-billing psychiatry and limited access to psychiatry in the community prevents access to many individuals who require this type of service and limits the capacity of service providers to provide optimum care to their clients.
- Perception that withdrawal can only occur in a bed-based facility, whereas in-home and outpatient withdrawal management and support can be highly effective and would increase access to this treatment type.
- While the GCPHN region provides the full spectrum of alcohol and other drugs services, there are challenges to transitioning people across services as their needs change. If the transition of care is not done well, people may disengage from treatment.
- It can be difficult for service providers to know what capacity services have, particularly for withdrawal and rehabilitation bed availability, which can delay access for clients while capacity is confirmed.
- The percentage of the health workforce that identifies as Aboriginal and Torres Strait Islander is not proportionally representative.

Service provider consultation

- Stronger referral pathways needed between mental health, housing, youth, justice, child safety, emergency relief and AOD services.

- Providers report difficulty recruiting AOD workers that are Aboriginal or Torres Strait Islander which limits capacity to provide culturally appropriate services to these clients, which can result in early disengagement from the service.
- Individuals requiring residential rehabilitation are limited due to upfront fees required, and financial costs required to maintain their home.
- Many services expressed demand for treatment outstrips capacity, and wait lists are common, people often disengage while waiting to get into treatment.
- Limited options for young people and people with children. There are no local withdrawal management options for under 18's and services are often considered not 'youth friendly'.
- Some individuals seeking AOD treatment will 'down-play' their mental health problem to secure treatment, particularly for residential services. Providers report once the client has detoxed in the service their mental health problems become visible and staff may not have the skills required to manage these.
- Parents are not seeking treatment for AOD use for fear of losing their children. Treatment services do not accommodate children, limiting parents' options for accessing treatment
- Limited detox capacity on the Gold Coast. Barrier for people wanting to access rehabilitation as they are required to detox prior to rehabilitation (must not be using). Flexible options including in-home detox are required to meet this need.
- General Practitioners (GP) advised they require further information about availability of services, treatment options and appropriate referral pathways, particularly for methamphetamines.
- Limited in-home outreach services with a gap identified in the Coomera / Northern Corridor area. Transport is often a barrier to accessing services.
- Small operational budgets limit AOD staff to receive ongoing professional development, impacting workforce quality, planning and sustainability.
- Individuals with AOD problems often face difficulty accessing mental health or accommodation services due to those services not being funded or skilled to support AOD needs.
- Some providers have reported that methamphetamine (ice) use remains high at around 50% of all clients reporting this as their principal drug of concern.
- The capacity building working group identified complexity in relation to residential detox or rehabilitation treatment. The issue is not solely being lack of beds but also consumer readiness for the service and matching the consumer to the type of service.
- Referral pathways are still quite unclear, particularly for clients engaged with HHS that are transferred to community services and then have readmissions to hospital.
- At times there isn't a clear process regarding transfer of care and who remains the primary care coordinator of the client and for how long.
- Rehabilitation options for single parent families Is limited, no one to watch the children, lack of funds to cover housing cost while in rehabilitation which has created a barrier.
- There is a demand for more Aboriginal and Torres Strait Islander workers, particularly male workers for both mental health and alcohol and other drugs.
- Service providers from Youth Justice, Child Safety and Health and Hospital Service report increasing rates of youth chroming (inhaling solvents or other household chemicals).
- Anecdotally, older population with problematic drinking less likely to seek treatment.

- Importance of access to dual diagnosis or addiction specialists by mental health providers for coordinated care for complex clients.
- Stable, appropriate or safe housing remains an issue for clients of AOD services. Being homeless is a significant challenge for services being able to continue treatment with a person, while those who have accommodation often report it being unstable. Also, often the accommodation arrangements do not support good recovery activity (i.e. living in a house with others who use substances, accessibility of substances).
- Providers have reported an increase in poly-substance abuse, this is consistent across other PHN areas.
- People presenting with acute intoxication to mental health services for short term crisis support, there is currently no service apart from the Emergency Department equipped to appropriately respond to people presenting in this state.
- Closer linking of referral and triage processes so individuals are connected with the right type and intensity of service the first time.
- Opportunity to have stronger and more structured links between the AOD sector and homelessness services to support strategic planning, review needs, create referral pathways etc.
- Opportunity to better link services to share capacity information, streamline referrals or access to the next treatment type of the client's journey i.e., from detox to residential rehab.

Service user consultation

- Individuals trying to access treatment services such as detox and residential rehabilitation, often encounter barriers to accessing treatment in a timely way, such as lengthy wait lists. This compromised their recovery and motivation to engage and seek help again.
- Telehealth options are needed as they increase the accessibility of treatment and overcome many barriers.
- Improved capacity for mental health services to support people with drug and alcohol issues and provide a dual diagnosis response as many people felt AOD use was often a self-medicating strategy to cope with mental health issues.
- Individuals who present to mental health services with co-occurring drug and/or alcohol use are often told they will need AOD treatment before the mental health support can be provided.
- Relationships with key staff in the service were identified as critical for consumers to maintain recovery and engagement in their treatment. This is supported by considerable evidence in the field.
- Moving straight from wanting to discuss treatment or receive information, to residential detox or rehabilitation is challenging for many people. A bridging approach is required to support people still using to access services and support.
- Some sort of childhood trauma (mostly sexual abuse) featured in the majority of service user stories. This was often cited by the person as the reason why they start using substances.
- Judgement from police officers, hospital staff, ambulance staff and GP was often cited as negatively impacting on the service user's motivation to seek help.
- Family members often do not know what services are available or where to go to get their loved one help.

Aboriginal and Torres Strait Islander health

Local health needs and service issues

- Cultural competency, transport and costs affect access to services for Aboriginal and Torres Strait Islander people.
- Limited services in northern Gold Coast for Aboriginal and Torres Strait Islander people.
- Low proportions of chronic disease early identification and self-management.
- There are some indication that maternal health may be an issue but there are very small numbers involved.
- Low number of Aboriginal and Torres Strait Islander health assessments completed for Gold Coast Aboriginal and Torres Strait Islander people compared to national rate.
- Small number of Aboriginal and Torres Strait Islander health workers.
- Low rate of cancer screening among Aboriginal and Torres Strait Islander people.
- Service gaps in care coordination between health services, child safety and other services / supports / family.

Key findings

- The proportion of Aboriginal and Torres Strait Islander people is lower in the Gold Coast Primary Health Network (GCPHN) region (2.2%), than across the whole Australia (3.2%).
- Health outcomes for Aboriginal and Torres Strait Islander people across Queensland and Australia are generally poorer when compared to the non-Indigenous population, particularly for chronic conditions. Nearly one in five (18%) Indigenous adults had indicators of chronic kidney disease, which is 2.1 times as likely as for non-Indigenous adults.
- On the Gold Coast, maternal and child health outcomes for Aboriginal and Torres Strait Islander people are generally more positive than in other regions but still lower than for non-Indigenous outcomes.
- Indigenous mothers were less likely to have five or more antenatal visits than non-Indigenous mothers (83% and 95%). Tobacco smoking while pregnant is considered a leading preventable risk factor for adverse birth outcomes including low birthweight. Indigenous mothers were 4 times as likely as non-Indigenous mothers to have smoked during pregnancy.
- While the GCPHN region has some services targeted to Aboriginal and Torres Strait Islander people, including one Aboriginal Medical Service with three clinics, there are issues with accessibility, cultural competency, transport and cost, awareness, and appropriateness of services, particularly for mental health services.

Gold Coast Aboriginal and/or Torres Strait Islander population

Based on figures from the 2021 Census, there were 13,901 Aboriginal and Torres Strait Islander people living within the GCPHN region and 812,728 Nationally, with GCPHN having a lower percentage of Aboriginal and/or Torres Strait Islander peoples (2.2%) than nationally (3.2%). Local Aboriginal and Torres Strait Islander service providers report that the identified population are likely to be an underestimation.

Table 1 shows the GCPHN Statistical Area Level 3 (SA3) regions with the highest number of Aboriginal and Torres Strait Islander people include Ormeau-Oxenford, Nerang and Coolangatta.

Table 1. Aboriginal and Torres Strait Islanders population, Gold Coast SA3 region, 2021

	Aboriginal and/or Torres Strait Islander population	
	Number	% of Gold Coast Indigenous population
Queensland	237,303	
Gold Coast	13,901	5.9%
Broadbeach-Burleigh	1,013	7.3%
Coolangatta	1,429	10.3%
Gold Coast-North	1,292	9.3%
Gold Coast Hinterland	432	3.1%
Mudgeeraba-Tallebudgera	750	5.4%
Nerang	1,759	12.7%
Ormeau-Oxenford	4,359	31.4%
Robina	919	6.6%
Southport	1,419	10.2%
Surfers Paradise	528	3.8%

Source: AIHW analysis of MBS data and Australian Bureau of Statistics (ABS) population data. This data set is a component of the minimum data set.

50.8% of Aboriginal and Torres Strait Islander people living in the GCPHN region are females and 49.2% are males, which is similar for the overall regional population. However, there is a significant difference in the age profile. The median age for Aboriginal and Torres Strait people living on the Gold Coast is 24 years, whereas the median age for non-Indigenous people in the region is 39 years.

2021 Census data shows median weekly household income for Aboriginal and Torres Strait Islander people living in the GCPHN region was $1,834, which is higher than for Aboriginal and Torres Strait Islander people across Queensland and Australia. The median weekly rent was $450 and median monthly mortgage repayments were $2,001, which was comparable to all people living in the GCPHN region but higher than for the total Queensland and Australia.

Health status and outcomes

Since 2006, Aboriginal and Torres Strait Islander health Performance Framework (HPF) reports have provided information about Indigenous Australians health outcomes, key drivers of health and the performance of the health system. Key indicators extracted from the 2020 national report[1]:

Improving

- Cardiovascular disease
    - Age-standardised rate of deaths per 100,000 population decreased from 323 in 2006 to 229 in 2018.
- Education
    - Proportion of people aged 20–24 who had a year 12 or equivalent qualification increased from 45% in 2008 to 66% in 2018-19.
- Smoking
    - Those aged 15–17 reported that they had never smoked increased from 72% in 2008 to 75% in 2018-19.
- Health checks
    - The rate of Medicare health checks increased per 1,000 population from 68 in 2009-10 to 297 in 2018-19.

Not improving

- Cancer
    - Age-standardised rate of deaths per 100,000 population increased from 205 in 2006 to 235 in 2018.
- Out of home care
    - Rate of children in out of home care increased from 35 per 1,000 in 2009 to 54 per 1,000 in 2018.
    - Over representation of Aboriginal and Torres Strait children in the child protection system. Of kids in care, 97% have health issues.
- Imprisonment
    - Rate of adults increased from 1,337 per 100,000 in 2006 to 2,088 per 100,000 in 2019.
- Health service access
    - In 2018–19, 3 in 10 Aboriginal and/or Torres Strait Islander people who needed to go to a health provider did not go, which is the same proportion as in 2012–13.
    - Barriers included cost, and health services being unavailable, far away or with long waiting times.

Cancer

Cancer is currently the leading cause of death among Indigenous Australians. Between 2006 and 2018, the age-standardised death rate from cancer among Indigenous Australians increased from 205 to 235 per 100,000 people. During the same period, a decrease in the cancer death rate among non-Indigenous

[1] Australian Institute of Health and Welfare 2020. Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report. Cat. no. IHPF 2. Canberra: AIHW

Australians. Indigenous Australians have lower cancer screening rates and are more likely to be diagnosed with cancer at more advanced stages resulting in lower cancer survival rates.

National screening programs in Australia reduce the risk of death from breast, cervical and bowel cancer. Indigenous Australians have lower rates of participation in screening programs than non-Indigenous Australians for breast cancer (age-standardised) and bowel cancer, as seen in Table 2.

Table 2. Participation in cancer screening programs, national, 2017-18

	Indigenous population (%)	Non-Indigenous population (%)
Women aged 50–74 screened for breast cancer— age-standardised rate, 2017–2018	38	54
People aged 50–74 participating in National Bowel Screening Program, 2017	21	43
People aged 50–74 having follow up colonoscopy, where appropriate, 2017	51	67

Sources: HPF Table D3.04.9—AIHW analysis of BreastScreen Australia data; AIHW 2019e

In 2020, a reduction was seen in number of screening mammograms completed through BreastScreen Australia for people aged 50 to 74. Between January to September in 2018, there was 9,575 completed mammograms through BreastScreen Australia by Indigenous Australians aged 50 to 74, compared to 8,574 completed in 2020 in the same time frame, a decrease of 11%[2] .

Cardiovascular disease

Cardiovascular disease, also referred to as circulatory disease, includes conditions such as coronary heart disease and stroke. It is the second leading cause of death among Aboriginal and Torres Strait Islander people, accounting for 23% of deaths (3,300) in 2014–2018 (data from NSW, Qld, WA, SA and NT combined). For Indigenous adults aged 25–54, rates of self-reported cardiovascular disease are about double those of non-Indigenous adults in corresponding age groups in both non-remote and remote areas[3].

Analysing data extracted from Gold Coast PHN's PATCAT system which captures de-identified patient data submitted by registered general practices throughout the GCPHN region[4]. As of March 2022, of the 11,860 active Indigenous patients (three visits in the past two years) 11% (n=1,297) had a cardiovascular diagnosis. Table 3 highlights Indigenous and non- Indigenous population with coded cardiovascular diagnoses and management indicators.

[2] AIHW analysis of state and territory BreastScreen register data (as at November 2020).
[3] HPF Table D1.05.2—AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19 and National Health Survey 2017–18.
[4] Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

Table 3. Patients with cardiovascular disease, Indigenous and non-indigenous patients, Gold Coast, 2022

	Indigenous patients		Non-Indigenous Patients	
	Number	Percent	Number	Percent
Total population	11,860		529,509	
Patients with cardiovascular disease	1,297	10.9%	95,251	18.0%
Patients with cardiovascular disease and smoking status recorded	1,258	97.0%	92,586	97.2%
Patients with cardiovascular disease and blood pressure recorded	1,138	87.7%	86,092	90.4%
Patients with cardiovascular disease and LDL recorded	863	66.5%	74,287	78.0%
Patients with cardiovascular disease and a GPMP recorded in the last 12 months	649	50.0%	51,107	53.4%
Patients with cardiovascular disease and TCA recorded in the last 12 months	612	47.2%	47,836	50.2%

Source: PATCAT. Notes: Data is sourced from general practices excluding Kalwun.

Diabetes

Diabetes is a chronic condition marked by high levels of glucose in the blood. The main types of diabetes are Type 1, Type 2 and gestational. Type 2 diabetes is the most common form and is largely preventable by maintaining a healthy lifestyle.

- **Type 1 diabetes:** lifelong autoimmune disease that usually has onset in childhood or early adolescence. A person with type 1 diabetes requires daily insulin replacement to survive.
- **Type 2 diabetes:** The most common form of diabetes. It involves a genetic component but is largely preventable and is often associated with lifestyle factors including physical inactivity, poor diet, being overweight or obese, and tobacco smoking.
- **Gestational diabetes:** characterised by glucose intolerance of varying severity that develops or is first recognised during pregnancy, mostly in the second or third trimester. It usually resolves after the baby is born but can recur in later pregnancies and significantly increases the risk of developing type 2 diabetes in later life, both for the mother and the baby.

In 2018-19, the rate of Aboriginal and Torres Strait Islander adults reported having diabetes or high blood sugar levels was about 17 per 100 people, compared to [5] per 100 people for non-Indigenous Australians[6].

Data from PATCAT system which captures de-identified patient data submitted by registered general practices throughout the GCPHN region[7] show that in March 2022, of the 11,860 active Indigenous patients

[6] HPF Table D1.09.2—AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19 and ABS National Health Survey 2017–18.

[7] Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

(three visits in the past two years), 4.7% (n=560) had a diabetes diagnosis. Table 4 highlights Indigenous and non-Indigenous population with diabetes diagnoses and management indicators.

Table 4. Patients with diabetes diagnoses, Indigenous and non-indigenous patients, Gold Coast, 2022

	Indigenous patients		Non-Indigenous patients	
	Number	Percent	Number	Percent
Total population	11,860		529,509	
Patients with a diabetes diagnosis	560	4.7%	26,939	5.1%
Patients with diabetes type 1	66	11.8%	2,596	9.6%
Patients with diabetes type 1 who had a HbA1C result recorded in the last 12 months	34	51.5%	1,925	74.2%
Patients with coded diabetes type 2	396	70.7%	20,565	76.3%
Patients with diabetes type 2 who had a HbA1C result recorded in the last 12 months	310	78.3%	18,053	87.8%
Patients with coded gestational diabetes	86	15.4%	3,885	14.4%
Patients with diabetes and a GPMP recorded in the last 12 months	304	54.3%	18,271	7.8%
Patients with diabetes and TCA recorded in the last 12 months	299	53.4%	17,640	65.5%
Patients with diabetes prescribed oral or injectable antidiabetic medication	437	78.0%	14,008	52.0%

Source: PATCAT. Notes: Data is sourced from general practices excluding Kalwun.

Chronic obstructive pulmonary disease (COPD)

Chronic obstructive pulmonary disease is a preventable and treatable lung disease characterised by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. GPs are often the first point of contact for people who develop COPD. According to Bettering the Evaluation and Care of health (BEACH) survey, in the ten-year period from 2006–07 to 2015–16, the estimated rate of COPD management in general practice was around 0.9 per 100 encounters[8].

Data from Gold Coast PHN's PATCAT system which captures de-identified patient data submitted by registered general practices throughout the GCPHN region[9] show that in March 2022, of the 11,860 active Indigenous patients (three visits in the past two years), 2.0% (n=245) had a coded chronic obstructive pulmonary disease diagnosis. Table 5 highlights active Indigenous and non-Indigenous population with chronic obstructive pulmonary diagnoses and management indicators.

Table 5. Patients with obstructive pulmonary disease diagnoses, Indigenous and non-indigenous patients, Gold Coast, March 2022

	Indigenous patients	Non-Indigenous patients

[8] Britt H, Miller GC, Bayram C, Henderson J, Valenti L, Harrison C et al. 2016. A decade of Australian general practice activity 2006–07 to 2015–16. General practice series no. 41. Sydney: Sydney University Press

[9] Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

	Number	Percent	Number	Percent
Total population	11,860		529,509	
Patients with coded chronic obstructive pulmonary disease diagnosis	245	2.1%	12,519	2.4%
Patients with COPD and smoking status recorded	242	98.8%	12,307	98.3%
Patients with COPD and a GPMP recorded in the last 12 months	134	54.7%	7,857	62.8%
Patients with COPD and TCA recorded in the last 12 months	126	51.4%	7,452	59.5%

Source: PATCAT. Notes: Data is sourced from general practices excluding Kalwun.

Maternal and child health outcomes

The proportion of babies born at low birth weight (i.e., less than 2500 grams) to Aboriginal and/or Torres Strait Islander mothers in the GCPHN region in 2018 was 10.4% (total of 14 births were underweight of the 135 total births), which was below the Queensland rate of 12.2%.

The proportion of babies born at low birth weight for non-Indigenous people across the GCPHN region during the same period was 6.0% (total of 396 births of the 6,585 total births). However, the low number of Aboriginal and Torres Strait Islander children born in the GCPHN region is likely to affect the reliability of the data.

A total of 23 (17%) Aboriginal and Torres Strait Islander women from the GCPHN region who gave birth in 2017 reported smoking during pregnancy. This was the lowest rate amongst Queensland Hospital and Health Service (HHS) regions but still significantly higher than for the non-Indigenous Gold Coast population at 4%.

Immunisation

Table 6 shows that immunisation rates for Aboriginal and Torres Strait Islander children in 2020 were slightly higher than for non-Indigenous children at 2 year and 5 years and are slightly lower at 1 years.

Table 6. Immunisation rates for Aboriginal and Torres Strait Islander children and all children, Gold Coast, 2021

Age group	Aboriginal and Torres Strait Islander children (%)	All children (%)
1 year	91.5%	92.6%
2 years	91.6%	89.9%
5 years	95.8%	92.5%

Source: Australian Institute of Health and Welfare analysis of Department of Human Services, Australian Immunisation Register statistics March 2020

Chronic disease risk factors

The National Aboriginal and Torres Strait Islander Social Survey, conducted by the Australian Bureau of Statistics every 6-8 years, provides data for a range health and wellbeing items for Aboriginal and Torres Strait Islander persons aged 15 years and over across Queensland. Findings from the 2014-15 survey include:

- 64.3% of Aboriginal and Torres Strait Islander people in Queensland had a long-term health condition, including 28% with a mental health condition,

- 38.1% were a current daily smoker,
- 49.9% had inadequate daily fruit consumption, and 95.4% had inadequate daily vegetable consumption,
- 29% had used substances in the last 12 months,
- 33% had exceeded the guidelines for alcohol consumption for single occasion, while 15.2% had exceeded guidelines for lifetime risk.

Mortality

The GCPHN region recorded the 5th lowest rate of all-cause mortality for Aboriginal and Torres Strait Islander persons of the 16 Queensland HHS regions between 2009-2013, with a total of 95 deaths during this period (rate of 697 deaths per 100,000 persons).

Data is not available at a regional level for cause of death, but across Queensland the leading cause of death during this period was cardiovascular disease (25%), followed by 'other' causes (24%) and cancers (21%). Aboriginal and Torres Strait Islander people in the GCPHN region have higher rates of premature death than non-Indigenous Australians.

Life expectancy

Life expectancy and deaths are widely used as indicators of population health. Although Australia's national life expectancy is high compared with that of other countries, there are significant disparities between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians.

Table 7 shows the median age at death over the period 2013 to 2017 for males and females by Indigenous status on the Gold Coast. This rate has remained stable among non-indigenous people but increased among Aboriginal and Torres Strait Islander people.

Table 7. Median age at death by Indigenous status, by sex, Gold Coast, 2013-2017

	Male	Female	All persons
Aboriginal and Torres Strait Islander	60	72.5	66.5
Non-Indigenous	78	84	81

Source: Data compiled by PHIDU, Torrens University from deaths data based on the 2013 to 2017 Cause of Death Unit Record Files.

Utilisation of health services

Inpatient admissions

Table 8 shows the number of inpatient admissions to Gold Coast public hospital, separated by patients' Indigenous status. In 2019-20, there were 5,505 inpatients at Gold Coast University and Robina Hospital that identified as Aboriginal and/or Torres Start Islanders.

Table 8. Number of hospital admissions to Gold Coast University and Robina Hospital, by Indigenous status, 2014-15 to 2019-20

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Aboriginal and/or Torres Strait Islander	2,894	3,854	3,880	4,171	4,849	5,505
Non-Indigenous	135,648	148,623	156,766	167,535	179,345	179,497
Not stated/unknown	918	552	502	529	608	591

Source: Gold Coast Hospital and Health Service, Inpatient Admissions Data. This data set is a component of the minimum data set.

Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPH) are a proxy measure of primary care effectiveness. PPH are certain hospital admissions that potentially could have been prevented by timely and adequate healthcare in the community. The term PPH does not mean that a patient admitted for that condition did not need to be hospitalised at the time of admission. Rather, the hospitalisation could have potentially been prevented through the provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings.

Admissions for potentially preventable conditions for Aboriginal persons in GCPHN region from 2014-15 to 2016-17 was below the national and Queensland rate across the three broad categories: chronic, acute and vaccine preventable conditions (Table 9).

Table 9. Admissions for potentially preventable conditions per 100,000 people, Aboriginal persons, 2014-15 to 2016-17

	Potentially preventable conditions - total	Vaccine-preventable conditions	Acute conditions	Chronic conditions
National	5,010	609	2,474	1,928
Queensland	5,152	471	2,684	1,993
Gold Coast	2,816	126	1,586	1,147

Source: National Hospital Morbidity Database via Public Health Information Development Unit. This data set is a component of the minimum data set.

Between July 2018 and June 2019, there were a total of 440 PPH for Aboriginal and Torres Strait Islander people in the GCPHN region, which represented 8.9% PPH of all admitted patient separations. This rate was slightly above the Gold Coast non-Indigenous rate of 22,915 PPH or 7% of all admitted patient separations.

The five leading categories for avoidable admissions amongst Aboriginal and Torres Strait Islander people during this period were:

- Diabetes complications: 55 admissions
- Convulsions and epilepsy: 48 admissions
- Urinary tract infections: 45 admissions
- Iron deficiency anemia: 42 admissions
- Cellulitis: 40 admissions

The above conditions were also among the leading PPH for non-Indigenous Gold Coast residents, except for convulsions and epilepsy which was the ninth leading reason for PPH.

Medicare Benefits Schedule

Aboriginal and Torres Strait Islander people can receive an annual health check, designed specifically for Indigenous Australians and funded through Medicare. The Indigenous-specific health check was introduced in recognition that Indigenous Australians, as a group, experience some specific health risks.

The aim of the Indigenous-specific health check is to encourage early detection and treatment of common conditions that cause ill health and early death. Table 10 provides a breakdown of the delivery of Aboriginal and Torres Strait Islander health checks across the sub-regions of the Gold Coast. GCPHN region has a lower rate of Indigenous health assessments completed in 2020-21, compared to both the national and Queensland rate.

Table 10. Indigenous-specific health checks, Gold Coast SA3 regions, 2020-21

Region	Indigenous-specific health	
	Number of patients	% of Indigenous regional population
National	236,610	27.2%
Queensland	82,324	33.7%
Gold Coast SA4	3,029	22.8%
Broadbeach - Burleigh	173	18.3%
Coolangatta	345	21.3%
Gold Coast - North	351	24.4%
Gold Coast Hinterland	85	20.0%
Mudgeeraba - Tallebudgera	132	19.2%
Nerang	376	22.8%
Ormeau - Oxenford	940	25.1%
Robina	178	20.9%
Southport	344	23.9%
Surfers Paradise	105	20.1%

Source: AIHW analysis of MBS data 'Indigenous-specific health checks include Medicare Benefits Schedule (MBS) items: 715, 228 (face-to-face) and 92004, 92011, 92016, 92023 (telehealth). This data set is a component of the minimum data set.

Indigenous health assessments are important for early detection of health concerns, however, improving health outcomes also requires appropriate follow-up of any issues identified during a health check[10]. Based on needs identified during a health check, Aboriginal and Torres Strait Islander people can access Indigenous-specific follow up services from allied health workers, general practice nurses or Aboriginal and Torres Strait Islander health practitioners (MBS items 10987, 81300-81360)

Indigenous Australians may also receive follow up care through other MBS items that are also available to non-Indigenous patients. As can be seen below, the rate of Indigenous-specific health check patients who received a follow-up service in the 12 months following their health check on the Gold Coast was above both the national rate and Queensland rate.

[10] Bailie J, Schierhout GH, Kelaher MA, Laycock AF, Percival NA, O'Donoghue LR et al. 2014, 2014. Follow-up of Indigenous-specific health assessments—a socioecological analysis. Medical Journal of Australia 200: 653–657.

Table 11. Indigenous-specific health check patients who received a follow-up service within 12 months of the assessment, Gold Coast SA3 regions, 2019-20

Region	Patients who received an Indigenous-specific health check	Patients who received an Indigenous-specific health check and an Indigenous-specific follow-up in the following 12 months	
		Number	%
National	238,837	111,503	46.7%
Queensland	84,003	44,767	53.3%
Gold Coast SA4	3,334	1,783	53.5%
Broadbeach - Burleigh	225	118	52.4%
Coolangatta	451	282	62.5%
Gold Coast - North	354	165	46.6%
Gold Coast Hinterland	85	39	45.9%
Mudgeeraba - Tallebudgera	157	89	56.7%
Nerang	395	212	53.7%
Ormeau - Oxenford	986	539	54.7%
Robina	189	106	56.1%
Southport	382	173	45.3%
Surfers Paradise	111	59	53.2%

Source: AIHW analysis of MBS data. NOTE: Indigenous-specific health check has MBS item 715.

Aboriginal and Torres Strait Islander Health Workforce

Appropriate, culturally safe accessible services are an essential component of healthcare for Aboriginals and Torres Strait Islander Australians[11]. Indigenous Australians are significantly under-represented in the health workforce, which may inhibit service accessibility.

The Indigenous workforce is essential to ensuring that the health system can address the needs of Indigenous Australians. Indigenous health professionals can align their unique clinical and sociocultural skills to improve patient care, improve access to services and ensure culturally appropriate care in the services that they and their non-Indigenous colleagues deliver.

Health workforce data from 2018 identified that of the 807 active GPs on the Gold Coast, 11 (1.4%) identified as Aboriginal and/or Torres Strait Islander, and 0.6% of specialists identified as Aboriginal and/or Torres Strait Islander. These data are largely consistent with the national figures; rate of GPs who identified as Aboriginal and/or Torres Strait Islander was 16 per 100,000 people, compared to 113 per 100,000 people among non-Indigenous Australians in 2018.

[11] Department of Health 2013. National Aboriginal and Torres Strait Islander Health Plan 2013–2023. Canberra: Department of Health

Table 12. Aboriginal and Torres Strait Islander people in the health workforce, Gold Coast, 2018

	GPs	Specialists
Total	807	904
Aboriginal and/or Torres Strait Islander	11	5
Rate of Indigenous workforce	1.4%	0.6%

Source: Health Workforce Data, Department of Health, 2018

Service system

Services	Number in the GCPHN region	Distribution	Capacity Discussion
General practices	212	Clinics are generally well spread across Gold Coast; majority in coastal and central areas.	• Health Workforce data suggests around 1% of GPs on the Gold Coast identify as Aboriginal and Torres Strait Islander. • There are some Indigenous GPs on the GC who do not openly identify due to their own professional, cultural and privacy preferences.
Kalwun Development Corporation including the Kalwun Health Service	1	3 Aboriginal Medical Service locations (Bilinga, Miami, Oxenford) 1 community care service for frail aged or disability (Bonogin) 1 dental and allied health (Miami) 2 family wellbeing service (Burleigh and Coomera)	• Kalwun run 3 Medical clinics GP clinics offering a comprehensive suite of services. • Locations offer reasonable accessibility and there are a range of comprehensive services at each site. • While services target Aboriginal and Torres Strait Islander patients, most services are open to all patients. • Transport assistance provided to patients who need it. • Kalwun also provide support and programs for Indigenous people with chronic conditions.
Krurungal; Aboriginal & Torres Strait Islander Corporation for Welfare, Housing & Resource	1	1 located at Coolangatta Airport, Bilinga	• Krurungal are GCPHN funded for the Community Pathway Connector program. A non-clinical service aimed at connecting people to appropriate health and support services. • Transport assistance is provided, where required by people accessing services. • Emergency Relief program. • Children and Schooling Program (CASP • Cultural Awareness Training.

Mungulli Wellness Clinic, Gold Coast Health	1	Helensvale and Robina Outreach clinics also available	• Adults who identify as either an Aboriginal or Torres Strait Islander person are eligible. • A culturally safe chronic disease management program for people with complex needs relating to respiratory, kidney disease, heart failure or diabetes. Aboriginal and Torres Strait Islander Health Worker is the first point of contact for clients. • Demand remains stable—GPs are referring clients into programs.
Aboriginal Health Service, Gold Coast Health	1	Gold Coast University Hospital (Southport) and Robina Hospital	• Provides service navigation support to Indigenous patients. • Access to mainstream primary health services is supported through two Closing the Gap staff members. • This service is a member of the Karulbo Aboriginal and Torres Strait Islander Health Partnership.
Aboriginal Health Service, Gold Coast Health	1	Gold Coast University Hospital (Southport) and Robina Hospital	• Provides service navigation support to Indigenous patients. • Access to mainstream primary health services is supported through two Closing the Gap staff members. • This service is a member of the Karulbo Aboriginal and Torres Strait Islander Health Partnership.
Yan-Coorara, Gold Coast Health	1	Palm Beach	• Program aimed to support social and emotional health.
COACH Indigenous-specific stream, Queensland Health	State-wide	Phone service	• Free phone coaching service is available to support Indigenous people with chronic disease self-management.

			• Very low awareness of Indigenous specific stream of COACH. • Limited information on how service differs from mainstream COACH. • Very low referrals to COACH program in general, unsure if any indigenous referrals.
Kirrawe Indigenous Mentoring Service	1	Labrador	• Formal mentoring program. • Aims to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander young people. • Provides individual support, advice and guidance and help in practical ways at important transition points in their life.
Institute for Urban Indigenous Health	1	Staff based in each Kalwun clinic at Bilinga, Miami and Oxenford	• GCPHN funded care coordination services for Aboriginal and Torres Strait Islander patients with chronic disease. • Numbers of patients involved have been steadily increasing.

Consultation

Karulbo Aboriginal and Torres Strait Islander Partnership Council (September 2017)

- Potential service gaps in coordination of medication across Gold Coast Health and primary care support for transition to NDIS, services for young people transitioning out of Department of Child Safety care.
- Most commonly identified issues affecting access to mainstream services included transport, cultural competency, and cost.
- Most commonly identified issues affecting access to indigenous specific services included transport and cost.
- Coordination of holistic care was very important with information sharing and collaboration being seen as key elements to support this.
- Barriers to coordinated care include limited knowledge of roles and responsibilities, funding and red tape, lack of culturally specific roles in programs such as PIR, transport, limited outside of work hours service and limited access to specialists.
- There was strong belief that Gold Coast Aboriginal and Torres Strait Islander community are more likely to access services if they are provided by an Aboriginal and Torres Strait Islander health professional.
- Cultural competence for mainstream service providers was seen by all as very important and this was across all areas of healthcare.

GCPHN Community Advisory Council (CAC) (February 2017)

- Marginalised groups such as Aboriginal and Torres Strait Islander people “continually seem to fall through the cracks”.
- The CAC recommended a focus on health inequality, respectful and appropriate care, inclusion, and the impact of stigma.

Consultation and feedback from stakeholders throughout 2020-21

- The most identified issue affecting access to Indigenous specific services is transport.
- Housing issues, rental arrears, and lack of funds for food are ongoing system issues that are difficult to overcome.
- There is a demand for more Aboriginal and Torres Strait Islander workers, particularly male workers for both mental health and alcohol and other drugs.
- Indigenous Health checks may not align to the national guide to preventive Aboriginal and/or Torres Strait Islander health.
- Service users have indicated limited after-hours services at the three Kalwun medical services. It is difficult to get consultation for a child outside of school hours.
- Mainstream services lack confidence delivering culturally competent Aboriginal and Torres Strait Islander services.

Social & emotional wellbeing for Aboriginal and Torres Strait Islander people

Health needs and service issues

- Limited Aboriginal and Torres Strait Islander health workers.
- Mental health, suicide prevention, alcohol and other drugs services continue to actively work towards reconciliation and improving health equity and cultural needs in mainstream service providers.
- Access and awareness of appropriate services is limited.
- Uncoordinated and inconsistent approach to assessment, referrals, and intake.
- System navigation is difficult for General Practitioners (GPs) and the broader community.
- Low uptake to Aboriginal and Torres Strait Islander Social and Emotional wellbeing services in the Psychological Services Program.
- Changes to the service system result in GPs being unclear about available services and the pathways to access these services.
- Low rate of Aboriginal and Torres Strait Islander people with a mental health diagnosis in Gold Coast mainstream general practices.

Key findings

- National data indicates the Aboriginal and Torres Strait Islander community is particularly vulnerable.
- Indigenous patients on the Gold Coast have a lower prevalence of coded mental health diagnoses compare to non-Indigenous in Gold Coast general practices (excluding Kalwun).
- Indigenous patients with a coded mental health diagnoses had a slightly higher rate compared to non-Indigenous for people who had claimed a mental health treatment plan in the last 12 months (Excluding Kalwun).
- Gold Coast has a relatively small Aboriginal and Torres Strait Islander population with higher density in Coolangatta, Nerang, Ormeau-Oxenford, and Southport.
- There are limited Aboriginal and Torres Strait Islander specific mental health services and workers, and cultural needs are not well met by mainstream service providers.
- There can be stigma associated with Aboriginal and Torres Strait Islander people seeking treatment, and for men there can be “shame” associated with accessing services.
- High rate of emergency department presentations for mental health for Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander people require access to services that are joined up, integrated, culturally appropriate, and safe, and designed to holistically meet their social and emotional wellbeing needs of the community. These needs and responses must be culturally informed, and community led, including healing initiatives to more sustainably address the ongoing effects of colonisation and forced removal policies. Services need to complement and link with other closely connected activities, such as social and emotional wellbeing services, mental health services, suicide prevention approaches and alcohol and other drug services. Culturally appropriate health service providers facilitate more effective mental health service delivery and improved mental health outcomes for Aboriginal and Torres Strait Islander people. This requires cultural awareness, cultural respect, cultural safety, an understanding of the broader cultural determinants of health and wellbeing, including colonisation, stolen generations and racism that continue to impact on the lives of Aboriginal and Torres Strait Islander peoples.

While many service providers identify Aboriginal and Torres Strait Islander peoples as a target group within their broader programs, only Kalwun - Gold Coast Aboriginal Medical Service (Kalwun), Krurungal Aboriginal and Torres Strait Islander Corporation for Welfare, Resource and Housing (Krurungal), and the Aboriginal and Torres Strait Islander Health Service - Gold Coast Health, offers specific Aboriginal and Torres Strait Islander services. The Karulbo partnership brings together these three key partners to improve collaboration between services and provide a platform for community and other services to come together to collaboratively progress the health and wellbeing of the Aboriginal and Torres Strait Islander community.

Kalwun's Social Health Program offers comprehensive support for Aboriginal and Torres Strait Islander people who are struggling with their mental health or for those with alcohol and other drug needs. The program works within a social and emotional wellbeing framework and provides clinical and non-clinical treatment and a range of psychotherapeutic interventions.

Krurungal provides community-based support for Aboriginal and Torres Strait Islander people within the Gold Coast Primary Health Network (GCPHN) region. This culturally safe connection point and referral service supports individuals and families who are seeking support for a variety of needs, including mental health, suicide prevention, alcohol, and other drug concerns.

To help bridge the gap between mainstream mental health and drug and alcohol services, the Gold Coast Health's Aboriginal and Torres Strait Islander Health Service delivers a range of services to the Aboriginal and Torres Strait Islander community with the Yan-Coorara and Hospital Liaison Services providing advocacy and cultural support to assist the Aboriginal and Torres Strait Islander community to access services. This service within Gold Coast Health also provides cultural awareness training and has recently introduced the Courageous Conversations About Race Program to support and build cultural capability and provide tools to have conversations about race and racism.

Utilisation of health services

Based on figures from the 2021 Census, the estimated resident population was 13,901 Aboriginal and Torres Strait Islander people living within the GCPHN region, which represents approximately 2.2% of the total Gold Coast resident population. This is lower than the greater Queensland rate of 4.6%. Local Aboriginal and Torres Strait Islander service providers report that the identified population are likely to be an underestimation.

The Statistical Area Level 3 (SA3) regions with the highest numbers of Aboriginal and Torres Strait Islander residents on the Gold Coast were Ormeau-Oxenford (4,359 people), Nerang (1,759 people) and Coolangatta (1,429 people).

The 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey found than 9 out of 10 Aboriginal and Torres Strait Islander people felt happy some, most, or all the time. However, findings also indicated that around 30% of Aboriginal and Torres Strait Islander adults experienced high or very high levels of psychological distress in the 4 weeks before the survey; three times more likely to feel than non-Indigenous adults. Applying this figure to the Gold Coast Aboriginal and Torres Strait Islander population, an estimated 1,724 people regularly experience high levels of psychological distress.

Mental health ED presentations

In 2017-18, Aboriginal and Torres Islander people, who represent 3.3% of the Australian population[1], accounted for 6.7% of all ED presentations and 10.9% of mental health-related ED presentations. The rate of mental health-related ED presentations for Indigenous Australians was more than four times that for other Australians (455.9 and 106.8 per 10,000 population, respectively)[2].

In 2019-20, a total of 7,403 mental health-related ED presentations occurred at Gold Coast University Hospital and Robina Hospital. Of these, 375 (5%) were Aboriginal and Torres Strait Islander people.

Social and emotional wellbeing

An Australian Bureau of Statistics survey, which asked respondent if they had been diagnosed with a long-term mental health (for example depression and anxiety) and behavioural condition (for example alcohol and drug problems, attention deficit hyperactivity disorder), produced the following findings for the Indigenous Australian population in 2018-19[3]:

- An estimated 24% (187,500) reported a mental health or behavioural condition.
- Anxiety was the most reported metal health condition (17%), followed by depression (13%).
- The rate of Indigenous Australians reporting 'high or very high' levels of psychological distress was 2.3 times the rate for non-Indigenous Australians, based on age-standardised rates.

Data from GCPHN PATCAT system which captures de-identified patient data submitted by registered general practices throughout the GCPHN region[4] show than in March 20222, of the 11,3860 active Indigenous patients (three visits in the past two years), 27% (n=3,199) had a coded mental health diagnosis.

Table 1 highlights active Indigenous and non-Indigenous population with mental health diagnoses and management indicators.

[1] ABS (Australian Bureau of Statistics) 2018. Estimates of Aboriginal and Torres Strait Islander Australians, June 2016. Cat. No. 3238.0.55.001. Canberra: ABS

[2] Mental health services in Australia, Australian Institute of Health and Welfare, 2020

[3] ABS (Australian Bureau of Statistics) 2019. National Aboriginal and Torres Strait Islander Health Survey, 2018–19. ABS cat. no. 4715.0. Canberra: ABS.

[4] Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple general practices.

Table 1. Patients with mental health diagnoses, by Indigenous status, Gold Coast, 2021

	Indigenous patients		Non-Indigenous patients	
	Number	Percent	Number	Percent
Total active population	11,860		529,509	
Patients with a mental health diagnoses	3,199	27.0%	108,913	20.6%
Patients with a mental health diagnoses with current prescribed mental health medication	2,157	67.4%	70,462	64.7%
Patients with a mental health diagnoses and a mental health treatment plan (MHTP) in the last 12 months	1,657	51.8%	55,684	51.1%
Patients with a mental health diagnoses and a MHTP review in the last 12 months	605	18.9%	19,544	17.9%
Patients with a mental health diagnoses and a MHTP consult in the last 12 months	1,003	31.4%	33,018	30.3%

Source: PATCAT. Data is from all general practices excluding Kalwun.

Suicide

Suicide and self-harm behaviours arise from a complex web of personal, social, and historical factors[5]. Experiencing the sorrow and loss of family and community members in short succession can mean being in a constant state of grief and mourning[6].

The suicide rate in Queensland Aboriginal and Torres Strait Islander peoples is twice that of the non-Indigenous population, and suicide occurs at a much younger age. Intentional self-harm is the fifth highest cause of death for Indigenous people, with males representing the vast majority (83%) of suicide deaths[7].

Of the 757 suicides reported in 2019 in Queensland. Aboriginal and Torres Strait Islander females in Queensland accounted for 11.9% of all female suicides, and males accounted for 8.3% of all male suicides[8]. The age group of 20-24 had the highest number of suicides by Aboriginal and Torres Strait Islander Queenslanders.

Gold Coast recorded the third lowest number of suicides by Aboriginal or Torres Strait Islander people in Queensland for the 2019-21 period. True suicide mortality figures in Aboriginal and Torres Strait Islander populations remain poorly understood due to incomplete data collection processes and inaccurate classification systems[9].

[5] Dudgeon P, Calma T & Holland C 2017. The context and causes of the suicide of Indigenous people in Australia. Journal of Indigenous Wellbeing 2(2):5–15

[6] Silburn S, Robinson G, Leckning B, Henry D, Cox A & Kickett D 2014. Preventing suicide among aboriginal Australians. In: Dudgeon P, Milroy H & Walker R (eds). Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. 2nd edn. Canberra: Australian Government, pp. 147-64

[7] Australian Bureau of Statistics (2018). Catalogue 3303.0—Causes of Death. Canberra. Australia.

[8] Leske, S., Adam, G., Schrader, l., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith

[9] S Leske, G Adam, A Catakovic, B Weir and K Kõlves, Suicide in Queensland: Annual Report 2022, Australian Institute for Suicide Research and Prevention, World Health Organization Collaborating Centre for Research and Training in Suicide Prevention, School of Applied Psychology, Griffith University, Brisbane, Queensland, Australia, 2022

Psychological Services Program

The Psychological Services Program (PSP) provides short term psychological interventions for financially disadvantaged people with non-crisis, non-chronic, moderate mental health conditions or for people who have attempted, or at risk of suicide or self-harm. This program targets seven underserviced priority groups including children, people at risk of homelessness and suicide prevention. From the 1st of July 2021 to 30th June 2022, PS had:

- 1,620 referrals
- 6,999 sessions delivered

Of those, 111 referrals were for occurred Aboriginal and Torres Strait Islander people, leading to 383 sessions.

Table 2. Number of persons accessing Psychological Services Program, Gold Coast, 2021-22

	Referrals (number)	% of referrals from each group	Sessions (number)	Sessions as % of referrals
Adult Suicide Prevention	1,056	65.2%	4,909	70.1%
Children	235	14.5%	849	12.1%
Aboriginal and Torres Strait Islander	111	6.9%	383	5.5%
Homeless	55	3.4%	197	2.8%
CALD	47	2.9%	248	3.5%
Perinatal	68	4.2%	215	3.1%
LGBTIQAP+	48	3.0%	197	2.8%
General (COVID19 Response)	0	0	1	0.01%
TOTAL	1,620		6,999	

Source: PIR-FIXUS This data set is a component of the minimum data set.

Aboriginal and Torres Strait Islander Health Workforce

Appropriate and culturally safe accessible services are an essential component of healthcare for Aboriginals and Torres Strait Islander Australians[10]. Indigenous Australians are significantly under-represented in the health workforce, which potentially contributes to reduced assess to care services for the broader Indigenous Australian population. The Indigenous workforce is essential to ensuring that the health system can address the needs of Indigenous Australians. Indigenous health professionals can align their unique technical and sociocultural skills to improve patient care, improve access to services and ensure culturally appropriate care in the services.

Health workforce data in 2018 found that on the Gold Coast, 1.4% (n=11) of GPs and 0.6% of specialists identified as Aboriginal and/or Torres Strait Islanders. These data are consistent with the national figures; in 2018, the age-standardised rate of GPs who identified as Aboriginal and/or Torres Strait was 16 per 100,000 people, compared to 113 per 100,000 people among non-Indigenous Australians.

[10] Department of Health 2013. National Aboriginal and Torres Strait Islander Health Plan 2013–2023. Canberra: Department of Health

Table 3. Aboriginal and Torres Strait Islander people in the workforce, Gold Coast, 2018

	GPs	Specialists
Total	807	904
Aboriginal and/or Torres Strait Islander	11	5
Rate of Indigenous workforce	1.4%	0.6%

Source: Health Workforce Data, Department of Health, 2018

Service system

Services	Number in GCPHN Region	Distribution	Capacity Discussion
Psychological Services Program (PSP), Aboriginal and Torres Strait Islander Social and Emotional Wellbeing service.	18 PSP providers	Providers are situated across the region	• There are limited mental health services on the Gold Coast that are specifically for Aboriginal and Torres Strait Islander people. • While many service providers identify Aboriginal and Torres Strait Islander people as a target group within their broader programs, only the Gold Coast Aboriginal Medical Service (AMS), Krurungal and Gold Coast Health offer specific Aboriginal and Torres Strait Islander services. • The Aboriginal and Torres Strait Islander Health service (Gold Coast Health) deliver one Indigenous specific mental health and AOD program providing supported access for Aboriginal and Torres Strait Islander people to mainstream mental health and AOD services. • Aboriginal Mental Health Navigator to be appointed by Gold Coast Health 2018. • The Community Pathway Connector program provides a culturally safe, flexible connection point for Aboriginal and Torres Strait Islander peoples to be supported through an assessment of needs, and warm facilitation of onward referrals through health services and other social determinants of health to support overall wellbeing. This service is limited in capacity.
e-mental health services	AIMhi Stay Strong App	Online Services. Public and health professional knowledge of these services would drive uptake/demand	
Gold Coast Health – 2 programs specifically for Aboriginal and Torres Strait Islander people (focus is on supporting access to mainstream services), also client liaison support outside of programs.	2 (Aboriginal and Torres Strait Islander Health & Yan-Coorara)	Palm Beach and outreach	
Gold Coast Aboriginal Medical Service - counselling, psychology, mental health nurse, case manager, suicide prevention worker, Alcohol and Other Drugs clinician and GPs	1	3 clinics, 1 in Bilinga, 1 in Miami and 1 in Oxenford	
Kalwun - Non-clinical care coordination for Alcohol and other Drugs issues.	1	3 Aboriginal Medical Service locations (Bilinga, Miami, Oxenford)	
GCPHN Funded Community Pathway Connector Program	1	GCPHN region	

Consultation

Various consultation activity was undertaken across the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one-to-one interviews, industry presentations, working groups and co-design processes.

Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services

- The link between racism and poor health outcomes is well established, and a high proportion on of Aboriginal and Torres Strait Islander peoples experience high levels of direct and indirect racism on a daily basis.
- Reconciliation on promotes unity and respect and helps to address racism and discrimination by starting conversations and strengthening relationships. While not explicitly focused on service delivery, Reconciliation is about changing attitudes, recognising a shared past, and creating a culturally safe environment.
- Through this collective action, we can address the broader determinants of health and improve social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander peoples.
- Holistic approaches with specific Aboriginal and Torres Strait Islander workers that support mainstream services has been identified as essential for the region to provide more equitable and effective service delivery and improved outcomes for Aboriginal and Torres Strait Islander people.
- Social and emotional wellbeing is an important foundation for Aboriginal and Torres Strait Islander peoples' health. However, many models of care, including Aboriginal and Torres Strait Islander health checks in primary care, do not include social and emotional wellbeing screenings.

Service provider consultation

The consultation with service providers identified that there is a clear need for capacity building to ensure cultural capability exists in all mental health services. Wrap around care and more formalised care coordination and case management as well as support worker options need to be available for Aboriginal and Torres Strait Islander service users. This best promotes client satisfaction and engagement in their care. A holistic approach, outreach models, specific Aboriginal and Torres Strait Islander workers that support mainstream services and establishing strong relationships between mainstream and Aboriginal and Torres Strait Islander services were identified as essential elements to ensure this client group benefit from effective and trusted referral pathways. The limited presence of Aboriginal and Torres Strait Islander workers in the region was a key point throughout the consultation. Particularly the need was identified for an Aboriginal and Torres Strait Islander workers that is skilled in providing suicide prevention.

Service user consultation

Service users stated that enhancing the Aboriginal and Torres Strait Islander workforce to enable workers to provide care coordination and specialist mental health services such as suicide support would be received positively. Accordingly, feedback also suggested that service user satisfaction could be improved through increasing the coordination of services by using established, well-developed, and trusted pathways to support client referrals into culturally appropriate services. Likewise, client satisfaction could also be improved by increasing the cultural competency of mainstream services to safely and effectively work with Aboriginal and Torres Strait Islander clients.

Due to unforeseen circumstances, capturing the graphically recorded consumer journey of an Aboriginal and Torres Strait Islander client was not possible. There is also limited data or input provided through direct

consultation with this group. However, feedback did identify that stigma and the "shame factor" can prevent people in this group seeking help. There are some groups on the Gold Coast that provide soft entry points for Aboriginal and Torres Strait Islander men, and it is reported that these are working effectively and have the potential to be expanded.

Consultation and feedback from stakeholders throughout 2020/21

- The most common issues affecting access to Indigenous specific services is transport, with secondary issues including access to brokerage funds to cover expenses such as go cards, phone credit and fuel.
- Housing issues, rental arrears, and lack of funds for food are ongoing system issues that are difficult to overcome. Increase in clients and families that are experiencing/are at risk of homelessness.
- There is a demand from community for more Aboriginal and Torres Strait Islander workers, particularly male workers for both mental health and alcohol and other drugs. There is a limited pool of workers and recruitment to new positions is challenging.
- Continued presentation of situations of a more complex nature to mental health services, requiring a longer and more coordinated response. Care coordination for this setting would enhance opportunity to engage in a multidisciplinary way and over a longer period.
- Increased need for MH, alcohol and other drugs and psychological services/workforce.
- Complexity of people and their situations continues to be an issue unmet on the Gold Coast - where specific skills and cultural safety are required.
- Service users have indicated limited after-hours services at the three Kalwun medical services. It is difficult to get consultation for a child outside of school hours.
- Mainstream services lack confidence delivering culturally competent Aboriginal and Torres Strait Islander services.

COVID-19 impacts

The Wesley Mission Queensland COVID-19 Recovery Service was established to provide responsive wellbeing support for people aged 16+ in the GCPHN region whose wellbeing has been impacted by the ongoing effects of COVID-19. Most common presentations to the service were due to:

- Loneliness and social isolation,
- Suicidal ideation,
- Problems with secure housing,
- Financial barrier's such as loss of employment/struggles to secure adequate ongoing employment,
- Overall anxiety and depressive presentations – low mood and lack of motivation,
- Struggles with accessing services such as Centrelink and NDIS,
- Loss of routine,
- Grief and loss,
- difficulties in accessing appropriate higher mental health services in a timely manner due to long waitlists.

In addition, very early on in the rollout of this service it became apparent that schools needed support as children's anxiety levels had increased; anecdotally home-schooling had a massive impact on some students finding it difficult to re-engage in face-to-face learning. Parents were also struggling with how to deal with the impact of COVID-19 on the mental health and wellbeing of their children.

Section 5 - Checklist

This self-assessment checklist can be used to confirm that the key elements of the NA process have been undertaken. PHNs must be prepared, if required by the Department, to provide further details regarding any of the requirements listed below. Refer to the PHN Needs Assessment Policy Guide and the PHN Needs Assessment Completion Guide for further information.

Requirement	✓
Provide a brief description of the PHN's Needs Assessment development process and the key issues discovered.	Y
Outline the process for utilising techniques for service mapping, triangulation and prioritisation.	Y
Provide specific details on stakeholder consultation processes.	Y
Provide an outline of the mechanisms used for evaluating the Needs Assessment process.	Y
Provide a summary of the PHN region's health needs.	Y
Provide a summary of the PHN region's service needs.	Y
Summarise the priorities arising from Needs Assessment analysis and opportunities for how they will be addressed.	Y
Appropriately cite all statistics and claims using the Australian Government Style Manual author-date system.	Y
Include a comprehensive reference list using the Australian Government Style Manual.	Y
Use terminology that is clearly defined and consistent with broader use.	Y
Ensure that development of the Needs Assessment aligns with information included in the PHN Needs Assessment Policy Guide.	Y

Appendix 4 - All 175 Health Needs and services issues identified through the needs assessment process

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
General Practice and Primary care	Care coordination. • Not all providers using secure messaging. • Clinical handover, particularly to general practice on discharge from hospitals.	*Population Health*	*Access*	• General practice is supported in the adoption of evidence based best practice methods and meaningful use of digital systems to inform quality improvement, promoting the uptake of practice accreditation and ensuring timely provision of information, resources and or education to support changes in programs and policy that impact on general practice. • General practice adoption of evidence based best practice methods to achieve high performing primary care in the Gold Coast. This aims to improve the quality of care through supporting continuous quality improvement methodologies and utilisation of health information management and other building blocks of high performing primary care to inform quality improvements in health care,	• GCPHN • Key stakeholders • Gold Coast general practices • Gold Coast Health
General Practice and Primary care	High number of people requiring chronic wound management services in general practice and Residential Aged Care Facilities.	*Population Health*	*Chronic conditions*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**

General Practice and Primary care	My Health Record not yet embedded in usual practice for all providers and practices unable to provide detailed support to consumers.	*Digital Health*	*System integration*	specifically, the collection and use of clinical data.
				• Clinical and social expected outcomes of secure exchange of clinical information through secure messaging
				  • Facilities access to clinical information to improve patient care
				  • Reduced time managing paper-based correspondence
				  • Improved communication between health care providers as part of an end-to-end clinical workflow
				  • Improved privacy and security of patient information
				• Achieving increased access to contemporary evidence-based resources and localised service and referral information
				• Increase direct links to local service provider information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways.
				• General Practices and Pharmacy ae equipped with PPE
				
				Create a single integrated healthcare system for the Gold Coast by:	

General Practice and Primary care	Difficult for general practices and pharmacies to adopt to digital health including: • New systems that need to be integrated in general practice systems and workflow • Initially low uptake of video conferencing under telehealth	*Digital Health*	*System integration*		
General Practice and Primary care	70% of Gold Coast PIP QI 10 improvement measures are below the national rate	*Population Health*	*Practice support*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
General Practice and Primary care	Gold Coast rate of potentially preventable hospitalisations above the national rate: Six highest number of PPHs on the Gold Coast are - Urinary tract infection, Iron deficiency anaemia, Dental conditions, Cellulitis and Ear, nose and throat infections.	*Population Health*	*Potentially preventable hospitalisations*	• Improving the coordination of care to ensure consumers receive the right care at the right place at the right time by the right person. • Increasing the effectiveness and efficiency of health services for consumers. • Engaging and supporting clinicians to facilitate improvements in our health system. Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms. • Identifying high risk groups for proactive care. • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time by the right person. • Providing clinical audit functions e.g., pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles.	
General Practice and Primary care	Low uptake of free translation services in by Gold Coast general practitioners, specialist, pharmacy, and nurse practitioners potentially limiting access and quality of care	*Population Health*	*Appropriate care (including cultural safety)*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
				• Primary Sense will also enhance the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time. • Contribute to prevention of increasing numbers of Emergency Department presentations • Reduce the burden in Emergency Departments by reducing the number of unnecessary or inappropriate presentations • Achieving increased access to contemporary evidence-based resources and localised service and referral information • Increase direct links to local service provider information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways.	

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Primary Health Care Workforce	Variability in formal education, practical experience, and resources in relation to alcohol and other drugs, mental health, and domestic violence limits capacity of GPs to identify issues and have conversations with patients.	*Health Workforce*	*Health literacy*	• Achieving increased access to contemporary evidence-based resources and localised service and referral information • Increase direct links to local service provider information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways.	• GCPHN
Primary Health Care Workforce	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Health Workforce*	*HealthPathways*		
Primary Health Care Workforce	High levels of burnout have negative impact on health professionals' wellbeing	*Health Workforce*	*Other*		
Primary Health Care Workforce	Service providers report that it is difficult to recruit and retain doctors willing to work in the after hours for the remuneration available, which impacts the ability to deliver services to meet demand levels.	*Health Workforce*	*Access*		
Primary Health Care Workforce	There is a projected shortfall in the GP workforce by 2030	*Health Workforce*	*Access*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Determinants of Health	Numerous SA3 regions on the Gold Coast have a high rate of need for assistance with a profound or severe disability compared to Queensland rate.	*Population Health*	*Social determinants*	• Increased uptake of Translating and Interpreting services in health settings on the Gold Coast	• GCPHN and key stakeholders
Determinants of Health	Language barrier for people accessing health services.	*Population Health*	*Social determinants*		
Determinants of Health	Limited of social housing on the Gold Coast.	*Population Health*	*Social determinants*		
Determinants of Health	Higher risk of poor wellbeing for children with no parents employed.	*Population Health*	*Social determinants*		
Older Adults	Rate of potentially preventable hospitalisations in the Gold Coast Primary Health Network (GCPHN) region is above the national rate for people aged 65 and over. Top conditions of PPH include: urinary tract infections, iron deficiency anaemia, dental conditions, cellulitis, ear, nose and throat infections.	*Population Health*	*Potentially preventable hospitalisations*	• Development of strong partnerships with community palliative care supports and services and GPs • Implementation and adoption of clinical guidelines and protocols focused on key best practices for generalist primary palliative care within RACFs • Engagement of RACF Staff in training to increase role appropriate competence in primary palliative care skills • Enhanced clinical competency of professionals within RACF in primary palliative care management • Increased awareness of palliative care clinical management and its integration into patient centred care	• GCPHN • Gold Coast Health • Gold Coast Residential Aged Care Facilities
Older Adults	Lack of confidence and skills to provide palliative care needs at resident's place of choice as per Advance Care Plan.	*Population Health*	*Palliative care / End of life care*		
Older Adults	Referral pathways, including available capacity (to prevent navigation to nowhere).	*Population Health*	*Access*		
Older Adults	High prevalence of older people with frailty leads to many complex medical problems and is associated with an increased rate of future falls.	*Aged Care*	*Aged care*		
Older Adults	Falls and wounds lead to increased Emergency Department (ED) presentations and hospitalisations.	*Aged Care*	*Aged care*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Older Adults	High estimated number of people in GCPHN region are socially isolated.	*Population Health*	*Social determinants*	• Decrease in avoidable admissions to Emergency Department • Increase in number of Advance Care Plans and upload to My Health Record.	
Older Adults	There are limited culturally appropriate services available for culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander people.	*Aged Care*	*Appropriate care (including cultural safety)*		
Older Adults	Transient workforce in the older people's sector does not necessarily have the skills to manage the high complexity and care needs of older adults.	*Health Workforce*	*Safety and quality of care*		
Older Adults	The rate of people aged 65 and over is projected to grow steadily over the coming decades with limited capacity to meet demand.	*Population Health*	*Other*		
Older Adults	Some acute but low urgency needs such as minor infections are reportedly being admitted to hospital via ambulance as RACFs and home-based carers who are not aware of pathways to treat within the community.	*Aged Care*	*HealthPathways*		
Older Adults (Age care services)	Long wait times for appropriate support and/or aged care services at home lead to a higher level of care provided by a RACF service providers.	*Aged Care*	*Aged care*		
Older Adults (Age care services)	Community services to support longer stays in community are not felt to be adequate and resulting in presentations to EDs as no other options exist or are known.	*Population Health*	*Other*		
Older Adults (Age care services)	RACFs on the Gold Coast do not have sufficient beds to meet permanent or respite care demands, which is resulting in unnecessary and lengthy hospital admissions when care needs cannot be met.	*Aged Care*	*Aged care*		
Older Adults (Age care services)	Residents in RACF are presenting to health services with increasing complexity of care including dementia.	*Aged Care*	*Aged care*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Older Adults (Age care services)	Aged care staff lack understating of the language of the aged care system (e.g., Centrelink, My Aged Care).	*Aged Care*	*Aged care*		
Older Adults (Age care services)	Aged care service often employs transient workforce that does not necessarily have the skills to manage the high complexity and care needs of older adults in RACF.	*Aged Care*	*Safety and quality of care*		
Older Adults (Age care services)	There is limited capacity to provide a coordinated and sustained coverage for palliative and end of life care within RACF.	*Aged Care*	*Palliative care / End of life care*		
Older Adults (Age care services)	Lack of role clarity and access to the relevant information to support early identification and management of palliative and end of life care in RACF.	*Aged Care*	*Palliative care / End of life care*		
Older Adults (Age care services)	There is a limited number of registered nurses working in aged care.	*Aged Care*	*Workforce*		
Older Adults (Age care services)	There is lack of a physical support to guide a person through the complex aged care system, and high dependency on a congested My Aged Care phone line.	*Aged Care*	*Aged care*		
Older Adults (Age care services)	RACF adoption of digital health: • clinical software is outdated • lack of access to and use of secure messaging to comply with Privacy Act when communicating with other healthcare providers for their residents • record keeping	*Aged Care*	*Aged care*		
Older Adults (Dementia)	Care needs for older persons are getting more complex, and rates of dementia are on the rise.	*Population Health*	*Aged care*		
Older Adults (Dementia)	Dementia care extends across a continuum from diagnosis through to palliative care, and includes prevention, primary care	*Population Health*	*Aged care*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
	and hospital care. Inexpert dementia care can cause unnecessary distress.				
Older Adults (Dementia)	Support for families and carers for people with dementia is needed.	*Aged Care*	*Aged care*		
Older Adults (Dementia)	Clinical coordination tools and processes that result in fragmentation of the local health system in patient centered care particularly for patients with dementia are needed.	*Aged Care*	*Care coordination*		
Older Adults (dementia)	There is currently limited understanding of the referral pathways, including available capacity (to prevent navigation to nowhere).	*Health Workforce*	*HealthPathways*		
Palliative Care	There is limited uptake of Advanced Care Plans (ACPs).	*Health Workforce*	*Palliative care / End of life care*	• Improved practical advice and support for families • Improved awareness by health, community and aged care providers regarding family access to bereavement support • Improved health, community and aged care provider understanding of end-of-life care, and appropriate referrals to specialist palliative care • The generalist healthcare workforce supported and mentored to increase capacity, knowledge and skills • Workforce better equipped to support an ageing population • Improved public understanding of end-of-life and palliative care uptake of ACP	• GCPHN • Gold Coast health • Gold Coast general practices • Kalwun Health Services • Cura Multicultural
Palliative Care	Limited systems to support care coordination and support to general practice to be the centre of care where possible	*Health Workforce*	*Practice support*		
Palliative Care	Current systems not always supportive to ensure planning, commissioning, and delivery of integrated and coordinated service matrix.	*Health Workforce*	*System integration*		
Palliative Care	Limited access to integrated palliative care system across the health and social sector.	*Population Health*	*Access*		
Palliative Care	Limited access to good quality end of life care 24/7.	*Population Health*	*Palliative care / End of life care*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Palliative Care	General practitioners understanding of the clinical triggers for commencing palliative care.	*Health Workforce*	*Palliative care / End of life care*		
Palliative Care	Limited access to clear communication, and accessible information for patients, families, and healthcare professionals.	*Population Health*	*Palliative care / End of life care*		
Palliative Care	General practitioners understanding of the clinical triggers for commencing palliative care can vary.	*Health Workforce*	*Health literacy*		
Palliative Care	Over half of GPs on the Gold Coast were trained overseas which may affect their understanding of palliative care services.	*Aged Care*	*Health literacy*		
After Hours	There is decreasing availability of face-to-face primary care options in after hours, which impacts older people, palliative patients and vulnerable people who find it difficult to travel.	*Population Health*	*After hours*	Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms. • Identifying high risk groups for proactive care. • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time by the right person. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk	• GCPHN with partners • Gold Coast Health • Contractors
After Hours	Highest demand for services is 6pm to 8pm.	*Population Health*	*After hours*		
After Hours	Potential areas of higher geographic need for after hours primary care services are the southern (Coolangatta SA3) and less populated western areas (Mudgeeraba-Tallebudgera SA3), as well as the northern corridor (Ormeau- Oxenford SA3) due to sheer demand.	*Population Health*	*After hours*		
After Hours	Among the top reasons for non-urgent presentations (category 4 and 5) to Emergency Department (ED) in the after hours, most relate to injuries (ankle sprains, wounds, and injuries).	*Health Workforce*	*After hours*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
				stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. • Primary Sense will also enhance the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling, and tracking outcomes over time. • Direct links to local service providers information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways	
After Hours	There are difficulties in recruitment and retention of doctors to deliver primary care services in the after hours.	*Health Workforce*	*After hours*		• GCPHN • Gold Coast Health • Gold Coast general practices
After Hours	Flexible delivery of AODs services outside of usual business hours is a factor in successful completion of treatment.	*Population Health*	*After hours*		
After Hours	Access to support in the after hours for people with mental health concerns is particularly high in the northern corridor (Ormeau- Oxenford SA3).	*Population Health*	*After hours*		
After Hours	RACFs have experienced increasing wait times for after hours doctors and operational issues due to staffing issues.	*Population Health*	*After hours*		
Cancer	Participation in BreastScreen, Bowel and Cervical cancer screening below national rate. • Lower screening rates for breast, cervical and bowel cancer in 2020 due to COVID	*Population Health*	*Access*	• Increase in awareness and uptake of screening services for breast, bowel and cervical screening. • Increased skin cancer and prostate cancer checks.	• GCPHN • Gold Coast Health
Cancer	Participation in BreastScreen, bowel and cervical cancer screening is below national rate.	*Population Health*	*Early intervention and prevention*		
Cancer	Low participation in all cancer screening in Ormeau-Oxenford.	*Population Health*	*Early intervention and prevention*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Cancer	Rate of new cancers diagnosed annually in the Gold Coast region is above the national rate in 2013-2017.	*Population Health*	*Chronic conditions*		
Cancer	Breast cancer and colorectal cancer had the highest number of cases in the Gold Coast region between 2013-2017.	*Population Health*	*Chronic conditions*		
Cancer	Higher rates of melanoma across the Gold Coast region compared to national rates.	*Population Health*	*Chronic conditions*		
Cancer	General practice has limited view of screening data to support proactive steps with patients.	*Population Health*	*Chronic conditions*		
Cancer	Limited BreastScreen translated resources available for people from culturally and linguistically diverse backgrounds.	*Population Health*	*Health literacy*		
Cancer	Low community awareness of eligibility for cancer screening in the Gold Coast region, for men in particular.	*Population Health*	*Health literacy*		
Immunisation, communicable diseases and COVID 19	Gold Coast rate of children fully immunised for one, two, and five-year old's below the national rate.	*Population Health*	*Immunisation*	• Increase in awareness and uptake of vaccinations.	• GCPHN • Gold Coast health • Gold Coast general practices
Immunisation, communicable diseases and COVID 19	High number of children (aged 1, 2 and 5) not fully immunised in Ormeau-Oxenford SA3 region.	*Population Health*	*Immunisation*		
Immunisation, communicable diseases and COVID 19	Lower rates of HPV vaccination on Gold Coast compared to the national figure.	*Population Health*	*Immunisation*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Immunisation, communicable diseases and COVID 19	Vaccine potentially preventable hospitalisations on the Gold Coast have increased 322% between 2012-13 to 2017-18	*Population Health*	*Potentially preventable hospitalisations*		
Immunisation, communicable diseases and COVID 19	Ensuring accurate and timely Information to general practices in relation to COVID-19	*Health Workforce*	*Practice support*		
Immunisation, communicable diseases and COVID 19	Slow uptake of COVID-19 vaccination for RACF residents and staff				
Perinatal and early childhood	High rates for children who are developmentally vulnerable across two or more domains in the Ormeau-Oxenford and Gold Coast-north SA3 regions.	*Population Health*	*Vulnerable population (Non-First Nations specific)*	• Younger mothers can receive the right care in the right place at the right time by the right person	• GCPHN • Gold Coast Health • Key partners • Key stakeholders
Perinatal and early childhood	Younger Mothers (aged under 20) have higher rates of smoking while pregnant, low birthweight babies and are less likely to breastfeed compared to mothers aged 20 years old and over on the Gold Coast.	*Population Health*	*Social determinants*		
Perinatal and early childhood	Aboriginal and Torres Strait Islander women have higher rates of smoking while pregnant and low birthweight babies compared to non-Aboriginal and Torres Strait Islander women on the Gold Coast.	*Aboriginal and Torres Strait Islander Health*	*Social determinants*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Perinatal and early childhood	Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs. Addressing these issues is hampered by: • Long wait times for assessment and treatment in the public system. • Cost of private services. • Barriers sharing information and centralised depository from medical history that non-health professionals can contribute to. • Limited availability of low-cost assessments for diagnosis and NDIS applications.	*Mental Health*	*Access*		
Perinatal and early childhood	Increasing rate of women being diagnosed with perinatal depression.	*Mental Health*	*Early intervention and prevention*		
Persistent Pain	There are high rates of musculoskeletal conditions in Southport, Coolangatta, Ormeau-Oxenford, and Gold Coast-North.	*Population Health*	*Chronic conditions*	• Improved self-management of pain management	• Contractor
Persistent Pain	Pain management frequently focusses on medication.	*Population Health*	*Appropriate care (including cultural safety)*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Persistent Pain	High levels of opioid dispensing across region, particularly Southport.	*Alcohol and Other Drugs*	*Social determinants*		
Persistent Pain	Limited awareness and support for prevention and self-management on persistent pain.	*Population Health*	*Health literacy*		
Persistent Pain	Suboptimal focus on multidisciplinary and coordinated care.	*Health Workforce*	*Multi-disciplinary care*		
Persistent Pain	Concerns for potentially ineffective and unnecessary treatments for persistent pain.	*Population Health*	*Care coordination*		
Chronic Disease	Limited systems to support care coordination	*Digital Health*	*Care coordination*	Create a single integrated healthcare system for the Gold Coast by: • Improving the coordination of care to endure consumers receive the right care at the right place by the right person • Increasing effectiveness and efficiency of health services for consumers • Engaging and supporting clinicians to facilitate improvements in our health system. • Improvement in health outcomes in the community.	• GCPHN • Gold Coast health • Key stakeholders including RACGP
Chronic Disease	Minimal focus on prevention, early identification, and self-management.	*Population Health*	*Early intervention and prevention*		
Chronic Disease	High numbers of people with chronic disease in Ormeau-Oxenford and Gold Coast North SA3 regions.	*Population Health*	*Chronic conditions*		
Chronic Disease	Rate of potentially preventable hospitalisations in the Gold Coast Primary Health Network region is above the national rate, with top conditions being: o urinary tract infections o iron deficiency anaemia	*Population Health*	*Potentially preventable hospitalisations*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
	o chronic obstructive pulmonary disease cellulitis o vaccine preventable conditions			Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms. • Identifying high risk groups for proactive care. • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity, and polypharmacy profiles. • Primary Sense will also enhance the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	
Chronic Disease	Rates of people in the Gold Coast Primary Health Network region with chronic obstructive pulmonary disease and asthma are above the national rate.	*Population Health*	*Chronic conditions*		
Family and domestic violence	There is a lack of clear health pathways within primary care for domestic and family violence victims and perpetrators.	*Population Health*	*HealthPathways*	• Direct links to local service providers information in health topic areas and	• GCPHN

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Family and domestic violence	Some health professionals do not understand dynamics of domestic violence.	*Health Workforce*	*Health literacy*	information and resources published online to support appropriate, timely referrals and agreed service pathways	• Key partners • Gold Coast Health
Family and domestic violence	Family and domestic violence can have severe consequences on child development.	*Population Health*	*Early intervention and prevention*		
Family and domestic violence	People who experience domestic violence have higher rates of mental health issues.	*Mental Health*	*Social determinants*		
Family and domestic violence	Not many mental health clinicians have a high degree of understanding of domestic violence issues.	*Mental Health*	*Health literacy*		
People at risk of developing mild and moderate mental illness	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Health Workforce*	*HealthPathways*	• Improve targeting of evidence based psychological interventions and models of service to most appropriately support people with, or at risk of, mild mental illness. • Enhance the capacity and effectiveness of the funded organisations, General Practice, and the broader sector to meet the needs of their client group.	• GCPHN • Gold Cold Coast Health • Contracted providers • Gold Coast general practices
People at risk of developing mild and moderate mental illness	Limited promotion and support of low intensity services to general practice support	*Health Workforce*	*Health Pathways*		• GCPHN, • Cold Coast Health • Contracted providers • Gold Coast general practices

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
People at risk of developing mild and moderate mental illness	Limited use and accessibility of evidence based electronic (digital) mental health services.	*Digital Health*	*Access*		
People at risk of developing mild and moderate mental illness	System navigation is difficult for GP's and people	*Digital Health*	*System integration*		
People at risk of developing mild and moderate mental illness	Increasing demand for all mental health services	*Mental Health*	*Access*		• Contracted providers • Beyond blue • GCPHN
People at risk of developing mild and moderate mental illness	Timely access to services for people seeking mental health support	*Mental Health*	*Access*		
Severe and complex mental illness	Current electronic systems limit communication and shared care planning with consumers across the network or services	*Digital Health*	*System integration*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Severe and complex mental illness	System navigation is difficult for GP's and people	*Population Health*	*HealthPathways*		
Severe and complex mental illness	Some people may need ongoing support (e.g., when diagnosed with personality disorders) but do not meet the criteria for care coordination or supports designed for severe and complex mental illness.	*Mental Health*	*Continuity of care*		
Severe and complex mental illness	Many general practitioners feel they do not have the information and resources required to assist patients with severe and persistent mental illness.	*Mental Health*	*HealthPathways*		
Severe and complex mental illness	Evolving service system results in general practitioners being unclear about available services and the pathways to access these services.	*Mental Health*	*Access*		
Sever and complex mental illness	Increasing demand for all metal health services	*Mental Health*	*Access*		
Severe and complex mental illness	Timely access to services for people seeking mental health support.	*Mental Health*	*Access*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Child, youth and families mental health	Northern corridor increasing population of young people with limited early intervention and therapeutic services available locally.	*Population Health*	*Access*	• Increased access to care for young people (aged 12-18) who are at significant risk or have severe mental illness. Improved mental health for clients.	• Headspace • Contracted providers • GCPHN with potential providers
Child, youth and families mental health	Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs. Addressing these issues is hampered by: *Long wait times for assessment and treatment in the public system *Cost of private services *Barriers sharing information and centralised depository from medical history that non-health professionals can contribute to *Limited availability of low-cost assessments for diagnoses for NDIS applicants	*Mental Health*	*Appropriate care (including cultural safety)*		
Child, youth and families mental health	Multiple barriers for families and carers to support the health of young people including a consistent understanding of confidentiality and consent for sharing information.	*Population Health*	*Appropriate care (including cultural safety)*		
Child, youth and families mental health	Funded models often require the service to work with an individual client and do not have the capacity to work with the family unit.	*Health Workforce*	*Safety and quality of care*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Child, youth and families mental health	Evolving service system results in GPs being unclear about available services and the pathways to access these services	*Health Workforce*	*Appropriate care (including cultural safety)*		
Child, youth and families mental health	Limited services that provide support for young people with highly complex situations.	*Health Workforce*	*Continuity of care*		
Child, youth and families mental health	Increasing demand for all mental health services	*Health Workforce*	*Access*		
Child, youth and families mental health	System navigation is difficult for GP's and people	*Population Health*	*System integration*		
Child, youth and families mental health	Timely access to services for people seeking mental health support.	*Mental Health*	*Access*		
Adult mental health	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Mental Health*		* Increased access to care for adults (aged 19-64) who are at significant risk or have severe	• GCPHN contracted providers

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Adult mental health	People who may need ongoing support (e.g. personality disorders) but do not meet criteria for care coordination or supports designed for severe and complex mental illness.	*Mental Health*	*Continuity of care*	mental illness. Improved mental health for clients.	
Adult mental health	There are unmet psychosocial needs for people with severe mental illness who are not eligible for assistance through the NDIS, and who are not receiving psychosocial services through National Psychosocial Support Measure programs.	*Mental Health*	*Continuity of care*		
Adult mental health	System navigation is difficult for GP's and people	*Population Health*	*System integration*		
Adult mental health	People with an existing mental health concern through the perinatal stage.	*Mental Health*	*Social determinants*		
Adult mental health	Increasing demand for all mental health services	*Mental Health*	*Access*		
Adult mental health	Timely access to services for people seeking mental health support	*Mental Health*	*Access*		
Older people mental health	Mental health and aged care related issues (e.g., dementia) are often treated in isolation of each other or as separate disciplines.	*Mental Health*	*Aged care*	* Increased access to care for older people (aged 65+) who are at significant risk or have	• GCPHN contracted

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
				severe mental illness. Improved mental health for clients.	providers Gold Coast RACF
Older people mental health	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Mental Health*	*HealthPathways*		
Older people mental health	Limited access to assessment and treatment by public sector geriatricians to patients in the community.	*Health Workforce*	*Access*		
Older people mental health	Gaps in clinical resources, knowledge and supports in the community result in people referring to Older Person's Mental Health unit (tertiary service) as a default option or last resort.	*Mental Health*	*HealthPathways*		
Older people mental health	High levels of isolation and loneliness among older people on the Gold Coast	*Aged Care*	*Social determinants*		
Older people mental health	System navigation is difficult for GP's and people	*Population Health*	*HealthPathways*		
Older people mental health	Timely access to services for people seeking mental health support	*Mental Health*	*Access*		
Older people mental health	Increasing demand for all mental health services	*Mental Health*	*Access*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Mental health – underserviced	Limited data on underserviced groups for mental health services	*Population Health*	*Other*	• Psychological services are provided for each target group. • Improve targeting of evidence based psychological interventions and models of service to support people most appropriately with, or at risk of, mild and moderate mental illness.	• GCPHN contracted providers
Mental health – underserviced	Underserviced groups not feeling comfortable accessing mainstream services.	*Population Health*	*Appropriate care (including cultural safety)*		
Mental health – underserviced	Access and awareness of appropriate services limited for underserviced groups: • Psychosocial • Psychological • primary health • Mental health services for people within the mild to moderate range	*Population Health*	*Access*		
Mental health – underserviced	LGBTIQAP+ organisations are time limited and must facilitate communication with broader health services.	*Population Health*	*Other*		
Mental health – underserviced	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Population Health*	*HealthPathways*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Mental health – underserviced	Low uptake of free translation services in by Gold Coast general practitioners, specialist, pharmacy, and nurse practitioner.	*Population Health*	*Practice support*		
Aboriginal and Torres Strait Islander health	Cultural competency, transport and cost all affect access to services for Aboriginal and Torres Strait Islander people.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*	• Increased number of Aboriginal and Torres Strait Islander health assessments by culturally competent trained workforce; improved coordination of care, supporting mainstream service providers to provide culturally appropriate services. • Improve health equity for Aboriginal and Torres Strait Islander people through culturally appropriate mainstream primary care, provide assistance to Aboriginal and Torres Strait Islander People to obtain primary health care as required, and provide care coordination services to eligible people with chronic disease who require coordinated, multidisciplinary care. Improve service users' capacity to self-manage conditions/health.	• Kalwun with support from GCPHN • GCPHN in partnership with IUIH (Via Brisbane North PHN) and Kalwun Health Services and mainstream primary care services. • GCPHN
Aboriginal and Torres Strait Islander health	Limited services in northern Gold Coast for Aboriginal and Torres Strait Islander people	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Aboriginal and Torres Strait Islander health	Low proportions of chronic disease early identification and self-management.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Aboriginal and Torres Strait Islander health	There are some indication that maternal health may be an issue but there are very small numbers involved.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Aboriginal and Torres Strait Islander health	Low number of Aboriginal and Torres Strait Islander health assessments completed for Gold Coast Aboriginal and Torres Strait Islander people compared to national rate	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Aboriginal and Torres Strait Islander health	Small number of Aboriginal and Torres Strait Islander health workers	*Aboriginal and Torres Strait Islander Health*	*Workforce*	Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management system and applying evidenced based algorithms. • Identifying high risk groups for proactive care. • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time by the right person. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. • Primary Sense will also enhance the level and detail of service planning that PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	
Aboriginal and Torres Strait Islander health	Low rate of cancer screening among Aboriginal and Torres Strait Islander people.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Aboriginal and Torres Strait Islander health	Service gaps in care coordination between health services, child safety and other services / supports / family.	*Population Health*	*Care coordination*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Limited Aboriginal and Torres Strait Islander health workers.	*Aboriginal and Torres Strait Islander Health*	*Workforce*	• Facilitate local relationships and partner with mainstream and Aboriginal and Torres Strait Islander services for the delivery of primary care services. • Improve health equity for Aboriginal and Torres Strait Islander people by addressing access issues. • See cultural competency section above • Higher rates of successful engagement with Aboriginal and Torres Strait Islander clients and more effective treatment. • Increased capacity of local Aboriginal and Torres Strait Islander service providers.	• GCPHN in partnership with local service providers
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Mental health, suicide prevention, alcohol and other drugs services continue to actively work towards reconciliation and health equity, cultural needs improving in mainstream service providers.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Access and awareness of appropriate services limited.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	System navigation is difficult for GP's and broader community.	*Aboriginal and Torres Strait Islander Health*	*Care coordination*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Uncoordinated and inconsistent approach to assessment, referrals, and intake.	*Aboriginal and Torres Strait Islander Health*	*Care coordination*		
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Low uptake to Aboriginal and Torres Strait Islander Social and Emotional wellbeing service in Psychological Services Program.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Changes to the service system result in GPs being unclear about available services and the pathways to access these services.	*Aboriginal and Torres Strait Islander Health*	*Access*		
Social & emotional wellbeing for Aboriginal and	Low rate of Aboriginal and Torres Strait Islander people with a coded mental health diagnosis in Gold Coast mainstream general practices.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Torres Strait Islander people					
Crisis Support and Suicide Prevention	Suicidal people often visit primary care providers in the weeks or days before suicide but often their suicide risk is not identified	*Mental Health*	*Appropriate care (including cultural safety)*	• Improve targeting of evidence based psychological interventions and models of service to most appropriately support people at risk of suicide. • Commissioned providers will improve access to high-quality aftercare to support at risk individuals to stay safe; connect individuals to community-based services; connect individuals with support networks including families, friends and careers; and reduce distress and improve wellbeing. • The Joint Regional Plan has aligned future needs assessment and service planning while also identifying key pieces of work in the short term that developed new ways of working together to improve outcomes with existing resources. The Joint Regional	• GCPHN with contracted providers • Gold Coast Health • Beyond Blue
Crisis Support and Suicide Prevention	Limited supports are available for people in distress who end up in ED by default or on a mental health trajectory.	*Mental Health*	*Potentially preventable hospitalisations*		
Crisis Support and Suicide Prevention	Carers are at the frontline of suicide prevention and many sit daily with this risk and responsibility but may not having any training or skills to equip them for this.	*Mental Health*	*Appropriate care (including cultural safety)*		
Crisis Support and Suicide Prevention	When challenges occur during a crisis, it is often at the points of intersection between different sectors.	*Mental Health*	*System integration*		
Crisis Support and Suicide Prevention	Service providers do not always know what the best evidence-based treatments are for people experiencing suicidal thoughts and behaviours or how to access local services and supports.	*Mental Health*	*Access*		
Crisis Support and Suicide Prevention	Organisations can be very risk averse due to a culture of blame. People in suicidal crisis can be passed back and forth between organisations without receiving the care they need.	*Mental Health*	*Care coordination*		
Crisis Support and Suicide Prevention	Many mental health clinicians do not have specific training in suicide prevention or know what the best evidence based treatments are for people experiencing suicidal thoughts and behaviours.	*Mental Health*	*Appropriate care (including cultural safety)*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Crisis Support and Suicide Prevention	Many people in the community lack the confidence and skills to address people in suicidal distress or crisis.	*Mental Health*	*Other*	Plan aims to lay the groundwork for collaborative action by: • Developing a better shared understanding of current service system • Identifying specific opportunities for the future service system • Establishing joint governance structures to leverage in the future	
Crisis Support and Suicide Prevention	People with a lived experience of suicide have the potential, to inform, influence and enhance local suicide prevention solutions but may lack the confidence, skills and readiness to participate.	*Mental Health*	*HealthPathways*		
Crisis Support and Suicide Prevention	Confidentiality and legal concerns along with lack of formal arrangements limit information sharing between providers.	*Mental Health*	*Access*		
Alcohol and other drugs	Flexible delivery of AODs services outside of usual business hours is a factor in successful completion of AODs treatment.	*Alcohol and Other Drugs*	*Care coordination*	• Timely access to services to capture clients wanting to address their drug use and maximize the effectiveness of the intervention • Increased access for young people to AOD services. • Enhance the capacity and effectiveness of the funded organisations, General Practice and the broader alcohol and other drugs (AOD) treatment sector and	• GCPHN with commissioned providers
Alcohol and other drugs	Limited availability of withdrawal management often impacts an individual's ability to access residential rehabilitation support given that adequate detoxification is often a pre-requisite to enter residential treatment	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	High demand and limited AOD service options in the northern Gold Coast region	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	Variability in formal education, practical experience, and resources in relation to alcohol and other drugs limits capacity of GPs to identify AOD issues and have conversations with patients related to AOD use.	*Alcohol and Other Drugs*	*Health literacy*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Alcohol and other drugs	Evolving service system results in GPs being unclear about available services and the pathways to access these services. There is a need for timely and accurate information to support GPs to connect people to suitable AOD services.	*Alcohol and Other Drugs*	*Care coordination*	their ability to meet the needs of their client group • Increased capacity of local Indigenous service providers	
Alcohol and other drugs	Inefficient transitions between services, particularly from inpatient services to community-based services, can lead people to disengaging from treatment	*Alcohol and Other Drugs*	*Care coordination*		
Alcohol and other drugs	Limited availability of suitable service options specifically designed to support older population.	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	Barriers exists to accessing residential rehabilitation due to upfront financial costs, childcare responsibilities, and funds to cover housing costs while in rehabilitation.	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	Alcohol and other drugs services report challenges in recruiting workers that identify as Aboriginal and Torres Strait Islander.	*Alcohol and Other Drugs*	*Aboriginal and Torres Strait Islander Health*		
Alcohol and other drugs	It can be difficult for service providers to know what capacity services have, particularly for withdrawal and rehabilitation bed availability, which can delay access for clients while capacity is confirmed.	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	An inconsistent approach to assessment (e.g various tools) leads to inconsistent assigned levels of care, resulting in discrepancies in the type of care provided across providers for similar clinical presentations.	*Alcohol and Other Drugs*	*Care coordination*		

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"Building one world class health system for the Gold Coast."

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Gold Coast Primary Health Network (GCPHN) gratefully acknowledges the financial and other support from the Australian Government Department of Health.

Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and the tradi□onal prac□ces of the families of the Yugambeh Language Region of South East Queensland and their Elders past, present and emerging.