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GOLD COAST

An Australian Government Initiative

Gold Coast Primary Health Network
Needs Assessment 2023

1. BACKGROUND

1.1 Introduction

Needs Assessment is a method of identifying the health needs of a population. It informs PHN's understanding of their region by ensuring they undertake a detailed and systematic assessment of the regional population's health needs, the local health care services, and engage in stakeholder and community consultation.

The Needs Assessment is the first stage in the broader PHN's commissioning framework and provides the basis for planning and commissioning of services.

Needs Assessments are a contracted deliverable that PHNs must submit to the Department of Health and Aged Care (DoHAC) every 3 years. However, in addition to triannual submission, GCPHN has historically also undertaken an annual refresh of the HNA, considering the feedback from internal and external stakeholders, the GCPHN board and Gold Coast Health, policy drivers, DoH deliverables, and any changes to funding and Commonwealth requirements.

Gold Coast Primary Health Network (GCPHN) submitted the 2022 Needs Assessment to DoHAC in November 2022. Following the submission, the prioritised health needs and services issues informed the GCPHN Activity Work Plans for 2023.

Once approved by DoHAC, the 2022 Needs Assessments was 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.

Early in 2023, GCPHN commenced scoping for an annual update of the Needs Assessment. It was determined that a light review, including data updates, was appropriate for all topics. Some of the previously separate topic areas were merged into combined chapters (for example, Mental Health, and Aboriginal and Torres Strait Islander Health).

1.2 Consultation process

Individual modules of 2023 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, and
- Meetings with GCPHN relevant program managers and/or project officers responsible for the individual topic areas, specifically to review and refine the health needs and service issues.

1.2.1 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 national and state health trends, and view the different SA3s within the Gold Coast as distinct regions with 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, and
- Aggregated general practice data sourced through Primary Sense.

1.2.2 Primary Sense

- Primary Sense is a clinical decision support, population health management and data extraction tool installed in 161 eligible general practices (of a total of 210) in the GCPHN region (as of November 2023). Primary Sense currently collates comprehensive data on the primary care received by around a million 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 2023 Needs Assessment is sourced from Primary Sense.

1.2.3 Service mapping

Revision of service mapping was conducted using GCPHN's Client Relationship Management (CRM) tool to determine any changes in providers of health services across the region and workforce. 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 in validation of the accuracy of the service mapping.

1.2.4 Consultations

During 2023, GCPHN asked the community and health professionals to provide feedback on the 2022 Needs Assessment. The feedback was promoted through:

- Social media
- Publications to General Practices and General Practitioners
- Direct emails to stakeholders
- Funded providers
- Community newsletters

Questions asked in the feedback form included:

- Are there any topic areas you think are missing from the 2022 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?

The above 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

GCPHN also conducted targeted engagement with numerous groups during the development of the 2023 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.

1.3 Health needs and Service issues

Each topic area within HNA has a list of identified health need and service issues. In 2023, these health needs and services issues were updated to align with the latest data and consultation that occurred during 2023. 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. Reprioritisation is planned for the 2024 HNA.

1.4 Additional feedback

GCPHN undertakes deep dives in areas where resources and priorities indicate the need for a more detailed understanding of a particular topic. GCPHN also continues to work closely with our local Hospital and Health Service on their Local Area Needs Assessment (LANA) process to ensure that our needs assessments are built on a single comprehensive set of data for the 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 region.

1.5 Market Assessment

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, with 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 developed to include one satellite hospital at Tugun, one Urgent Care Clinic in Oxenford, and a 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.

In comparison to national averages, Gold Coast Primary Health Network (GCPHN) region has a comparable or higher rates of rates of population accessing services and available health workforce across most clinical professions (described in more detail in the Primary Health Care Workforce chapter of HNA).

From 2013 to 2019, an average increase in the number of primary health care practitioners was 46.5%, with the largest increases observed in occupational therapists, osteopaths, physiotherapists. As at October 2023, there are currently 857 GPs working across 210 general practices in the GCPHN region. The 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.

Gold Coast mental health services across Gold Coast Health, private psychologists, allied health, and non-government organisations (NGOs) are stretched and at capacity. Access for hard-to-reach groups has been negatively impacted by the increasing demands for services and the Government's changes to increase access to psychological services through MBS. As a result, some private service providers prefer to offer services to MBS clients, which increases wait-times to access NGO and GCPHN-funded psychological services.

1.5.1 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.

1.6 Commissioning

GCPHN commission a range of services including local mental, alcohol and other drugs, suicide prevention and chronic diseases services to meet the needs of people in the GCPHN region. As part of the commissioning process, GCPHN facilitates competitive tendering processes with many different providers, including some from other states, submitting 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.

2. DEMOGRAPHY

2.1 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 growth 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

	Estimated resident population			Growth rate (%)
Region	**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.

2.2 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

As of the 30 June 2020, the median age for the GCPHN region was 38.8 years. Gold Coast Hinterland had the highest median age (46.1 years), and Ormeau-Oxenford had the lowest (33.5 years).

2.3 Indigenous population

Based of 2021 Census data, 13,901 people in the Gold Coast identified as Aboriginal and/or Torres Strait Islander, accounting for 5.9% of the total population. Almost a third of Gold Coast Aboriginal and/or Torres Strait Islander population lived in Ormeau-Oxenford SA3 region (n=4,359 or 31.4%).

Table 3. Population by Aboriginal and Torres Strait Islander status, Gold Coast SA3 regions, 2021

Region	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.

2.4 Projected population

Projected annual population growth for the Gold Coast region until the year 2041 is 2.0%, which means that by then, 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, with an average annual rate of 3.2% per year.

Table 4. Projected population, Gold Coast SA3 regions, 2021-2041

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

2.5 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 5. 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-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. Note: ESB: Based on the main English-speaking countries of UK, Ireland, Canada, USA, South Africa and New Zealand.

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%), Portuguese (0.8%), Spanish (0.8%), and Korean (0.6%).

2.6 Migration

Tables 6 shows that the 17.0% of people in the GCPHN region had a different address one year ago, and 44.8% had a different address five years ago.

Surfers Paradise SA3 region saw the largest proportion of migration in the last year (24.2%), and Ormeau-Oxenford SA3 region in the last five years (54.0%).

Table 6. Different address one and five years ago, Gold Coast SA3 regions, 2021

SA3 Region	1 year ago		5 years ago	
	Number	%	Number	%
Queensland	868,358	17.0%	2,178,913	44.8%
Gold Coast SA4	115,913	18.3%	296,707	48.9%
Broadbeach-Burleigh	12,637	19.2%	30,335	47.9%
Coolangatta	9,265	16.3%	24,049	44.1%
Gold Coast North	12,469	18.1%	31,891	47.9%
Gold Coast Hinterland	2,538	12.7%	7,397	38.6%
Mudgeeraba-Tallebudgera	4,826	13.5%	13,725	40.4%
Nerang	9,315	13.5%	26,627	40.5%
Ormeau-Oxenford	29,866	19.2%	81,205	55.4%
Robina	10,553	19.8%	26,534	51.8%
Southport	13,596	21.3%	31,324	50.7%
Surfers Paradise	10,854	24.2%	23,615	54.0%

2.7 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 7 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 2021, 7.1% of Gold Coast population was living in areas of most disadvantage and 17.4% in areas of least disadvantage.

Southport SA3 had the largest percentage of population in the most disadvantaged quintile (21.8%) and Mudgeeraba-Tallebudgera had the most people in the least disadvantaged quintile (42.6%)

Table 7. Population by Index of Relative Socio-Economic Disadvantage quintiles, Gold Coast SA3 regions, 2021

Region	Quintile 1 (most disadvantaged) (%)	Quintile 2 (%)	Quintile 3 (%)	Quintile 4 (%)	Quintile 5 (least disadvantaged) (%)
Queensland	20.0%	20.0%	20.0%	20.0%	20.0%
Gold Coast SA4	7.4%	19.8%	26.1%	29.3%	17.4%
Broadbeach-Burleigh	1.3%	9.8%	21.2%	39.2%	28.5%
Coolangatta	1.6%	17.7%	25.3%	41.9%	13.5%
Gold Coast-North	19.4%	32.8%	21.6%	16.2%	10.1%
Gold Coast Hinterland	0.0%	1.5%	36.0%	43.6%	19.0%
Mudgeeraba-Tallebudgera	1.2%	6.9%	19.6%	29.8%	42.6%
Nerang	6.7%	17.6%	29.0%	32.3%	14.4%
Ormeau-Oxenford	5.5%	22.6%	22.4%	30.3%	19.2%
Robina	3.2%	12.4%	39.2%	31.9%	13.3%
Southport	21.8%	26.4%	31.6%	17.9%	2.2%
Surfers Paradise	6.7%	28.3%	27.2%	16.5%	21.4%

2.8 Total family income

Table 8 shows the median total family income in Gold in 2021 was $104,468 per year. In this same year, 11,626 or 6.7% were low-income families.

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 8. Median annual family income, Gold Coast SA3 region, 2021

Region	Median income $/year
Queensland	105,248
Gold Coast SA4	104,468
Broadbeach-Burleigh	113,048
Coolangatta	107,536
Gold Coast-North	89,700
Gold Coast Hinterland	102,700
Mudgeeraba-Tallebudgera	116,584
Nerang	104,364
Ormeau-Oxenford	109,668
Robina	102,492
Southport	91,156
Surfers Paradise	99,840

2.9 APPENDIX: 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 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)** 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.

Statistical Area Level 4 (SA4)	Statistical Areas Level 3 (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

3. DETERMINANTS OF HEALTH

The determinants of health are "factors that influence how likely we are to stay healthy or to become ill or injured"[1], and can be categorised into:

- the social and structural environment (political and economic)
- the physical environment
- the persons biology and individual behaviours
- cultural influences
- health services

3.1 Socioeconomic determinants

Health and illness are not distributed equally within the Australian population, with one of the most significant determinants being the person's socioeconomic status. Socioeconomic status is the social standing of an individual as measured as a grouping of education, income and occupation. Variations in health status generally follow a gradient, with overall health tending to improve with improvements in socioeconomic status[2].

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 20163.
- 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 areas4

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 measure of all socioeconomic characteristics is the Socio-Economic Indexes for Areas (SEIFA), which uses area-based population attributes such as low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations.

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.

Table 9 breaks down each SA3 within the GCPHN region into five quintiles, from most disadvantaged to least disadvantaged. In 2021, Southport (21.8%) and Gold Coast-North (19.4%) had the highest percentage of population living in the most disadvantaged quintile, while Mudgeeraba-Tallebudgera (42.6%) had the highest percentage of population among the least disadvantaged quintile.

[1] Australian Institute of Health and Welfare. (2016). Australia's health 2016.
[2] Kawachi, I., et al. (2002). A glossary for health inequalities. *Journal of Epidemiology & Community Health,* 56(9), 647-652.
[3] Australian Bureau of Statistics. (2016) Population by age and sex, regions of Australia.
[4] Department of Health. (2018) Queensland preventive health surveys.

Table 9. Population by Socioeconomic Index for Areas (SEIFA), Gold Coast SA3 regions, 2021

Region	Quintile 1 (most disadvantaged)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (least disadvantaged)
Queensland	20.0%	20.0%	20.0%	20.0%	20.0%
Gold Coast SA4	7.4%	19.8%	26.1%	29.3%	17.4%
Broadbeach-Burleigh	1.3%	9.8%	21.2%	39.2%	28.5%
Coolangatta	1.6%	17.7%	25.3%	41.9%	13.5%
Gold Coast-North	19.4%	32.8%	21.6%	16.2%	10.1%
Gold Coast Hinterland	0.0%	1.5%	36.0%	43.6%	19.0%
Mudgeeraba-Tallebudgera	1.2%	6.9%	19.6%	29.8%	42.6%
Nerang	6.7%	17.6%	29.0%	32.3%	14.4%
Ormeau-Oxenford	5.5%	22.6%	22.4%	30.3%	19.2%
Robina	3.2%	12.4%	39.2%	31.9%	13.3%
Southport	21.8%	26.4%	31.6%	17.9%	2.2%
Surfers Paradise	6.7%	28.3%	27.2%	16.5%	21.4%

Source ABS 2033.0.55.001 Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016.

3.1.1 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[5]. In the GCPHN region in 2021, the median total person income was $40,820 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.

Table 10. Median annual income, Queensland, Gold Coast SA3 regions, 2021

Region	Median annual income
Gold Coast SA4	$40,820
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

[5] Braveman, P., & Gottlieb, L. (2014). The social determinants of health: it's time to consider the causes of the causes. *Public health reports*, *129*, 19-31.

3.1.2 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[6].

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 with highest level of schooling being 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 11. 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	1,373	2.5%	11,217	20.4%	38141	69.3%
Coolangatta	1,235	2.7%	12,085	26.0%	29,911	64.5%
Gold Coast-North	2,343	4.0%	15,509	26.5%	35,843	61.3%
Gold Coast Hinterland	379	2.4%	4,200	26.3%	10,267	64.3%
Mudgeeraba-Tallebudgera	620	2.3%	6,261	23.7%	18,145	68.6%
Nerang	1,589	3.0%	14,256	26.6%	34,686	64.8%
Ormeau-Oxenford	2,989	2.6%	28,612	24.7%	77,113	66.7%
Robina	1,153	2.7%	8,480	19.8%	30,443	71.2%
Southport	1,685	3.1%	10,608	19.8%	36,334	67.9%
Surfers Paradise	899	2.3%	7,031	18.0%	26,629	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.

3.1.3 Unemployment

Unemployed individuals have poorer perceived mental health profiles, are more likely to delay healthcare services due to cost, and are less likely to have access to healthcare than employed people[7].

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%).

[8] Shankar, J., Ip, E., Khalema, E., Couture, J., Tan, S., Zulla, R. T., & Lam, G. (2013). Education as a social determinant of health. *International journal of environmental research and public health*, 10(9), 3908-3929.

[7] 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*. 1-7.

Table 12. Unemployment rate, Gold Coast SA3 regions, September quarter 2019

	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.

3.2 Australian Early Development Census

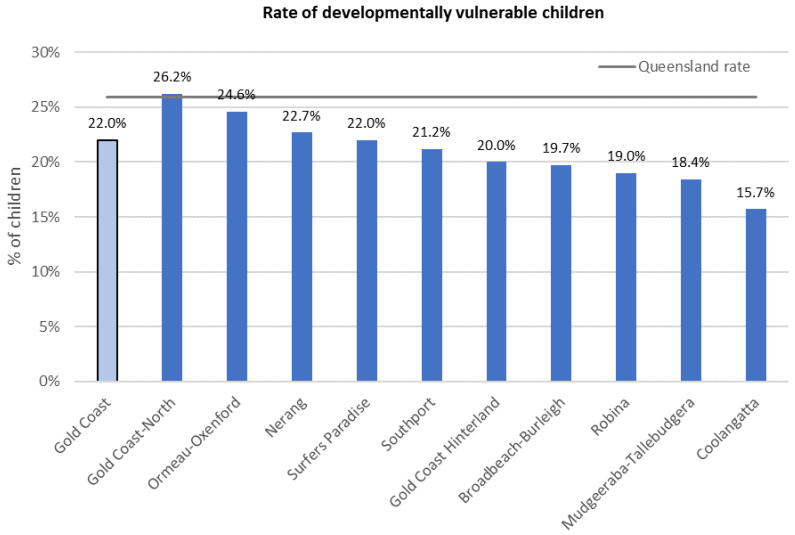
The foundations of adult health are laid in early childhood[8]. The different domains of early childhood development include physical health and wellbeing, social competence communication skills and general knowledge, emotional maturity, and language and cognitive skills. These domains are assessed in 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].

[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] *Department of Education and Training (2019).* Australian Early Development Census *National Report* 2018.

Figure 1. Developmentally vulnerable children across one or more domains, Gold Coast SA3 regions, 2018



Source: Australian Early Development Census, 2018.

3.3 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"[10]. Reports have indicated that 35% of people with disabilities report poor or fair health, compared with 5% of people without disabilities[11].

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.

Table 13. Need for assistance with a profound or severe disability, Gold Coast SA3 regions, 2021

	Number	%
Queensland	309,366	6.0%
Gold Coast SA4	35,066	5.5%
Gold Coast-North	5,207	7.5%
Southport	4,259	6.6%
Nerang	3,989	5.7%
Robina	3,008	5.6%
Coolangatta	3,026	5.3%
Gold Coast Hinterland	1,036	5.1%
Ormeau-Oxenford	8,040	5.1%
Mudgeeraba-Tallebudgera	1,665	4.6%
Broadbeach-Burleigh	2,960	4.5%
Surfers Paradise	1,871	4.1%

Source ABS, Census of Population and Housing, 2021.

[10] United Nations (2007). General Assembly: Convention on the Rights of Persons with Disabilities,
[11] Kavanagh, A & Krnjacki, L. (2012). 'Unpublished analysis of the Survey of Disability and Carers (2009), University of Melbourne.

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%).

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.

The number of NDIS participants in the GCPHN region 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 14 shows all Gold Coast SA3 regions participant as of December 2021.

Table 14. NDIS participants, Gold Coast SA3 regions, December 2021

Region	Number
Ormeau - Oxenford	3,212
Nerang	1,298
Gold Coast - North	1,204
Southport	1,203
Robina	847
Coolangatta	796
Broadbeach - Burleigh	790
Mudgeeraba - Tallebudgera	624
Surfers Paradise	431
Gold Coast Hinterland	324

3.4 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[12], 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[13]. This was more prevalent 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.

[12] Kennedy, S., Kidd, M. P., McDonald, J. T., & Biddle, N. (2015). The healthy immigrant effect: patterns and evidence from four countries. *Journal of International Migration and Integration*, *16*, 317-332..

[13] Jatrana, S., Richardson, K., & Pasupuleti, S. S. R. (2018). Investigating the dynamics of migration and health in Australia: a longitudinal study. *European Journal of Population*, *34*, 519-565.

In 2021 in the GCPHN region, 185,278 (28.9%) of people were born overseas (Table 15). 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 15. 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.

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%)

3.5 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.

3.5.1 Physical environment

Poor physical home environments may be a potential source of stress for children and produce poor health outcomes[14]. Access to appropriate, affordable, and secure housing can limit the risk of being social excluded through homelessness, overcrowding and poor physical and mental health.

[14] Shaw, M. (2004). Housing and public health. *Annu. Rev. Public Health*, *25*, 397-418.

The number of applications for social housing with the applicant first locational preference in the GCPHN region was 2,742 in 2019, an increase of 27% from 2,165 the year before[15]. Of the 2,742 applicants, 28% indicated that they are experiencing one or more of the below circumstance:

- 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.

3.5.2 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[16]. One Australian study found that experiences common to stressed 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 2021, 36.9% 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 51.0%, while Gold Coast Hinterland had the least (23.3%).

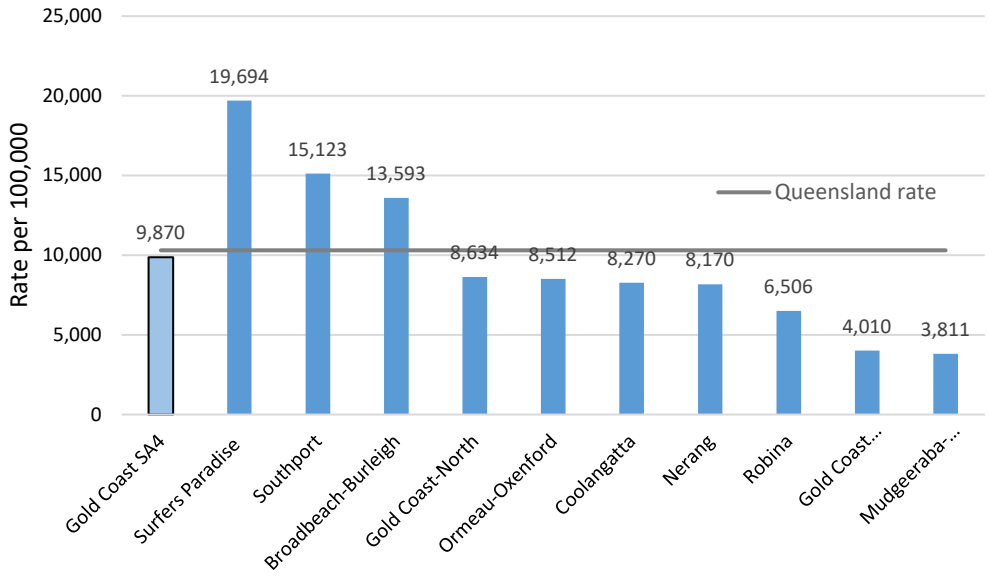
3.5.3 Crime

Fear of crime is associated with poorer mental health and greater limitations in physical functioning[17]. In the GCPHN region during 2018-2019, a total 62,970 offences were recorded, accounting for a rate of 9,870 per 100,000 people. This was below the Queensland rate of 10,306 per 100,000 people.

In 2018/19, highest rates of reported offences were in Surfers Paradise, followed by Southport and Broadbeach-Burleigh, while Mudgeeraba-Tallebudgera had the lowest rate of crime.

[15] Queensland Government (2019) Open Data Portal Social Housing Register.
[16] Yates, J., and Milligan, V. (2007) *Housing affordability: a 21st century problem*, AHURI Final Report No. 105, Melbourne.
[17] Stafford, M., Chandola, T., & Marmot, M. (2007). Association between fear of crime and mental health and physical functioning. *American journal of public health,* 97(11), 2076–2081.

Figure 2. Total number of reported offences per 100,000 people, Gold Coast SA3 regions, 2018-2019



3.5.4 Volunteering

People who engage in voluntary work have been reported to have better health and greater happiness than people who do not; a difference that is not driven by socioeconomic differences between volunteers and non-volunteers[18].

During 2021 in the GCPHN region, 60,938 or 11.5% of people undertook voluntary work, which was lower than the Queensland percentage of 14.4%. Within the 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.

3.5.5 Availability of health services

Access to health services (primary, secondary, tertiary care) is an important determinant of health. The GCPHN region is generally well serviced with 857 GPs across 210 general practices, two public hospitals and three private hospitals. More details on those are available in chapter General Practice and Primary Care.

3.6 Proximal determinants

Proximal determinants refer to any determinant of health that is directly associated with the change in health status.

3.6.1 Physical activity

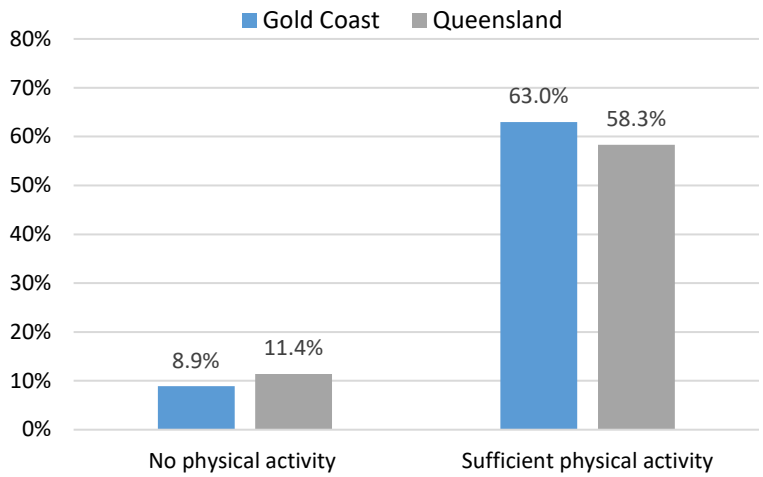
Physical activity includes structured activities such as sport or organised recreation, and unstructured activities such as incidental daily activities at work or home. In 2003, physical inactivity accounted for 6.6% of the burden of disease in Australia[19].

Sufficient physical activity for adults is based on physical activity guidelines, requiring >150 minutes of physical activity or >75 minutes of vigorous activity per week over five or more sessions.

[18] Borgonovi F. (2008). Doing well by doing good. The relationship between formal volunteering and self-reported health and happiness. *Social science & medicine (1982)*, *66*(11), 2321–2334.
[19]Begg. S., Vos. T., Barker. B., Stevenson. C., Stanley. L., Lopez. AD (2007). The burden of disease and injury in Australia Canberra: AIHW.

In 2020, 63.0% of residents in the GCPHN region aged 18 and over undertook sufficient physical activity, which was more than the Queensland average of 58.3%.

Figure 3. Activity status among Gold Coast and Queensland residents, 2020



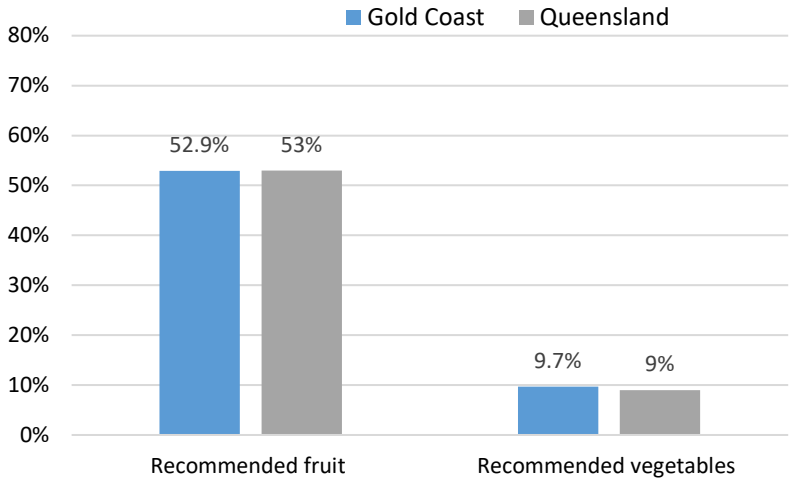
Source: Queensland Health. The health of Queenslanders 2020.

3.6.2 Dietary pattern

A healthy dietary pattern consisting of a variety of nutritious foods in appropriate amounts leads to a reduced risk of chronic disease and improved health outcomes.

In 2019, 52.9% of residents of the GCPHN region met the guidelines for recommended daily amount of fruit (two or more serves), while only 9.7% of met the guidelines for vegetables (five to six or more serves for people aged 18 and over).

Figure 4. Gold Coast residents meeting recommended intake of fruit and vegetables, 2019



Source: Queensland Health. The health of Queenslanders 2020.

3.6.3 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, and

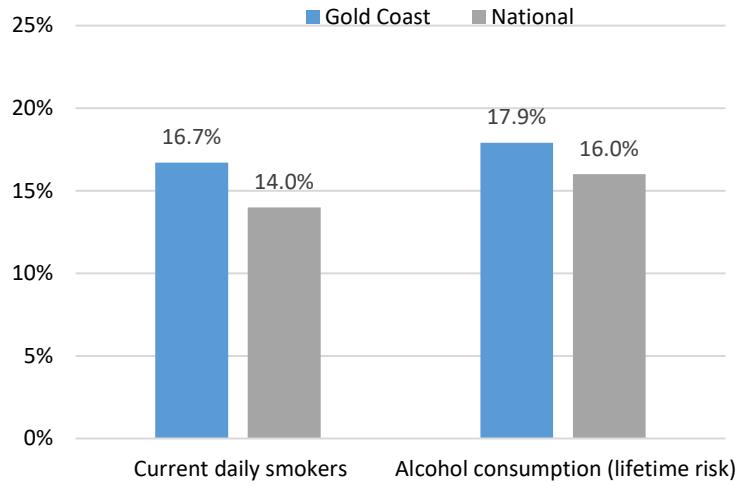
- 14% of the burden due to suicide and self-inflicted injuries[20].

Lifetime risk of drinking alcohol is defined as consuming on average 2 or more 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[21].

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[24].

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%[25].

Figure 5. Rate of daily smokers and alcohol consumption in adults, Gold Coast and national, 2017-18



Source: ABS 2019. Microdata: National Health Survey, 2017–18.

3.6.4 Healthy communities

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.

[20] AIHW (2019). *Australian Burden of Disease Study*: impact and causes of illness and death in Australia 2015.
[21] ABS (2019). Microdata: National Health Survey, 2017–18. ABS cat no. 4324.0.55.001. Canberra: ABS. Customised data report.

3.7 Consultations

GCPHN Community Advisory Council (July 2020):

- 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):

- 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

Identified specific health needs and service issues for people with a disability:

- access to adequate housing (many people with disabilities are inappropriately housed in aged care homes),
- accessibility,
- timely access to & effective health services,
- employment.

4. PRIMARY HEALTHCARE WORKFORCE

KEY FACTS:

- Percentage of GPs self-identifying as female has risen from 35% in 2015 to 44% in 2022.
- 25% of Australian GPs intend to retire in the next 5 years.
- 13.8% of Australian medical students consider general practice as a preferred career path.
- 73% of Australian GPs have experienced feelings of burnout over the past 12 months.

HEALTH NEEDS:

- High levels of burnout have a negative impact on health professionals' wellbeing.

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 GPs to have conversations around these issues with patients.
- Evolving service system results in GPs being unclear about available services and the pathways to access these services.
- 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 afterhours 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.
- Unfilled AGPT positions from the past seven years.
- Guanaba-Springbrook and South Tamborine-Canungra are two GCPHN regions recognised as Distribution Priority Areas for GPs.

4.1 General Practitioners

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

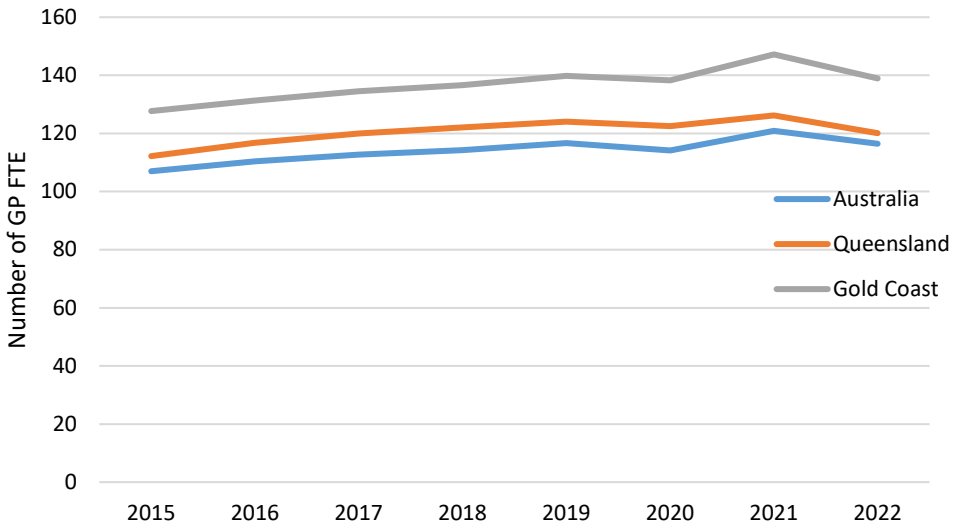
- are most likely the first point of contact in matters of personal health
- coordinate the care of patients and refers patients to specialists
- care for patients in a whole-of-person approach
- care for patients of all ages and sexes across all disease categories
- care for patients over a period of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

In the Gold Coast SA4 region, there were 138.9 GP Full Time Equivalents (GP FTE) per 100,000 residents in 2022, surpassing both the national proportion of 116.5 per 100,000 and Queensland's proportion of 120.1 per 100,000 for the same year.

Notably, there was an 8.3 GP FTE per 100,000 decline in the Gold Coast PHN region from 2021 to 2022, a trend that was mirrored at both the national level (with a 4.4 GP FTE decrease) and in Queensland (with a 6.1 GP FTE decrease).

It's important to highlight that despite an increase in the number of GPs in all the mentioned regions, the substantial population growth in these areas contributed to the decrease in GP FTE.

Figure 6. GP FTE per 100,000 people, National, Queensland and Gold Coast PHN, 2015 to 2022



Source. Commonwealth Department of Health and Aged Care HeaDS UPP Tool, extracted 10/10/2023.

4.1.1 Number of GPs

Table 16. Number of general practices and GPs, Gold Coast SA3 regions

Region	Number of general practices	Number of GPs	GP FTE per 100,000 perrons
Broadbeach-Burleigh	29	156	5.4
Coolangatta	20	94	4.7
Gold Coast-North	22	81	3.7
Gold Coast Hinterland	6	26	4.3
Mudgeeraba-Tallebudgera	7	27	3.9
Nerang	15	73	4.9
Ormeau-Oxenford	41	184	4.5
Robina	23	105	4.6
Southport	28	132	4.7
Surfers Paradise	19	68	3.6
TOTAL	212	857	4.1

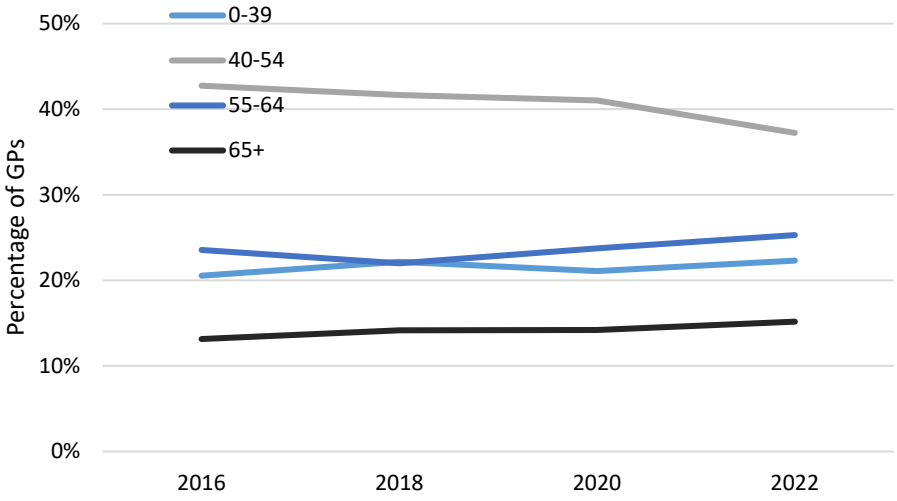
Source: GCPHN Client Relationship Management System. Data extracted 10 October 2023. Note: GPs may work at more than one general practice.

There are currently 857 GPs working across 210 general practices in the GCPHN region, with an average number of GPs per general practice being 4.1.

GPs by age group

From 2016 to 2022, most GPs in the Gold Coast PHN region were aged between 40 and 54 years. In recent years, there has been a rise in the proportion of GPs aged 65 years and older, suggesting an increase in those nearing retirement from 13.1% in 2016 to 15.2% in 2022.

Figure 7. GPs by age group, Gold Coast, 2016-2022

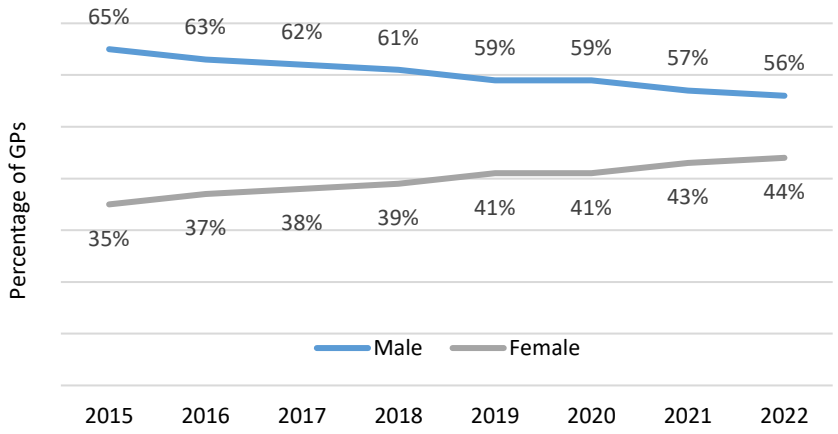


Source. Commonwealth Department of Health and Aged Care HeaDS UPP Tool, (Needs Assessment), extracted 10 October 2023.

GPs by sex

In the Gold Coast PHN region, the count of male GPs exceeded that of female GPs from 2015 to 2022. As illustrated in Figure 8, the percentage of female GPs has risen from 35% in 2015 to 44% in 2022.

Figure 8. GPs in the GCPHN region, by sex, 2015-2020



Source. Commonwealth Department of Health and Aged Care HeaDS UPP Tool, (Needs Assessment), extracted 10/10/2023.

4.1.2 The future GP workforce

While the Gold Coast region boasts a GP FTE ratio per 100,000 individuals that surpasses both the national and Queensland proportion, it faces an escalating demand for GP services.

This increased demand can be attributed to various factors, including population growth[22], an aging population[23], a rise in the frequency of patient visits, the increasing complexity of cases handled by GPs, which in turn extends the duration of GP consultations, and a growing prevalence of chronic diseases and comorbidities within the Australian population over the past decade[24].

However, this growing demand for GP services is not being met by a corresponding supply of GPs. This shortfall in the GP supply can be attributed to several underlying factors including:

- Reduced appeal with pursuing a career in general practice among medical students.
- Limited opportunities for medical students to gain exposure to and develop skills in general practice, leading to a lack of interest in GP training programs.
- Disparities in remuneration between GPs and their counterparts in hospital settings.

The declining availability of GPs highlights a concerning trend where the supply of GP FTE fails to keep pace with population growth. Furthermore, the decreasing interest among junior doctors in choosing general practice as their specialty presents a significant concern for the future supply of GPs.

Medical students selecting specialty of General Practice

The declining interest by junior doctors to enter the specialty of General Practice is a significant issue for the future supply of GPs. The National Health Workforce dataset shows that a higher proportion of junior doctors are continuing to choose non-GP specialty training, resulting in the number of non-GP specialists growing faster than GP specialists[25].

[22] Queensland Government Population Projections, 2023 edition (medium series)
[23] Regional population by age and sex, 2021, Australian Institute of Health and Welfare
[24] Chronic conditions and multimorbidity, Australian Institute of Health and Welfare, 2023
[25] National Health Workforce Dataset, Department of Health and Aged Care

There has been an overall decline in the number of medical students expressing interest in a general practice career at graduation. The peak body representing medical education, training and research in Australia and New Zealand, Medical Deans Australia and New Zealand, conducts an annual survey of final year medical students from all medical schools across Australia. The Medical Deans survey found that in 2015, 17.8% of medical students identified general practice as their preferred specialty for future practice compared to 13.8% in 2022[26].

Australian General Practice Training Program

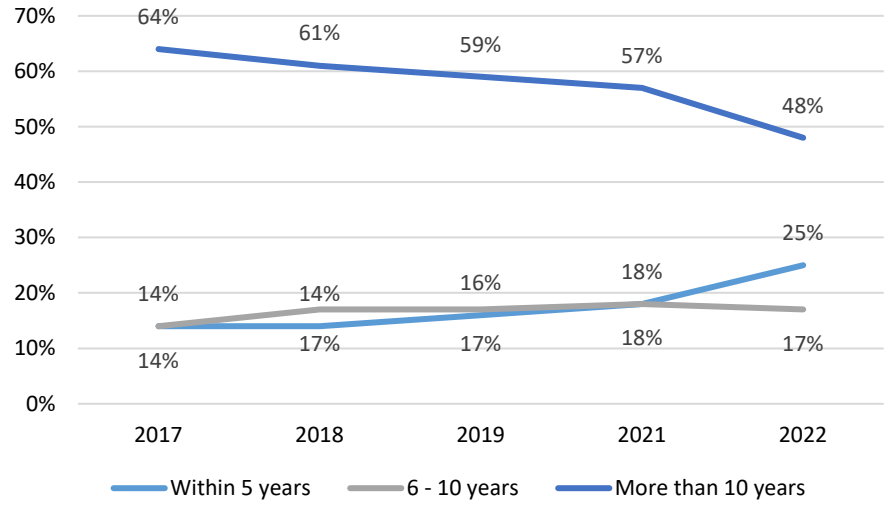
The Australian General Practice Training Program trains medical registrars in general practice. Registrars who achieve their fellowship under the program can work as GPs anywhere in Australia.

The program's 1,500 training places have not been filled since 2017. In 2022, the number of unfilled positions raised to 252[27]. The declining interest among medical students and postgraduate doctors is a significant concern for the future supply of the GP workforce.

GPs choosing to leave the profession

The 2022 General Practice Health of the Nation, conducted by the Royal Australian College of General Practitioners, surveyed 3,219 practicing GPs and identified that 25% reported intentions to retire within the next five years; an increase from 18% in the 2021 survey. Fewer than half of GPs (48%) intent to still be practicing in 10 years' time. However, retirement trends are not solely explained by an aging 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 practising in 10 years' time has decreased among those aged under 45 years from around 90% in 2017 to below 80% in 2022[28].

Figure 9. GPs and when they plan to retire, 2017 to 2022



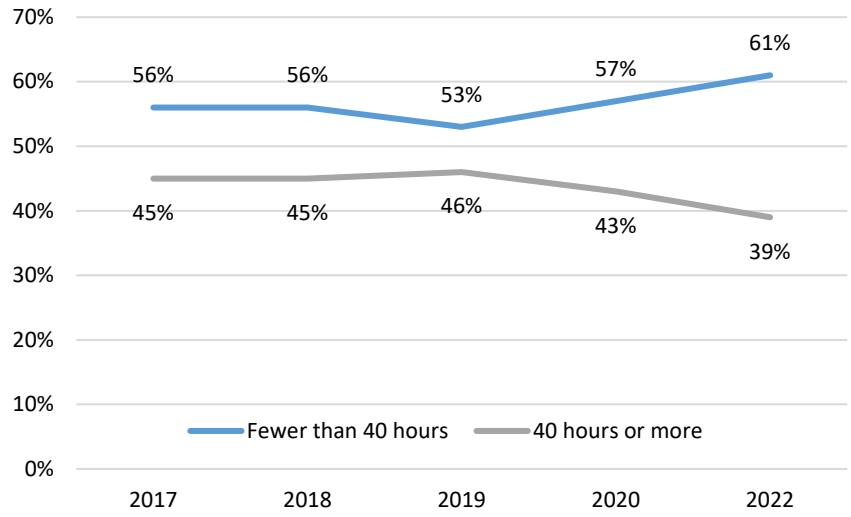
Source. General Practice Health of the Nation, Royal Australian College of General Practitioners, 2022.

GPs moving away from full-time work

The same Health of the Nation survey of 3,219 practicing GPs identified a shift towards more GPs working fewer than 40 hours (Figure 10). 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.

[26] Medical Deans Australia and New Zealand (2020). National Data Report 2020: 2015–2019
[27] RACGP training data (unpublished)
[28] General Practice Health of the Nation, Royal Australian College of General Practitioners, 2022

Figure 10. Number of hours GPs work during a typical week, 2022



Source. General Practice Health of the Nation, Royal Australian College of General Practitioners, 2022.

4.1.3 General practitioner Distribution Priority Area (DPA) areas

The DPA classification system identifies areas with lower levels of GP services, compared with a benchmark level. Initiatives aiming to increase the supply of GPs are then implemented in these areas.

The Department of Health and Aged Care (DoHAC) determines DPA classifications based on:

- Medicare billings by gender and age.
- Socio-economic status of patients living in the area.
- Remoteness of the area classified by the Modified Monash Model (MMM) geographical system.

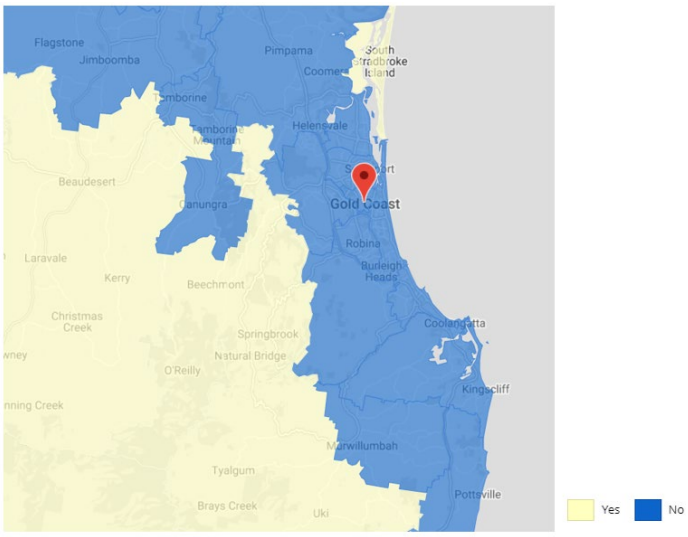
Each year, DoHAC use the DPA system to assess the level of access to GP services in each GP catchment. The DPA system looks at:

- The level of Medicare billed GP services patients received for the latest calendar year
- The demographics of the community including age, gender, and SEIFA.

If the actual billing level is lower than the relevant benchmark, DoHAC classify the GP catchment as a DPA. The DPA system also applies the following automatic rules:

- Areas that are MM 2 to 7 under the MMM are classified as a DPA.
- MM 1 inner metropolitan areas are not classified as a DPA.
- The Northern Territory is classified as a DPA.

Figure 11. 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).

4.2 Nurses

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, 83.8% of general practices employ at least one nurse. There is a total of 446 nurses of which some may work across more than one general practice.

Table 17. Number of general practices with one or more nurses, Gold Coast SA3 regions, 2023

Region	Number of general practices	Number of nurses	Average number of nurses per practice
Broadbeach-Burleigh	29	66	2.3
Coolangatta	20	47	2.4
Gold Coast-North	22	50	2.3
Gold Coast Hinterland	6	19	3.2
Mudgeeraba-Tallebudgera	7	16	2.3
Nerang	15	34	2.3
Ormeau-Oxenford	41	95	2.3
Robina	23	48	2.1
Southport	28	59	2.1
Surfers Paradise	19	32	1.7

Source: GCPHN Client Relationship Management System.

4.3 Wellbeing of the health workforce

4.3.1 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 professions[29].

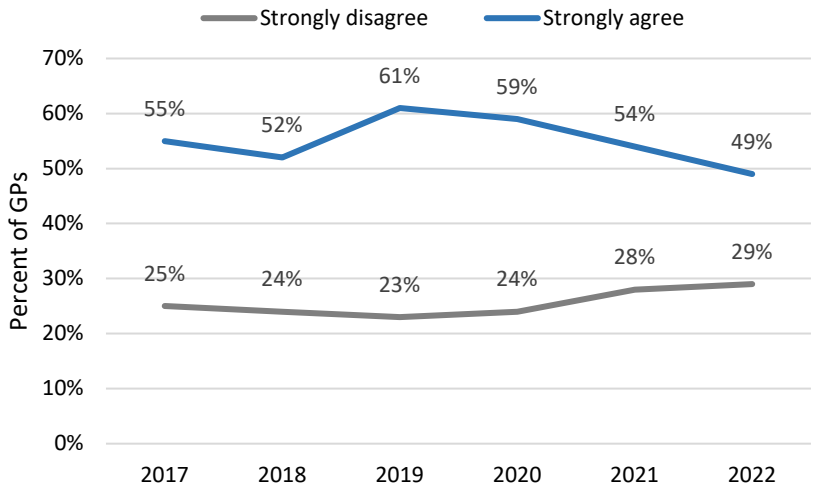
Physician burnout is an under-recognised and under-reported problem and is characterised by a state of mental exhaustion, depersonalisation, and a decreased sense of personal accomplishment[30]. While doctors and medical students have good understanding of the larger health system and have access to 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[29].

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 12).

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[31].

Figure 12. 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

[29] National Mental Health Survey of Doctors and Medical Students, Beyond Blue
[30] Lacy, B. E., & Chan, J. L. (2018). Physician Burnout: The Hidden Health Care Crisis. *Clinical gastroenterology and hepatology: the official clinical practice journal of the American Gastroenterological Association*, *16*(3), 311–317.
[31] The Navigators, RACGP Health of the Nation survey April/May 2022.

4.3.2 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[32]. 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[33]. This can decrease safety and quality of care for patients and negatively affect workforce retention and engagement.[37] 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[34].

4.3.3 Upskilling the 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:

- low number of nurses, psychologists and allied health practitioners working in mental health
- 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
- 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.

[32] Smallwood, N., Harrex, W., Rees, M., Willis, K., & Bennett, C. M. (2022). COVID-19 infection and the broader impacts of the pandemic on healthcare workers. *Respirology*, *27*(6), 411-426.
[33] Health of the Nation, RACGP, 2020.
[34] Stubbs, J.M., Achat, H.M. & Schindeler, S. (2021). Detrimental changes to the health and well-being of healthcare workers in an Australian COVID-19 hospital. *BMC Health Serv Res* 21, 1002.

4.4 Service system in GCPHN region

Services	Distribution	Information
Royal Australian College of General Practitioners (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	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.

4.5 APPENDIX A: Count of GP FTE in HeaDS UPP

The GP FTE is a measure of full-time work based on the MBS services claimed, with a GP FTE value of 1 representing the work of one full-time GP (40 hours a week, 46 weeks of the year). For indicative year-to-date summary, GP FTE is calculated using 40 hours a week, 11.5 weeks per quarter.

A multivariate analysis of Bettering the Evaluation and Care of Health (BEACH) data was conducted to determine:

- an estimate of the duration spent by each GP on each Medicare claim; and
- the characteristics statistically significant in determining the duration of an MBS claim

Of the results of the multivariate analysis, across all MBS items contained in the BEACH survey, the most significant factors determining the duration of GP's FTE were used to construct a primary model for estimating duration. That is, for each MBS item by the statistically significant demographic variables (such as age and gender), an estimate of average duration was provided. This accounted for around 80% of all items.

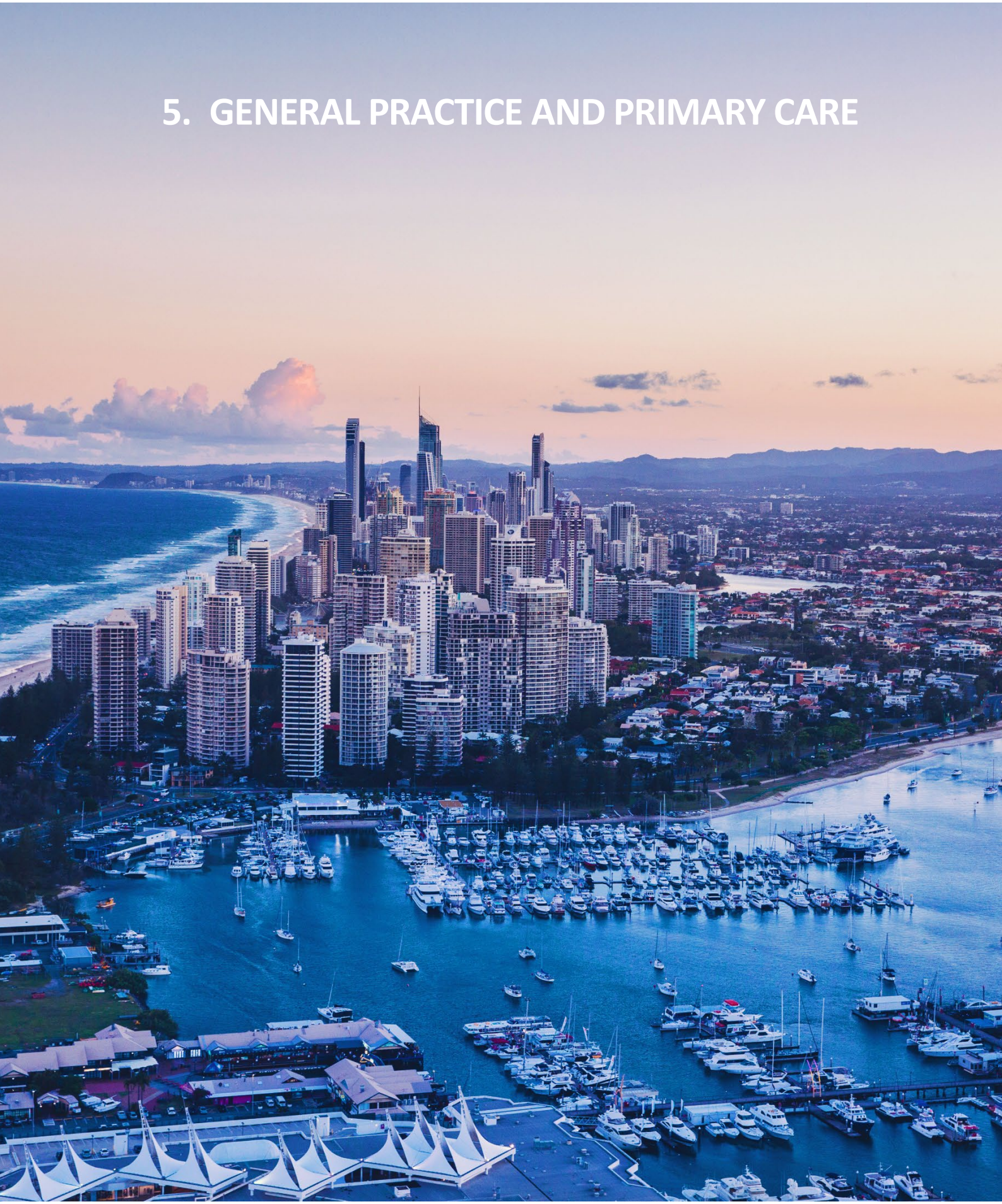
Those items not contained in the BEACH data (or with a frequency of less than 300) had their duration predicted using a multivariate weighted, log-linear model which estimates the duration of a claim based on the log of the schedule fee and GP sex.

Non-billable time was calculated by applying the average non-billable time per encounter within the BEACH data to GP age and sex as well as to the age of their patient, for each Medicare claim. The non-billable time considered only clinical time. Non-clinical hours are also estimated at the GP per location level according to data contained in the NHWDS that is the proportion of non-clinical time on average for each GP according to age, sex and Monash Modified Model (MMM).

Three components - billable time, non-billable time, and non-clinical time - are combined to produce the final GP FTE - Workforce figure based on a broad range of MBS items reviewed by Commonwealth Medical Advisors and GPs.

Some MBS items reviewed by Commonwealth Medical Advisors and GPs have been restricted in MM 1-2 to account for the difference in the scope of GP activity across metropolitan, regional, rural and remote areas.

5. GENERAL PRACTICE AND PRIMARY CARE



KEY FACTS:

- There are currently 210 general practices and 875 general practitioners in the GCPHN region.
- 82% of general practices in the GCPHN region have data extraction tools.
- 94% of GCPHN general practices that are eligible (accredited or in process of being accredited) are registered for the PIP QI.
- 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).
- There is a high number of people requiring chronic wound management services in general practice and Residential Aged Care Homes (RACH).
- 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, throat infections.
- Number of patients presenting to General Practices is increasing, as is the complexity of these patients leading to longer consultations.
- Care coordination/clinical handover is challenging, particularly to general practice on discharge from hospitals.
- My Health Record is not yet embedded to support team-based care.
- Challenges for general practices and pharmacies in adopting digital health.
- Doctors continue to avoid general practice as a specialty, growing gap between training places available and doctors successfully applying.

5.1 Strengthening Medicare

In July 2022, the Australian Government established the Strengthening Medicare Taskforce, consisting of prominent health leaders, to ensure that Australia's primary care system is capable of addressing present and future challenges and aligning with the evolving models of care in the 21st century. This included identifying the most critical investments required in primary care, building upon the guidelines established in Australia's Primary Health Care 10 Year Plan 2022-2032.

During their discussions, the Taskforce examined the advantages and obstacles associated with blended funding systems, data and digital reforms, voluntary patient registration, and multidisciplinary team-based care. They also focused on understanding the prerequisites for sustaining primary care in the future. The Taskforce took into consideration the need for primary care to be accessible and affordable for all Australians, including First Nations Australians, culturally and linguistically diverse individuals, those residing in rural and remote areas, people with disabilities, and individuals with limited connections to the health system.

The Strengthening Medicare Report, released in February 2023 puts forth recommendations for:

- Increasing access to primary care
- Encouraging multidisciplinary team-based care
- Modernising primary care
- Supporting change management and cultural change

These recommendations place patient-centred care at the core, advocating for the expansion of multidisciplinary care as a fundamental approach to managing the health of an aging population with complex and chronic diseases.

The report proposes the implementation of blended funding models integrated with the existing fee-for-service model. This approach would enable teams comprising of GPs, nurses, midwives, and allied health professionals to collaborate in delivering comprehensive care tailored to individuals' needs.

The Taskforce further identified that strengthening primary care by leveraging a broader range of healthcare professionals working to the fullest extent of their capabilities would optimise the utilisation of the health workforce within a strained primary care sector.

Furthermore, the Taskforce recognised that strengthening Medicare necessitates the modernisation of digital systems and significant improvements in the accessibility and sharing of patients' information across the health system. The report recommends a comprehensive revamp of the My Health Record system and enhancements to establish better connectivity among clinical IT systems across the entire healthcare landscape. These measures are intended to ensure safe, high-quality healthcare, enhance medication management for patients, and empower individuals to actively engage in their own healthcare decisions.

One of the Strengthening Medicare Initiatives is the Introduction of MyMedicare which is a new voluntary patient registration model. It aims to strengthen the relationship between patients, their general practice, GP and primary care teams. MyMedicare patients will have access to:

- Greater continuity of care with their registered practice, improving health outcomes,
- Longer MBS-funded telephone calls with their usual general practice,
- Triple bulk billing incentive for longer MBS telehealth consultations for children under 16, pensioners, and concession card holders.

Gold Coast PHN will assist general practices in the region with registering for MyMedicare and support them identifying patients who may be eligible for registration.

5.2 Rate of GP attendances

In 2020-21, the rate of GP attendances in the GCPHN region was above the national rate (761 vs 627 per 100 people). Both the GCPHN region and national rate of services has increased since 2015-16.

Table 18. 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.

As shown in Table 19, 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 19. GP attendances per 100 people, Gold Coast SA3 regions, 2020-21

Region	Rate of GP attendances
Australia	627
Gold Coast	761
Broadbeach–Burleigh	791
Coolangatta	742
Gold Coast–North	856
Gold Coast Hinterland	755
Mudgeeraba–Tallebudgera	685
Nerang	736
Ormeau–Oxenford	748
Robina	738
Southport	804
Surfers Paradise	711

5.3 Quality of Care

5.3.1 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 of general practice data on selected 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.

As of September 2023, 94% 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.

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 10 improvement measures are shown in Table 20.

In July 2023, the GCPHN region was above the national rate in eight of the ten PIP QI measures.

Table 20. Quality Improvement measures, July 2023

Quality Improvement Measure		Gold Coast	National
QIM 1	Patients who have Type 1 diabetes and who have had an HbA1c measurement result recorded	48.3%	57.6%
	Patients who have Type 2 diabetes and who have had an HbA1c measurement result recorded	65.9%	71.6%
	Patients who have unspecified, generic, or general diabetes diagnosis and who have had an HbA1c measurement result recorded	59.9%	64.7%
QIM 2	Patients with a smoking status	84.1%	65.1%
QIM 3	Patients with a weight classification	26.8%	23.0%
QIM 4	Patients aged 65 and over who were immunised against influenza	62.0%	59.0%
QIM 5	Patients with diabetes who were immunised against influenza	55.2%	51.9%
QIM 6	Patients with COPD who were immunised against influenza	66.0%	61.9%
QIM 7	Patients with an alcohol consumption status	82.1%	59.4%
QIM 8	Patients with the necessary risk factors assessed to enable CVD assessment	56.1%	52.6%
QIM 9	Female patients with an up-to-date cervical screening	38.2%	37.5%
QIM 10	Patients with diabetes with a blood pressure result	56.0%	56.9%

Source: Practice Incentives Program Quality Improvement Measures: Data update 2022-23.

5.4 Patient experiences

The Patient Experience Survey provides an indication of people's experiences with the health system at a local level. Good experiences can be associated with quality healthcare, clinical effectiveness, and patient safety.

Table 21 shows the results for the GCPHN region in comparison to the national average.

Table 21. Findings from selected items of Patient Experience Survey, 2019 - 2020

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

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

Overall, residents in the GCPHN region have a similar experience with the local primary healthcare system, when compared to national results, with some notable differences:

- GCPHN residents were more likely to rate their 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 all 31 PHNs.

5.5 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 required 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.

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 psychosocial care[35]. Care coordination is often 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. Some of the key issues and health needs in this context are:

5.6 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.

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%).

Approximately 450,000 Australians currently live with a chronic wound, directly costing the Australian healthcare system around AUD $3 billion per year. 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.

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.

Chronic wounds also represent a major health burden in RACFs, with residents often entering RACF with one or more chronic conditions and complex wounds. The elderly in general are at increased risk of impaired skin integrity due to age related changes to the skin, frailty, malnutrition, incontinence, immobility, and impaired cognition.

5.7 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 80.2% while the Gold Coast rate was 83.5%. 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[36].

Gold Coast data showed in September 2023, 33.3% (n=71) of general practices' billing system was bulk billing, while 53.5% (n=114) use mixed billing and 11.3% (n=24) private billing with four unknown[37].

5.8 Digital health

The Strengthening Medicare Taskforce report found that strengthening Medicare requires the modernisation of digital systems and significant improvements in the way patients' information is accessed and shared across the health system. Several new systems are being integrated in general practice software and workflows, including telehealth, Q scripts, smart referrals, health pathways and

[35] Oldroyd, J., Proudfoot, J., Infante, F. A., Powell Davies, G., Bubner, T., Holton, C., Beilby, J. J., & Harris, M. F. (2003). Providing healthcare for people with chronic illness: the views of Australian GPs. *The Medical journal of Australia, 179*(1), 30–33.
[36] Healthed webcast survey, 2 August 2022.
[37] GCPHN CRM extracted 14/09/2023.

electronic prescribing. The Strengthening Medicare Taskforce also recommended an overhaul of My Health Record.

5.9 Telehealth services

The outbreak of COVID-19 pandemic in Australia has had a significant impact on the way healthcare has been delivered throughout general practice. While the volume of visits has remained largely unchanged, the way these services are delivered have seen a significant shift.

Telehealth accounted for roughly 30% of all consultations in 2020 in Australia, with 97% of those occurring over the telephone[38]. Consultation 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 with consultation time
- 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
- 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
- availability/cost of equipment.

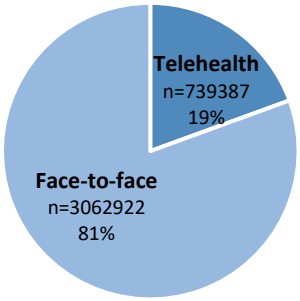
Avant Medical conducted a survey which had over 1,300 responses from health practitioners (just over half of respondents were GPs, and the remainder were physicians, surgeons, and other doctors). Interestingly, for 61% of respondents, the technical ability of patients was a barrier to using video telehealth.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

According to the HOTDOC Telehealth Patient Survey, conducted in 2020, younger people are much more likely to use telehealth compared to people aged 45 years and over. This was further supported by headspace report *Young people's experience of telehealth during COVID-19* which identified that of 1,348 clients who received a headspace service in May 2020, 94 % agreed that they had a positive experience with headspace while 78 % agreed that the telehealth was suitable for their needs.

Locally, data from 159 general practices that submit data to GCPHN through Primary Sense showed that in 2022/23, telehealth made up 19% (n=739,387) GP consultations. Of the telehealth items being claimed in the GCPHN region, 98% were through telephone while the remaining 2% were through video conference, which is consistent with national trends.

[38] MBS online, Medicare Benefits Schedule

Figure 13. Face-to-face and telehealth consultations in general practices, Gold Coast, 2022-2023



Source. Primary Sense, 159 Gold Coast general practices

In June 2021, the GCPHN Community Advisory Council, consisting of 16 members, completed a survey on their use of telehealth services. Results showed that 93.8% of households had at least one individual that utilised a telehealth service within the last 3-4 months. Of these, 60% strongly agreed that their health needs were met through using this service while 40% agreed their health needs were met. All participants 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 and Clinical Council regarding the use of telehealth also 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.

5.10 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[39].

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 by Australian Digital Health Agency *Secure Messaging National Scaling Final Report'*[40] 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. Of particular focus were environments that

[39] 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.
[40] Secure Messaging National Scaling Final Report, Australian Government Digital Health Agency, 21st November 2019

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.
- 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 and inconsistent support mechanisms[41].

5.11 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.

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.

5.12 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. However, as the volume of information generated and held within clinical information systems

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

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.

5.13 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 2022-23, 24.8% of GCPHN region's primary healthcare providers (n=132 of 533) were regularly uploading to My Health Record (defined as at least one document was uploaded in weekly), including:

- 19.5% (n=39 of 200 general practices)
- 57.8% (n=85 of 147 pharmacies)
- 0 of 71 allied health services
- 7.0% (n=8 of 115) specialist practices

5.14 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 is sent directly to the intended recipient. 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 2022-2023, there were 98,460 discharge summaries uploaded to My Health Record from hospitals in the GCPHN region: 46,246 (47.0%) from public hospitals and 52,214 (53.0%) from private hospitals.

5.15 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.

2019-2020 data from TIS showed 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 2021 census identified that there were 10,361 people living in the GCPHN region who did not speak English at home well or not at all[42]. 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.

[42] ABS, Census of Population and Housing, 2021, General Community Profile - G13

5.16 Service system in GCPHN region

Service Type	Number	Distribution	Capacity
General practice	212	Clinics are generally distributed across the GCPHN region, with the majority located in coastal and central areas.	• 876 GPs in the GCPHN region • 42 general practices deliver speciality services (e.g., skin checks) • Average number of GPs per general practice: 4.0 • 86% of general practices are accredited or working towards accreditation. • Many practices operate extended hours but this is an individual decision and subject to change.
Urgent non-life-threatening care	4	Urgent Care Clinic (UCC) - Oxenford Minor Injuries and Illnesses Clinic (MIIC)- Tugun After hours GP - Southport and Palm Beach	• The Gold Coast's first Medicare Urgent Care Clinic (UCC) will start seeing patients on Monday 13 November. The UCC will be located at Our Medical Gold Coast at Oxenford and will open from 8am until 10pm daily for people with an urgent but not life-threatening need for medical care. • The MIIC can be accessed for walk-in, urgent care for illnesses and injuries not anticipated to be life-threatening in nature, such as simple fractures, simple infections, toothache, minor burns and eye issues. The Minor Injury and Illness Clinic will operate from 8am to 10pm, 7 days a week.
Medical deputising services	5	Available across most of the GCPHN region, though some areas (such as the hinterland) are less well serviced	• In-home and after-hour visits from a doctor. • All consultations are bulk billed for Medicare and DVA card holders. • appointments can be requested by phone or online. ○ 13 Sick (national home doctor) ○ House call doctor ○ Gold Coast HOme Doctor ○ Hello Home Doctor ○ 13 Cure ○ Gold Coast After hours Doctors
Pharmacy	159	Well-distributed across the region	• Some have extended hours into the evening and weekends. There is one 24 Hour Chemist in Surfers Paradise. • Provide a variety of services:

			○ 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 private 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		Phone or online	There are a number of credible telephone and online information services to provide health information and advice, including: • Healthdirect • 13 HEALTH – health information and advice • Mental Health: Head to Health website and 1300MHCALL • Lifeline crisis support service • Pregnancy Birth and Baby • PalAssist – 24-hour palliative care support and advice line
Allied health services	428 services with 1,260 staff	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.

5.17 Consultations (2021-22)

General practice support

- General practice staff report a lack of capacity to focus on CQI activities.
- 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.
- 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.
- Continued promotion of privacy and security information required in telehealth.
- 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 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.

6. AFTER HOURS

KEY FINDINGS:

- In 2020/21, Gold Coast had a high level of accessibility to after-hours primary care services compared to the national rate, however, the rates has decreased substantially since 2015-16.
- 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.
- Only one general practice in the GCPHN region is open 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.
- People living in the higher density areas access after-hours GPs services at a higher rate than less densely populated areas.
- Among the top reasons for non-urgent presentations (category 4 and 5) to ED in the after hours, most relate to injuries (ankle sprains, wounds, and injuries).
- 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.
- The northern area of the GCPHN region is 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.
- 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.

LOCAL HEALTH NEEDS AND SERVICE ISSUES:

- Highest demand for services is 6pm to 8pm.
- Flexible delivery of AODs services outside of usual business hours is a factor in successful completion of treatment.
- 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.
- Potential area of higher geographic needs for after-hours primary care services is the northern corridor, including Ormeau – Oxenford SA3, due to sheer demand which continues to grow.
- 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.

6.1 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. PHNs work with key local stakeholders to plan, coordinate and support after hours health services, as well as provide an opportunity to improve access to after-hours services that are designed to meet the specific needs of different communities.

After hours services are defined for MBS purposes as those provided during:

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

6.2 After hours GP attendances

In 2020/21, 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 has decreased in recent years, in the GCPHN region and nationally.

Table 22. Rate of GP after hours attendances per 100 people, Gold Coast SA3 regions, 2017-18 to 2020-21

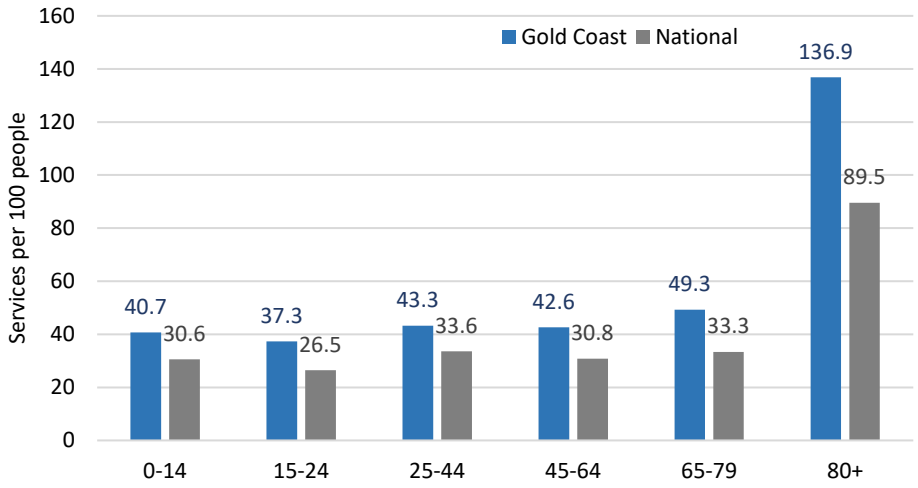
Region (SA3)	2017-18	2018-19	2019-20	2020-21
National	49.9	49.1	42.5	33.5
Gold Coast (SA4)	65.1	61.5	55.1	46.5
Broadbeach – Burleigh	53.1	51.7	48.2	38.1
Coolangatta	53.2	48.1	42.8	35.6
Gold Coast – North	73.5	66.7	60.8	52.4
Gold Coast Hinterland	45.0	46.2	44.3	41.4
Mudgeeraba – Tallebudgera	51.7	49.3	43.4	35.3
Nerang	74.0	68.5	59.4	47.4
Ormeau – Oxenford	70.4	71.1	67.4	55.6
Robina	57.9	54.2	48.4	37.9
Southport	78.5	68.4	62.7	54.0
Surfers Paradise	63.6	58.3	51.9	42.6

Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2013-14 to 2020-21.

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 (55.6 per 100 people), while Mudgeeraba – Tallebudgera had the lowest rate (35.3 per 100 people).

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 14). The lowest rates were recorded for age group 15-24 (37.3 per 100 people).

Figure 14. 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.

6.3 Urgent / non 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:

- 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[43].

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.[43]

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

In 2022-23, the rate of urgent after-hours services per 100 people in the GCPHN region was 2.3 times higher than the national rate (4.1 vs 1.7 per 100 people). Among Gold Coast SA3 regions, Ormeau-Oxenford had the highest rate and number (6.7 per 100 people, n= 7,608) of urgent after-hours GP attendances while Coolangatta had the lowest rate (1.6 per 100 people), and Gold Coast Hinterland had the lowest number (n = 309).

During the same period, the rate of non-urgent after-hours services in the GCPHN region was higher than the national rate (41.9 vs 29.1 per 100 people). Among SA3 regions, Southport had the highest rate of non-urgent GP after hours attendances (52.6 per 100 people), while Ormeau – Oxenford had the highest number (N=40,972). Coolangatta had the lowest rate (31.0 per 100 people), and Gold Coast Hinterland had the lowest number (n= 3,669) of non-urgent after-hours attendances.

[43] AIHW 2021. Medicare-subsidised GP, allied health and specialist health care across local areas: 2019–20 to 2020–21.

Table 23. Number and rate of urgent and non-urgent GP after hours attendances per 100 people, Gold Coast SA3 regions, 2022-23

Region	Rate of urgent attendances per 100 people	Number of urgent attendances	Rate of non-urgent attendances	Number of non-urgent attendances
National	1.7		29.1	
Gold Coast (SA4)	4.1	19,071	41.9	141,171
Broadbeach - Burleigh	2.6	1,341	34.5	11,821
Coolangatta	1.6	681	31.0	9,230
Gold Coast - North	4.8	2,329	51.1	16,832
Gold Coast Hinterland	2.0	309	32.3	3,669
Mudgeeraba - Tallebudgera	2.2	647	31.8	5,874
Nerang	4.6	2,343	47.3	17,159
Ormeau - Oxenford	6.7	7,608	44.4	40,972
Robina	2.7	1,235	34.2	9,254
Southport	4.2	1,924	52.6	16,542
Surfers Paradise	1.8	654	41.8	9,858

Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2022-2023.

6.4 13 Health

Besides 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, 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%).

6.5 Emergency Department use

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:

- 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.

Table 24 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 24. Rate of after-hours lower urgency ED 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. All results are based on where the person accessing service lived.

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). The highest number of presentations by residence was Ormeau – Oxenford (n=10,625), followed by Coolangatta (6,562).

Children and young people (15-24 years) attended lower urgency ED care at a higher rate than older age cohorts (43 per 1,000 people) and people aged 65+ had the lowest rate (15.2 per 1,000).

The top ten reasons for presentations to ED after hours for lower urgency care (triage category 4 and 5) to Gold Coast public hospitals are shown in Table 25.

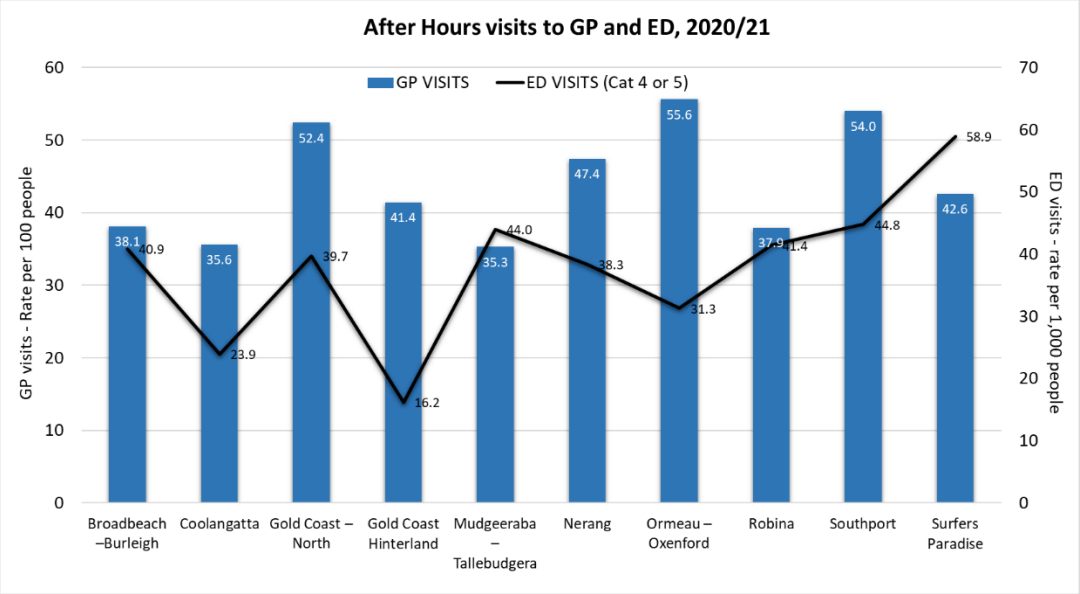
Table 25. Top 10 reasons for lower urgency care presentations in afterhours to Gold Coast ED, 2021/22

Reasons for presentations after hours	Number	%
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 15 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 15. 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).

6.6 Mental health ED presentations

People seek mental health-related services in EDs for multiple reasons, often as an initial point of contact for after-hours care[44]. Mental health-related ED presentations 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[45]. In 2019-20, 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%).

In 2019-20, there was a total of 6,586 mental health-related ED presentations in the Gold Coast region. Of those, just under 40% were during the after-hours period. Southport, Surfers Paradise and Gold Coast-North SA3 regions had the highest rate of mental health-related ED presentations.

[44] Morphet, J. F et al. (2012). *Managing people with mental health presentations in ED.* Australasian Emergency Nursing Journal 15:148-55
[45] Australian Institute of Health and Welfare. METEOR: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australia Modification 10th Edition

Table 26. ED mental health-related presentations in public hospital, Gold Coast SA3 regions, 2019-2020

Region	Rate per 10,000 population
National	121.6
Queensland	128.3
Broadbeach-Burleigh	100.6
Coolangatta	115.0
Gold Coast-North	128.2
Gold Coast Hinterland	94.7
Mudgeeraba-Tallebudgera	68.0
Nerang	80.0
Ormeau-Oxenford	81.6
Robina	98.4
Southport	156.2
Surfers Paradise	129.0

Source: Mental health services provided in emergency departments 2019-2020 by National, state, and SA3 regions.

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).

6.7 Safe Space

The After-Hours Safe Space service is a low to moderate intensity community-based service, with sites situated in 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 service is operational 7 days a week (6-9pm Monday - Friday, 12-8pm Saturday - Sunday).

In 2022-23, across the two sites there was a total of 2,838 service contacts (1,303 at Mermaid Beach location and 1,535 at Southport):

- Most popular times both services are accessed is between 6pm-8pm Monday – Friday, and between 12pm-5pm on the weekend;
- Around a third of people attending the service reported an improvement in mood after attending the service for supports;
- Around 50% of clients reported that attending the afterhours service provided an alternative to seeking supports through the Emergency Department.

6.8 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.

6.9 Service system in GCPHN region

Services	Number	Distribution	Capacity discussion
General Practice	210	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.	• 857 GPs in the GCPHN region. • 45 practices deliver speciality services such as skin checks. • Average number of GPs per general practice is 4.1. • 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	• Medication dispensing • Medication reviews • Medication management • Some screening and health checks

		• Extended hours Saturdays after noon: 21 • Extended hours Sundays: 18 • Extended hours public holidays: 15	
Emergency Departments	6	Southport and Robina (public) Southport, Robina, Benowa and Tugun (private)	• Private health insurance is required to access private 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.
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 MH 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 after-hours services		• 2 services	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	1	• Oxenford	The State and Federal Governments have made announcements regarding establishment of urgent care clinics and/or satellite hospital facilities. However, at the time of publishing this report, no further details have been provided.

6.10 Consultations

Community survey (June 2022)

An online survey received 44 responses from Gold Coast community members. Main findings were:

- 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.

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 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.
- Changes to MBS items have 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.

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 RACHs are lack of availability of staff to show the GP where to go or provide a handover to ensure patients' proper assessment, which is can lead to unnecessary hospitalisations.

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). 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.

Residential Aged Care Homes (September 2022)

- Most common times for call bells and falls in facilities is between 5pm-9pm.
- Regional Assessment Service and the Specialist Palliative Care in Aged Care team help the RACHs 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, and minor falls.
- Barriers to after-hours care for residents are often operational issues such as rostering staff over the peak period of 5-9pm, 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 (July 2022)

- There are longer wait times for home visiting deputising services than 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 ED, knowing that "the problem" will be sorted out.

7. POTENTIALLY PREVENTABLE HOSPITAL CARE

KEY FACTS:

- 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.
- Gold Coast Hospital and Health Service had the lowest PPH of all Queensland HHSs in 2020-2021 (6.9% of all hospitalisations, compared to Queensland average of 8.0%).
- 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.
- Leading potentially preventable hospitalisations among residents of the GCPHN region in 2019-2020 were due to:
    - 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)

7.1 Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPH) are used as a measure of access to timely, effective and appropriate primary and community healthcare. PPHs 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

7.1.1 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.

7.1.2 Factors that affect PPHs other than primary care

PPHs 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 for 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. Some of the conditions knowns to be impacted by these changes include hepatitis B, iron deficiency anaemia, angina, and some conditions requiring rehabilitation care.

7.1.3 The 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[46]. Overall, the most common reason for hospitalisation was urinary tract infections, including pyelonephritis. Urinary tract (acute PPH) and chronic obstructive pulmonary disorder 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.

7.1.4 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[47]. A wider disparity was observed in bed days (from admission to separation) among the two age cohorts.

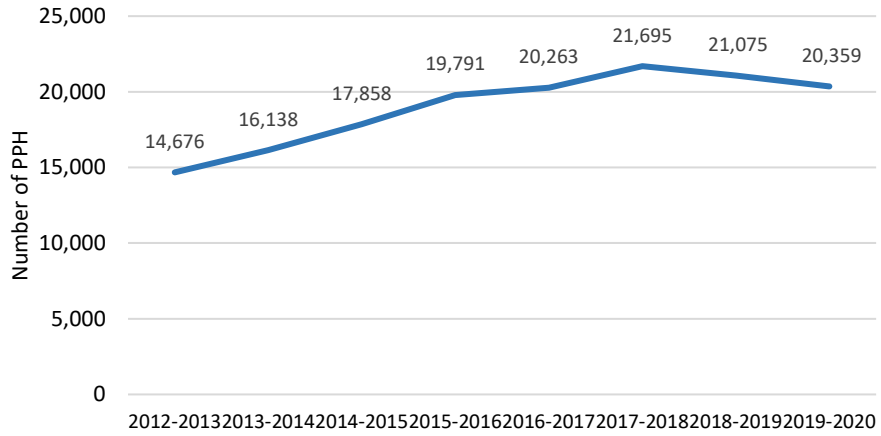
Of the total 67,351 bed days from PPH among residents of the GCPHN region in 2019-2020, people aged 65 years and under accounted for 35%, and people aged 65 years and over accounted for 65%. Across major public hospitals, the average cost to treat acute admitted patients was $4,680 in 2014-2015[48]. 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.

7.1.5 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.

Figure 16 highlights the increase of PPH in the GCPHN region from 2012-13 to 2017-18, followed by a slight decrease from 2017-18 to 2019-20.

Figure 16. Potentially preventable hospitalisations, Gold Coast, 2012-2013 to 2019-2020



Source. AIHW. Disparities in potentially preventable hospitalisations across Australia, 2012-2013 to 2017-2018.

As seen in Table 28, 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%.

[46] AIHW. (2020). Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18. Canberra: AIHW.
[47] AIHW (2019). Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019-20.
[48] AIHW (2018). Hospital Performance: Costs of acute admitted patients in public hospitals from 2012–13 to 2014–15. Canberra: AIHW.

Table 28. 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%

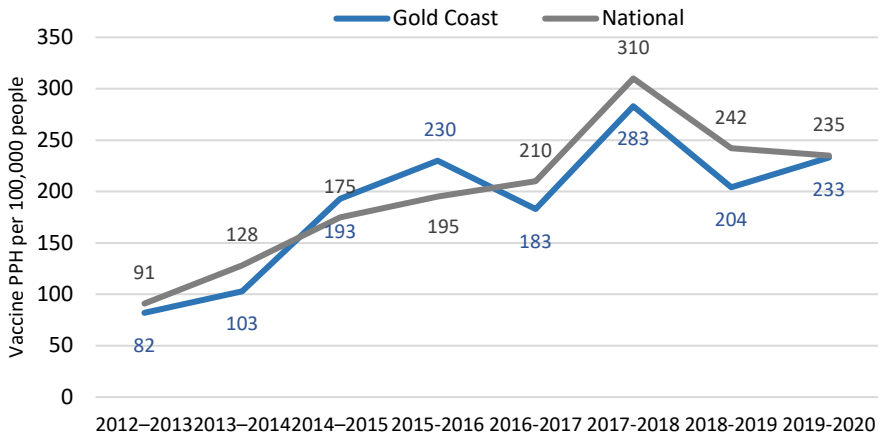
Source. Disparities in potentially preventable hospitalisations across Australia, Australian Institute of Health and Welfare, 2012-13 to 2019-20

7.1.6 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, mumps, polio, rotavirus, tetanus, and whopping cough (pertussis).

Vaccine preventable PPHs 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 17. Vaccine PPH per 100,000 people, national and Gold Coast, 2012-13 to 2019-20



Source. AIHW 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20.

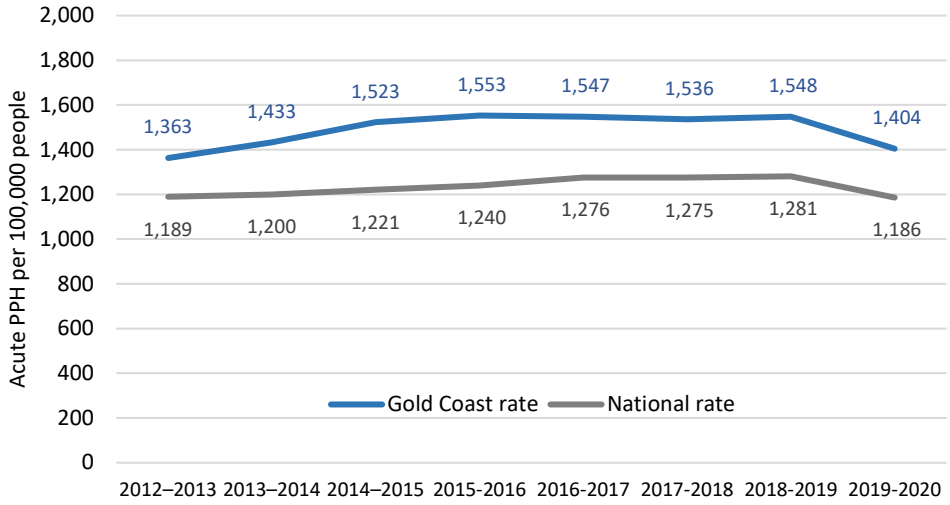
7.1.7 Acute preventable conditions

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), and urinary tract infections (including kidney infections).

The number of acute PPH have increased by 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 18 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 18. Total acute PPH per 100,000 people, national and Gold Coast, 2012-13 to 2019-20



Source: AIHW 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20.

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

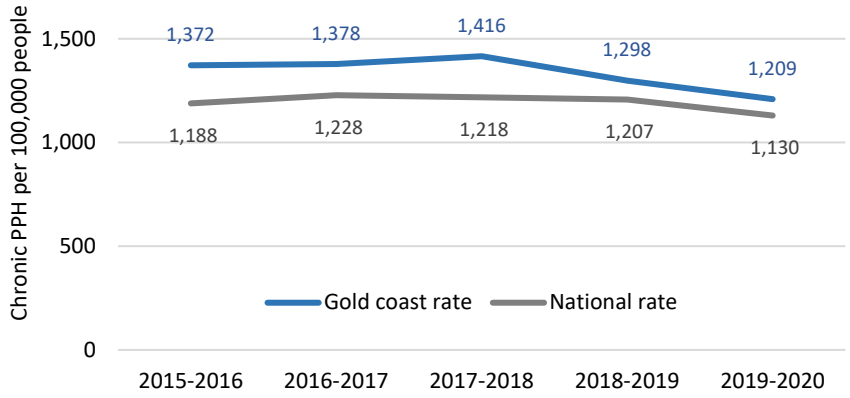
7.1.8 Chronic preventable conditions

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

Figure 19. Total chronic PPH per 100,000 people, national and Gold Coast, 2015-16 to 2019-20



Source: AIHW 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20.

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).

7.2 ED presentations 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.

ED presentations with triage categories 4 and 5 are often used as an indicator of presentations that could be managed by general practice or primary health, reflecting effectiveness of the region's primary healthcare system in preventing unnecessary hospital presentations.

The number of ED presentations for categories 4 and 5 have continued to increase between 2016-2017 to 2019-2020 (Table 29).

Table 29. Presentations to Gold Coast public hospital EDs in according to triage category, 2016-17 to 2019-20

Triage Category	2016-17	2017-18	2018-19	2019-20	Change 2016-17 to 2019-20
1 and 2	31,222	32,204	33,197	34,591	Increase of 10.8%
3	87,205	88,719	91,378	86,510	Decrease of 0.8%
4	45,485	49,764	50,473	63,015	Increase of 38.5%
5	4,587	5,176	5,075	5,208	Increase of 13.5%

In 2019/20, Gold Coast rate for lower urgency ED presentations was lower than the national average (85.5 vs 112.4 per 1,000 people). This was also true for all SA3 regions in the GCPHN region, except for Coolangatta (112.6 per 1,000 people). A reason for this may be the limited after-hours services available in this region, or the fact that many patients living in Coolangatta might in fact be visiting the ED in Tweed region (in New South Wales), yet due to their residential address, they would still be counted within Coolangatta.

Table 30 shows the number of lower urgency ED presentations for in and after hours in 2019-2020.

Table 30. Number of lower urgency ED presentations, Gold Coast SA3 regions, 2019-2020

SA3 region	In-hours lower urgency ED presentations	After-hours lower urgency ED presentations	Lower urgency ED presentations – total	
			Number	Rate per 1,000 population
Gold Coast SA4	55,016	20,358	34,657	85.5
Broadbeach - Burleigh	3,518	1,990	5,508	82.8
Coolangatta	4,117	2,445	6,562	112.6
Gold Coast - North	3,922	2,298	6,220	86.7
Gold Coast Hinterland	677	455	1,132	56.0
Mudgeeraba - Tallebudgera	2,482	1,238	3,720	102.1
Nerang	4,062	2,295	6,357	88.3
Ormeau - Oxenford	6,383	4,242	10,625	69.2
Robina	3,650	2,009	5,659	103.2
Southport	3,786	2,282	6,068	95.4
Surfers Paradise	2,064	1,107	3,171	68.5

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

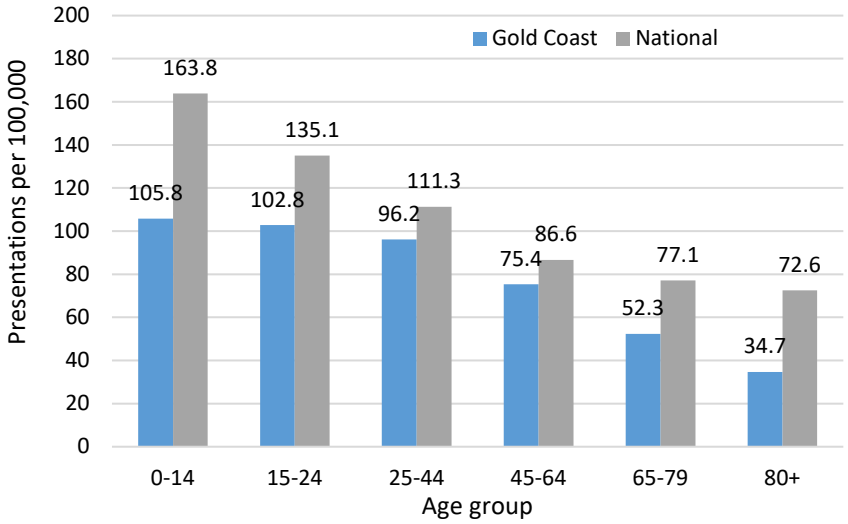
The rate of lower urgency ED presentations from residents in the GCPHN region increased by 46% from 2015-16, which is above the population growth rate.

Table 31. Total number of lower urgency ED presentations, Gold Coast, 2015-16 to 2019-20

	2015–16	2016–17	2017–18	2018–19	2019-20	Change 2015-16 to 2019-20
All persons	37,738	38,336	41,834	42,321	55,016	46%
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%
Females	16,923	17,207	18,985	19,381	27,396	62%
Males	20,813	21,127	22,842	22,938	27,617	33%

Under half of all lower urgency ED presentations (n=20,779; 38%) were by 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 (48 per 1,000 people).

Figure 20. Lower urgency ED presentations per 1,000 people, by age group, national and Gold Coast, 2019-2020



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

7.2.1 After-hours lower urgency ED presentations

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 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).

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.

7.3 Service system in GCPHN region

Services	Number	Distribution	Capacity discussion
General practice	210	Clinics are generally distributed across the GCPHN region with the majority located in coastal and central areas.	• 857 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, or 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.

7.4 Consultations

Primary Care Partnership Council (2021)

- 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.

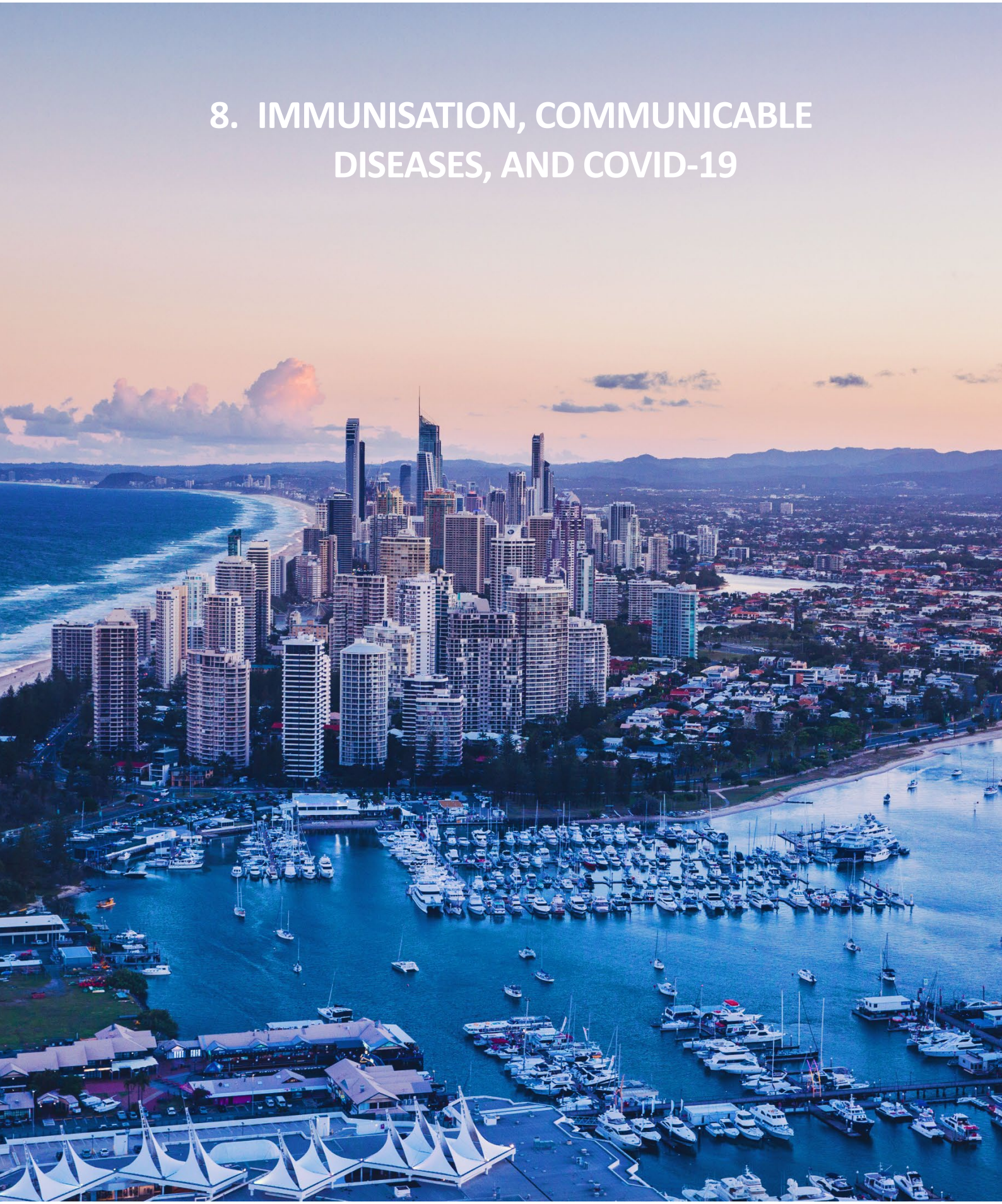
Community Advisory Council (2021)

- 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 (2021)

- Lower urgency ED presentations increased slightly in past years, but GP services increased 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 are still hesitant to do iron infusions but they are widely available.
- 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).
- Lower than average immunisation rate of flu on the Gold Coast – links to high potentially preventable hospitalisations.
- Aging population - increased utilisation of services and drop in private health insurance – leads to more PPHs.

8. IMMUNISATION, COMMUNICABLE DISEASES, AND COVID-19



KEY FACTS:

- The immunisation rates of children (aged 1, 2, and 5) in the GCPHN region remained stable in recent years, although are still below the national and Queensland rates.
- Immunisation rates for Aboriginal and Torres Strait Islander children are below the national rates in the GCPHN region for 1 year old, and above the national rate for 2- and 5-year olds.
- In the GCPHN region, rates of HPV vaccination are increasing but remain lower than national rates.

LOCAL HEALTH NEEDS:

- Areas with low immunisation rates include Surfers Paradise and Gold Coast Hinterland (however, their absolute numbers of not immunised children are low).
- The region with a highest absolute number of children not immunised is Ormeau-Oxenford.

SERVICE ISSUES

- 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.

8.1 Fully immunised children

Table 32 shows the percentage of children immunised against a range of infectious diseases, and those considered fully immunised according to Australian Immunisation Register at age one, two and five. These immunisations are based on the National Immunisation Program Schedule, which includes:

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

Table 32. 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
% Pneumonia	92.6%	95.9%	92.8%	95.5%	N/A	N/A
% Meningococcal	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

Table 33. 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%

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 of children.

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

Tables 34 and 35 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 44. Immunisation trends over time, all children, 2016 to 2021

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 35. 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

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 likely due to the relatively small Aboriginal and Torres Strait Islander child population in the region.

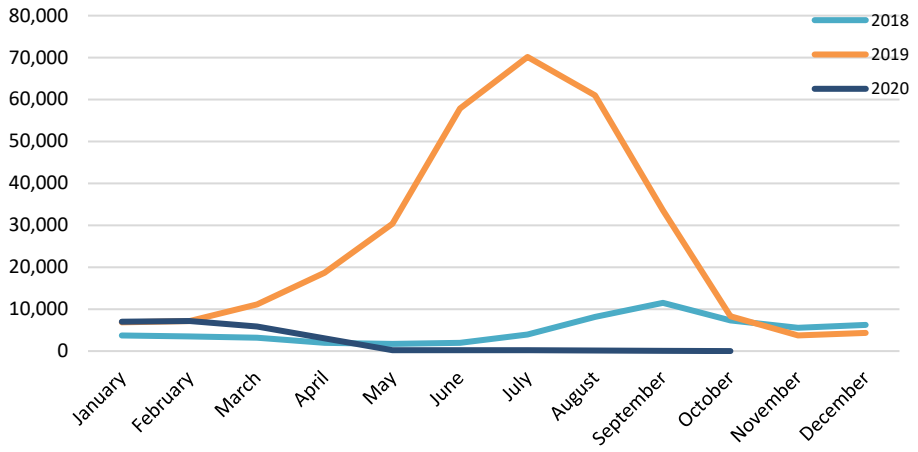
8.2 Influenza

In 2014-2018, influenza and pneumonia were the 14th leading cause of death in the GCPHN region with 278 deaths[49]. 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.

[49] Australian Institute of Health and Welfare. (2020). Mortality over regions and time (MORT) books [Dataset].

The GCPHN region saw a significant decline to 30 cases in 2020[50] (Figure 21); these trends are also being seen nationally.

Figure 21. Annual laboratory confirmed influenza numbers, Australia



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

Each year, the World Health Organization recommends the strains to be included in influenza vaccines based on the global influenza epidemiology[51]. The Australian Influenza Vaccine Committee uses this recommendation to determine the influenza virus composition of vaccines for use in Australia[52].

General practice data for the Gold Coast region, obtained from PATCAT from March 2022 showed that of the 587,244 active patients, 31.4% (n=184,338) received the influenza vaccination.

8.3 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 36 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 36. 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

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,

[50] Queensland Health. (2023). Notifiable conditions annual reporting [Dataset].
[51] World Health Organization (WHO). WHO recommendations on the composition of influenza virus vaccines.
[52] Therapeutic Goods Administration. Australian Influenza Vaccine Committee (AIVC). 2020.

- 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.

8.4 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 37 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 37. Percentage of children aged 15 years on 30th June 2017 who had received Dose 3 of HPV vaccine

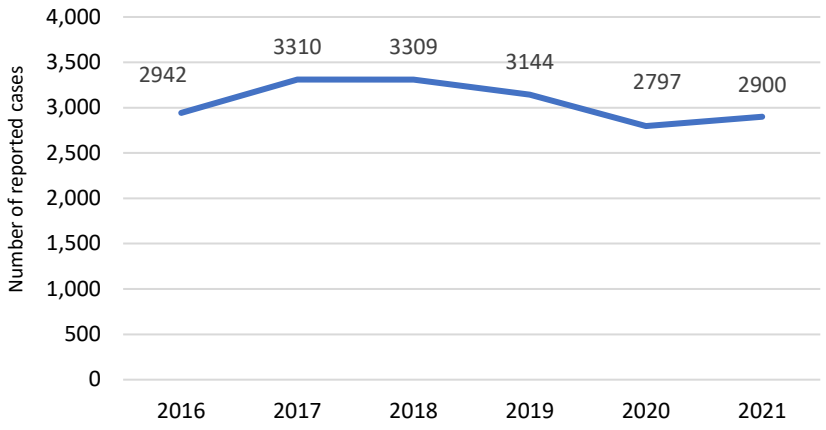
	Gold Coast	National
Females	74.4%	80.5%
Males	67.1%	76.1%

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

8.5 Sexually transmissible infections

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 22), 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. 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.

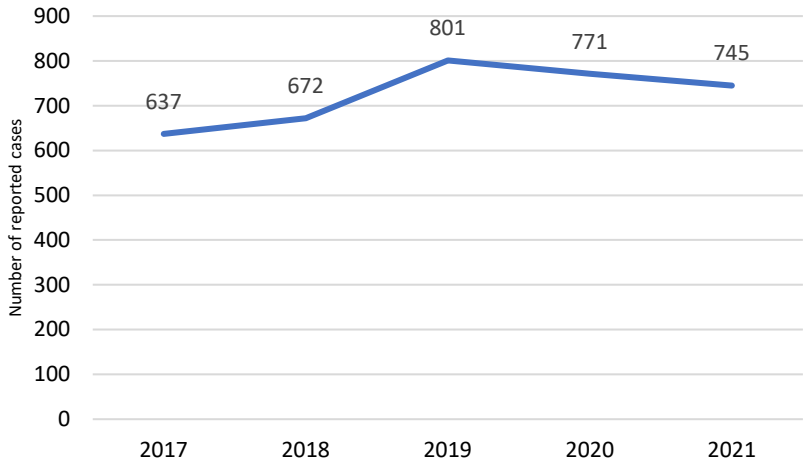
Figure 22. Number of sexually transmitted chlamydia reported cases on the Gold Coast, 2016-2021



Source: QLD Health, Notifiable conditions annual reporting

The number of cases of sexually transmitted gonorrhoea slightly decreased in the GCPHN region from 771 in 2020 to 745 in 2021 (Figure 23), which is comparable to the trends for total Queensland.

Figure 23. Number of sexually transmitted gonorrhoea reported cases on the Gold Coast, 2017 to 2021



Source: QLD Health, Notifiable conditions annual reporting

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.

8.6 Potentially preventable hospitalisations

Table 39 shows the rate of PPH per 100,000 people for vaccine- preventable conditions between 2015-2016 and 2017-2018. 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 38. 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

Table 39 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 and accrued a total of 9,646 hospital bed days.

Table 39. Potentially preventable hospitalisations per 100,000 people 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 5 and older people aged 65-75 have the highest percentage of people being admitted to hospital for influenza and pneumonia.

8.7 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 40 shows the numbers of notifications of selected diseases from 2018 to 2022 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 40. Notifiable conditions annual reporting number of cases, 2018 to 2022

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

Source: QLD Health, Notifiable conditions weekly totals, The elevated rate of shigella in 2018 and 2019 may be due to a change in in case definition.

8.8 Service system in GCPHN region

Services	Number	Distribution	Capacity discussion
General practices	210	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 ae 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	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	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.
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 QLD 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.

8.9 Consultations

GCPHN Community Advisory Council (September 2019)

- There is not as much "fear" with the newer generations when it comes to sexual health.
- There appears to be lack of understanding when it comes to contracting diseases orally, engaging in sexual activity with people from different age groups, and the risk of cancer/HPV.
- 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.

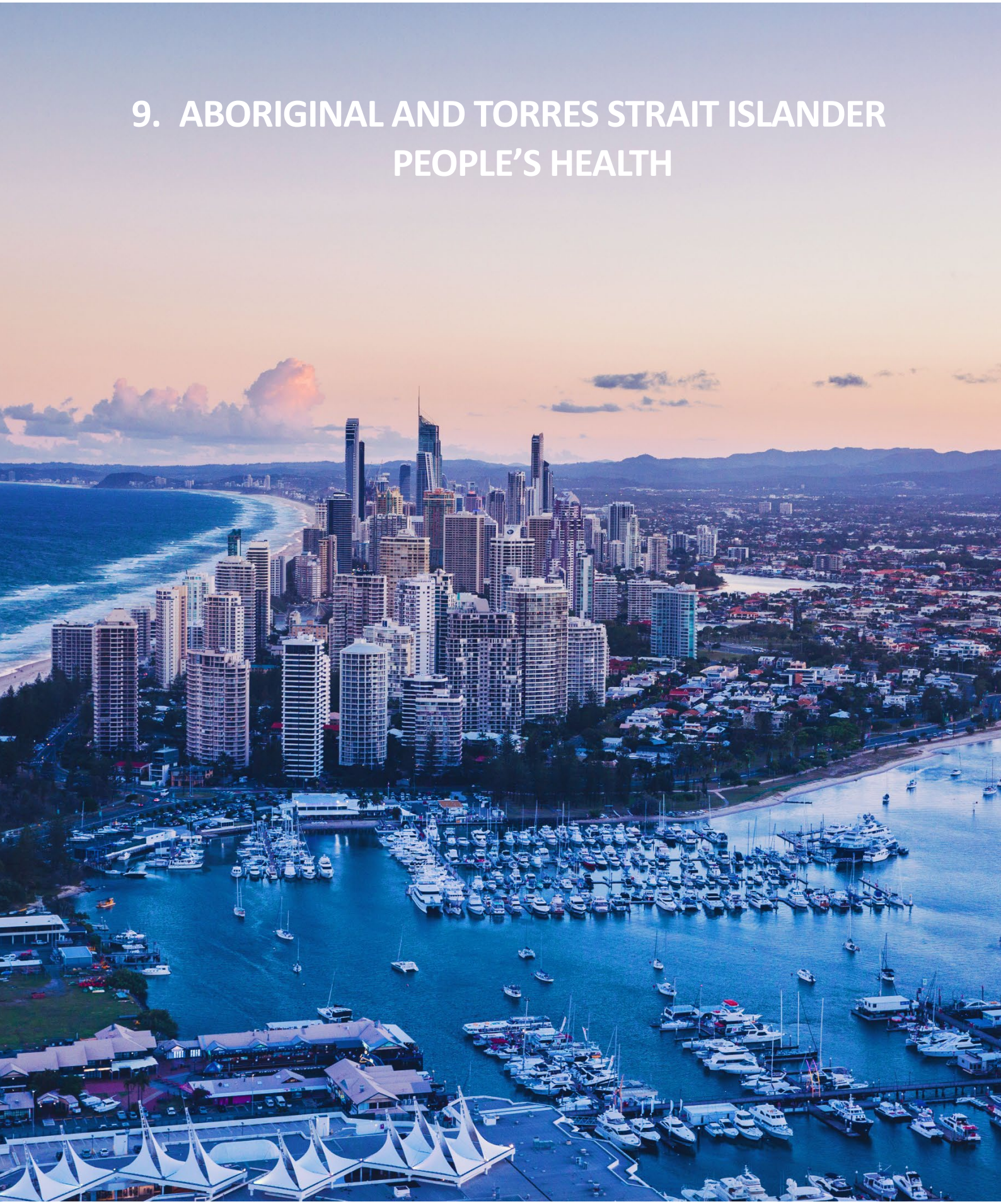
General practices and the GCPHN Primary Health Care Improvement Committee

- 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, likely due to media coverage.
- Some general practices advertise to the general population that flu vax is free 'for everyone' creating confusion for patients not eligible and the 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 skepticism 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.

9. ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE'S HEALTH



KEY FACTS:

- 64.3% of Aboriginal and Torres Strait Islander people in Queensland have a long-term health condition.
- 5,505 hospitalisations of Aboriginal and/or Torres Strait Islander people on the Gold Coast.
- Suicide rate in Queensland Aboriginal and Torres Strait Islander people is twice that of the non-Indigenous population.
- 1.4% of GPs on the Gold Coast identify as Aboriginal and/or Torres Strait Islanders.
- 18% Indigenous adults have indicators of chronic kidney disease.
- Indigenous mothers are four times as likely as non-Indigenous mothers to smoke during pregnancy.

HEALTH NEEDS:

- Low number of completed health assessments.
- Low proportions of chronic disease early identification and self-management.
- Low rate of engagement with general practices for mental health concerns.
- Low rate of cancer screening.
- Low rate of participation in psychological support programs.
- Higher rates of mothers smoking while pregnant and low birthweight babies.

SERVICE ISSUES:

- Limited access to and awareness of appropriate health services for Aboriginal and Torres Strait Islander people.
- Cultural competency, transport and cost affect access to services.
- Limited health services for Aboriginal and Torres Strait Islander people, particularly in the northern Gold Coast.
- Cultural awareness and health equity needs to be embedded into mainstream service delivery to support access.
- Uncoordinated and inconsistent approach to assessment, referrals, and intake.
- Small number of Aboriginal and Torres Strait Islander health workers.
- Service gaps in care coordination between health services, child safety and other support services.

9.1 Gold Coast Aboriginal and/or Torres Strait Islander population

Based on the 2021 Census, there were 812,728 people that identified as Aboriginal and Torres Strait Islander people in Australia (accounting for 3.2% of total population). The GCPHN region had a lower percentage of people that identified as Aboriginal and/or Torres Strait Islander peoples (n=13,901, or 2.2% of total population).

It is worth noting that local Aboriginal and/or Torres Strait Islander service providers report that the identified population figures are likely to be an underestimation.

Table 42 shows the distribution of Aboriginal and/or Torres Strait Islander peoples across the Gold Coast SA3 regions. The highest number of Aboriginal and/or Torres Strait Islander people reside in Ormeau-Oxenford region (n=4,359; almost a third of all Gold Coast Indigenous population).

Table 42. Aboriginal and Torres Strait Islanders population, Gold Coast SA3 region, 2021

	Number	% of Gold Coast Indigenous population
Queensland	237,303	
Gold Coast	13,901	
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.

Additional information on the sociodemographic profile of Aboriginal and/or Torres Strait Islander people living in the GCPHN region, based on 2021 Census data, include:

- 50.8% of Aboriginal and Torres Strait Islander people region are females and 49.2% are males, which is similar for the overall regional population.
- The median age for Aboriginal and Torres Strait people on the Gold Coast is 24 years, whereas the median age for non-Indigenous people in the region is 39 years.
- Median weekly household income for Aboriginal and Torres Strait Islander people living in the GCPHN region was $1,834, which is higher than for Indigenous 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.

9.2 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 include[53]:

Improving

- Cardiovascular disease: Age-standardised rate of deaths decreased from 323 per 100,000 population in 2006 to 229 in 2018.
- Education: Proportion of people aged 20–24 with 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 people in 2009 to 54 in 2018. There is an 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 / 100,000 in 2006 to 2,088 / 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 for help seeking included costs, and health services being unavailable, far away or with long waiting times.

9.3 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, and
- 33% had exceeded the guidelines for alcohol consumption for single occasion, while 15.2% had exceeded guidelines for lifetime risk.

[53] AIHW (2020). Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report.

9.4 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, there was a decrease in the cancer death rate among non-Indigenous 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[54], as seen in Table 43.

Table 43. Participation in cancer screening programs, national, 2019-20

	Indigenous population (%)	Non-Indigenous population (%)
Women aged 50–74 screened for breast cancer— age-standardised rate, 2019-2020	36	50
People aged 50–74 participating in National Bowel Screening Program, 2019-2020	35	46
People aged 20-74 participating in National Cervical Screening Program 2019-2020	50	56

Sources: HPF Table D3.04.9—AIHW analysis of BreastScreen Australia data; AIHW 2023

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, which accounted for a decrease of 11%[55] .

9.5 Cardiovascular disease

Cardiovascular disease includes conditions such as coronary heart disease and stroke. It is the 2nd leading cause of death among Aboriginal and Torres Strait Islander people, accounting for 3,471 (23%) deaths in 2015–2019 (combining data from NSW, Qld, WA, SA, and NT). For Indigenous adults aged 25–54, rates of self-reported cardiovascular disease are about double those of non-Indigenous adults[56].

Data extracted from Gold Coast PHN's PATCAT (Table 3) show that as of March 2022, of the 11,860 active Indigenous patients, 11% (n=1,297) had a cardiovascular diagnosis.

[54]Australian Institute of Health and Welfare. (2023). Aboriginal and Torres Strait Islander Health Performance Framework.
[55] AIHW analysis of state and territory BreastScreen register data (as at November 2020).
[56] Australian Bureau of Statistics (2018-19). *National Aboriginal and Torres Strait Islander Health Survey.*

Table 44. Patients with cardiovascular disease, Indigenous and non-indigenous patients, Gold Coast, 2022

	Indigenous patients		Non-Indigenous patients	
	Number	**%**	**Number**	**%**
Total population	11,860		529,509	
Patients with cardiovascular disease	1,297	10.9%	95,251	18.0%

9.6 Diabetes

Diabetes is a chronic condition marked by high levels of glucose in the blood. The main types of diabetes are Type 1 (lifelong autoimmune disease), Type 2 (the most common form tied to lifestyle factors and largely preventable) and gestational (develops during pregnancy).

Data from PATCAT system show that in March 2022, of the 11,860 active Indigenous patients, 4.7% (n=560) had a diabetes diagnosis. These numbers, and comparisons to non-Indigenous patients, are shown in Table 45.

Table 45. Patients with diabetes diagnoses, Indigenous and non-Indigenous populations, Gold Coast, 2022

	Indigenous patients		Non-Indigenous patients	
	Number	**%**	**Number**	**%**
Total patients	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 2	396	70.7%	20,565	76.3%
Patients with gestational diabetes	86	15.4%	3,885	14.4%

Source, PATCAT. Notes: Data is sourced from general practices excluding Kalwun.

9.7 Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is a preventable lung disease characterised by chronic obstruction of lung airflow that interferes with normal breathing. According to Bettering the Evaluation and Care of health (BEACH) survey, in the period from 2006–07 to 2015–16, the estimated rate of COPD management in general practice was around 0.9 per 100 encounters[57].

Data from Gold Coast PHN's PATCAT system 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 diagnosis of COPD. These numbers, and comparisons to non-Indigenous patients, are shown in Table 46.

Table 46. Patients with COPD diagnoses, Indigenous and non-indigenous patients, Gold Coast, March 2022

	Indigenous patients		Non-Indigenous patients	
	Number	**%**	**Number**	**%**
Total patients	11,860		529,509	
Patients with COPD	245	2.1%	12,519	2.4%

Source: PATCAT. Notes: Data is sourced from general practices excluding Kalwun.

[57] Britt, H., et al. (2016). A decade of Australian general practice activity 2006–07 to 2015–16. Sydney University Press.

9.8 Maternal and child health outcomes

The proportion of babies born at low birth weight (less than 2500 grams) to Aboriginal and/or Torres Strait Islander mothers in the GCPHN region in 2018 was 10.4% (14 births 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 during the same period was 6.0% (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 regions but still much higher than for the non-Indigenous Gold Coast population at 4%[58].

9.9 Immunisation

In 2023, immunisation rates for Aboriginal and Torres Strait Islander children were lower than for non-Indigenous children at 1 and 2 years, and a higher for children aged 5 (Table 47).

Table 47. Immunisation rates for Aboriginal and Torres Strait Islander and non-Indigenous children, Gold Coast, 2023

Age group	Aboriginal and Torres Strait Islander children (%)	Non-indigenous children (%)
1 year	90.1%	93.1%
2 years	88.9%	91.2%
5 years	95.6%	93.0%

Source: Queensland Government: Hospital performance, HHS statewide. Immunisation coverage for 12 months ending June 2023.

9.10 Social and emotional wellbeing

The 2019 Australian Aboriginal and Torres Strait Islander Health Survey found 31% people aged 18 years and over experienced high or very high levels of psychological distress in the 4 weeks before the survey. 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.

Further, the survey 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, or attention deficit hyperactivity disorder), and found that:

- 24% (187,500) reported a mental health or behavioural condition, with no differences between men and women,
- Mental health conditions were around three times higher for people living in non-remote areas (28%) than remote areas (10%),
- Anxiety was the most reported metal health condition (17%), followed by depression (13%),

Data from GCPHN PATCAT system show than in March 2022, of the 11,860 Indigenous patients, 27.0% had a coded mental health diagnosis, compared to 20.6% of non-Indigenous patients (Table 7).

[58] Australian Institute of Health and Welfare (2020) *Australia's mothers and babies 2018—in brief*.

Table 48. Patients with mental health diagnoses, by Indigenous status, Gold Coast, 2021

	Indigenous patients		Non-Indigenous patients	
	Number	%	Number	%
Total patients	11,860		529,509	
Patients with a mental health diagnoses	3,199	27.0%	108,913	20.6%

Source, PATCAT. Data is from all general practices excluding Kalwun.

9.11 Suicide

Suicide and self-harm behaviours arise from a complex web of personal, social, and historical factors[59]. True suicide mortality figures in Aboriginal and Torres Strait Islander populations remain poorly understood due to incomplete data collection processes and inaccurate classification systems[60].

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[61].

Of the 756 suicides reported in 2021 in Queensland. Aboriginal and Torres Strait Islander individuals living in Queensland had 57 deaths accounting for 7% of all suspected suicides by Queensland residents[62]. The age group of 20-29 had the highest number of suspected suicides (28) by Aboriginal and Torres Strait Islander Queenslanders.

9.12 Mortality

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 49 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 49. 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.

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%)[63].

[59] Dudgeon, P., Calma, T., & Holland, C. (2017). The context and causes of the suicide of Indigenous people in Australia. *J. Indig Wellb,* 2(1).
[60] Leske, S., Adam, G., Catakovic, A., Weir, B., & Kõlves, K. (2022). Suicide in Queensland: Annual report 2022.
[61] Australian Bureau of Statistics (2018). Catalogue 3303.0—Causes of Death. Canberra. Australia.
[62] S Leske, G Adam, A Catakovic, B Weir and K Kõlves, *Suicide in Queensland: Annual Report 2022*, AIRAP, Grifith university.
[63] Australian Institute of Health and Welfare (2023) *Deaths in Australia, AIHW*, Australian Government

9.13 Utilisation of health services

9.13.1 Indigenous-specific health check

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 experience some specific health risks, and to encourage early detection and treatment of common conditions that cause ill health and early death.

Table 50 shows that in 2020-21, GCPHN region has a lower rate of Indigenous health assessments completed (22.8%), compared to the national (27.2%) and Queensland rate (33.7%).

Table 50. Indigenous-specific health checks, Gold Coast SA3 regions, 2020-21

	Number of patients	% of Indigenous population
Australia	236,610	27.2%
Queensland	82,324	33.7%
Gold Coast SA4	3,029	22.8%

Source: AIHW analysis of MBS data 'Indigenous-specific health checks include Medicare Benefits Schedule (MBS) items.

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[64]. 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.

As seen in Table 51, the rate of Indigenous-specific health check patients who received a follow-up in the 12 months on the Gold Coast (53.5%) was similar to the Queensland rate (53.3%), and higher than the national rate (46.7%).

Table 515. 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 follow-up in the following 12 months	
		Number	%
Australia	238,837	111,503	46.7%
Queensland	84,003	44,767	53.3%
Gold Coast SA4	3,334	1,783	53.5%

Source: AIHW analysis of MBS data. NOTE: Indigenous-specific health check has MBS item 715.

9.14 Inpatient admissions

Table 52 shows the number of inpatient admissions to Gold Coast public hospitals, 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.

[64] Bailie, J., et al. (2014). Follow-up of Indigenous-specific health assessments-a socioecological analysis. MJA 200(11), 653-657.

Table 52. Hospital admissions to Gold Coast public hospitals, by Indigenous status, 2014-15 to 2019-20

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Indigenous patients	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.

9.15 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 53).

Table 53. Admissions for potentially preventable conditions per 100,000 people, Aboriginal and/or Torres Strait Islander persons, 2014-15 to 2016-17

	PPH - 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 440 PPHs 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 PPHs or 7.0% 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

9.16 Mental health ED presentations

In 2020-21, Aboriginal and Torres Islander people, who represent 3.8% of the Australian population[65], accounted for 7.7% of all ED presentations and 13% of mental health-related ED presentations. The

[65] Australian Bureau of Statistics. (2021). *Estimates of Aboriginal and Torres Strait Islander Australians*. Canberra: ABS

rate of mental health-related ED presentations for Indigenous Australians was more than 4.6 times that for other Australians (443 and 95 per 10,000 population, respectively)[66].

In 2019-20, a total of 7,403 mental health-related ED presentations occurred at Gold Coast University Hospital and Robina Hospital. Of those, 375 (5%) were Aboriginal and Torres Strait Islander people. Psychological Services Program

The Psychological Services Program (PSP) is funded by GCPHN to provide 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.

In financial year 2021/22, PSP received 1,620 referrals and delivered 6,999 sessions. Of those, 111 referrals (6.9%) were for Aboriginal and Torres Strait Islander people, leading to 383 sessions.

[66] AIHW (2023). *Mental Health: mental health services provided in emergency department.*

9.17 Service system in GCPHN region

Services	Number	Distribution	Capacity Discussion
General practices	210	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 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.
Yan-Coorara, GCH	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. • 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.

Services for Social and Emotional Wellbeing:

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.

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.

Services	Number	Distribution
Psychological Services Program (PSP), Aboriginal and Torres Strait Islander Social and Emotional Wellbeing service.	18 PSP providers	Providers are situated across the region.
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 (Bilinga, Miami and 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

9.18 Consultations

Various consultation activities were 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.

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.
- 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.
- 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.

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 of Aboriginal and Torres Strait Islander peoples experience high levels of direct and indirect racism on a daily basis.
- Reconciliation 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 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 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 skilled in providing suicide prevention, and 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.

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.
- 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. Client satisfaction could be improved by increasing cultural competency of mainstream services to safely and effectively work with Aboriginal and Torres Strait Islander clients.
- Stigma and the "shame factor" can prevent people 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.
- 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.
- 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.

10. CANCER

KEY FACTS:

- Participation in BreastScreen, bowel and cervical cancer screening is below national rate.
- Rate of new cancers diagnosed annually in the Gold Coast region is above the national rate.
- Breast cancer and colorectal cancer had the highest number of cases in the Gold Coast region.
- Higher rates of melanoma across the Gold Coast region compared to national rates.
- 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.

LOCAL HEALTH NEEDS:

- Low participation in all cancer screening, particularly in SA3 region Ormeau-Oxenford.
- Education is needed to support the change for cervical cancer screening to a 5-year timeframe.

SERVICE ISSUES:

- General practice has limited view of screening data to support proactive steps with patients.
- Limited translated resources available for people from culturally and linguistically diverse backgrounds.
- Low awareness of screening target groups and eligibility causes confusion with community and health professionals, resulting in fewer people being screened.
- Some areas with low participation rates require targeted strategies corresponding to screening type, age and specific locations.

10.1 Cancer incidence

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 number of cancers (2,761) and the highest rate per 100,000 people, while Robina had the lowest rate.

Table 54. All cancer incidence, number and rate per 100,000 people, Gold Coast SA3 regions, 2017

	Number	Rate per 100,000 people
Gold Coast SA4	3,913	546
Broadbeach – Burleigh	458	541
Coolangatta	421	551
Gold Coast – North	576	563
Gold Coast Hinterland	135	564
Mudgeeraba – Tallebudgera	196	537
Nerang	438	559
Ormeau – Oxenford	676	581
Robina	302	491
Southport	424	569
Surfers Paradise	287	489

Queensland Health. Oncology analysis system (OASys). Cancer Alliance Queensland.

10.1.1 Cancer types

Table 43 provides the incidence of selected cancer types across the GCPHN region. Between 2013 and 2017, GCPHN region had a higher rate of various types of new cancers diagnosed:

- 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 Coolangatta (111) having the highest rate among in the GCPHN region.

Table 55. 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..

10.1.2 Cancer mortality

AIHW mortality data[67] indicates that within the GCPHN region between 2017 and 2021:

- Cancer accounted for seven of the top 20 leading causes of death.
- Lung cancer caused 1,100 deaths at a rate of 27.4 deaths per 100,000 persons, same as the national rate of 27.4. It was the 4th leading cause of death.
- Colorectal cancer caused 668 deaths at a rate of 16.7 deaths per 100,000 persons in the GCPHN region compared to the national rate of 16.9. It was the 6th leading cause of death.
- Prostate cancer caused 484 deaths at a rate of 11.7 deaths per 100,000 persons in the GCPHN region compared to the national rate of 10.6. It was the 7th leading cause of death.
- Breast cancer caused 394 deaths at a rate of 10.3 deaths per 100,000 persons in the GCPHN region compared to the national rate of 10.2. It was the 10th leading cause of death for people.
- Pancreatic cancer caused 379 deaths at a rate of 9.4 deaths per 100,000 persons in the GCPHN region compared to the national rate of 10.2. It was the 11th leading cause of death.

10.1.3 Prevalence

Data extracted through PATCAT from 174 general practices in the GCPHN region from March 2022 show of 587,244 active patients, 27,285 patients (4.6%) had an active cancer condition. Table 56 shows the prevalence of each cancer types.

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

Table 56. GP patients with active cancer condition, Gold Coast, March 2022

Type of cancer	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.

10.2 Cancer screening rates

Table 57 shows the rates of participation in national cancer screening initiatives in the Gold Coast.

Table 57. Participation in national cancer screening programs, by Gold Coast 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. 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 GCPHN residents aged 50-74 years (37.6 %) was below the national rate (41.6 %).
- 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%).
- 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%).
- Among Gold Coast SA3 regions, Surfers Paradise had the lowest rates of screening for all three types of cancer.

10.3 Service system in GCPHN region

Services	Number	Distribution	Capacity discussion
General practice	210	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 (FOBT) kit and invited to complete the test.	• Current roll-out NBCSP results sent electronically to GP. • Follow up of abnormal results from the program incurs a variable wait time. • 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.	A shortage of culturally appropriate and culturally safe services inhibit access for CALD and many Aboriginal and Torres Strait Islander consumers.

10.4 Consultations

Community and stakeholders

- 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 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 costs 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.

GCPHN Community Advisory Council (2017)

There is limited awareness in Gold Coast community regarding screening and eligibility requirements:

- 66% knew about cervical cancer, 75% about breast cancer, 50% 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.

11. PERINATAL AND EARLY CHILDHOOD

KEY FACTS:

- 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.
- The percentage of women who smoke during pregnancy in the GCPHN is lower than the national rate.
- In 2021, 10.3% of Gold Coast children were developmentally vulnerable in two or more domains, compared to 13.2% across Australia.

LOCAL HEALTH NEEDS:

- 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.
- 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.
- Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs.
- Rate of women being diagnosed with perinatal depression are increasing.

SERVICE ISSUES:

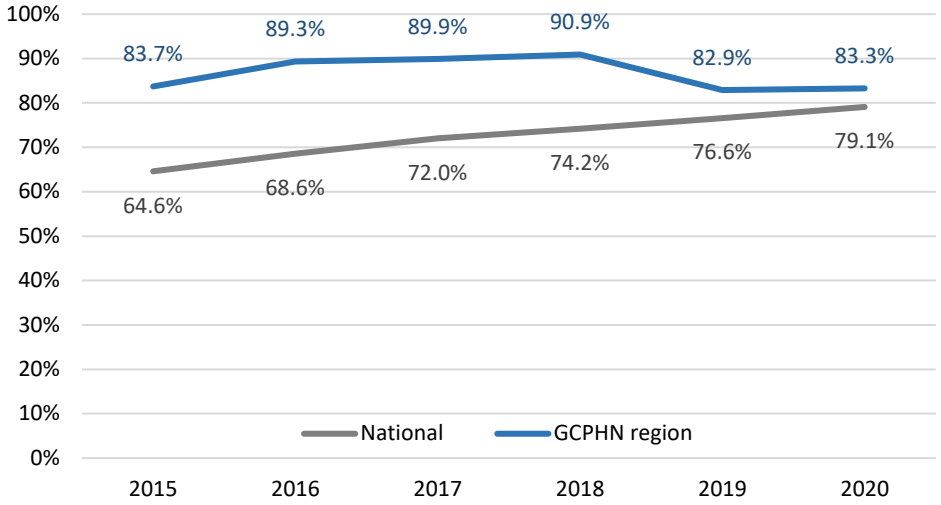
- There is need for preventive care around postnatal depression, with mental health assessed in the pre- and postnatal stages.
- There is a large waitlist for fetal alcohol spectrum disorder (FASD) assessments for children. Addressing mental health issues for children in care is hampered by:
    - long wait times for assessment and treatment in the public system,
    - cost of private services,
    - barriers around sharing information with non-health professionals, and
    - limited availability of low-cost assessments for diagnosis and National Disability Insurance Scheme applications.

11.1 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 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[68].

Figure 24. Women who had at least one antenatal visit in the first trimester, nationally and GCPHN, 2015-2020



Source: Australian Institute of Health and Welfare 2022. National Core Maternity Indicators.

11.2 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.

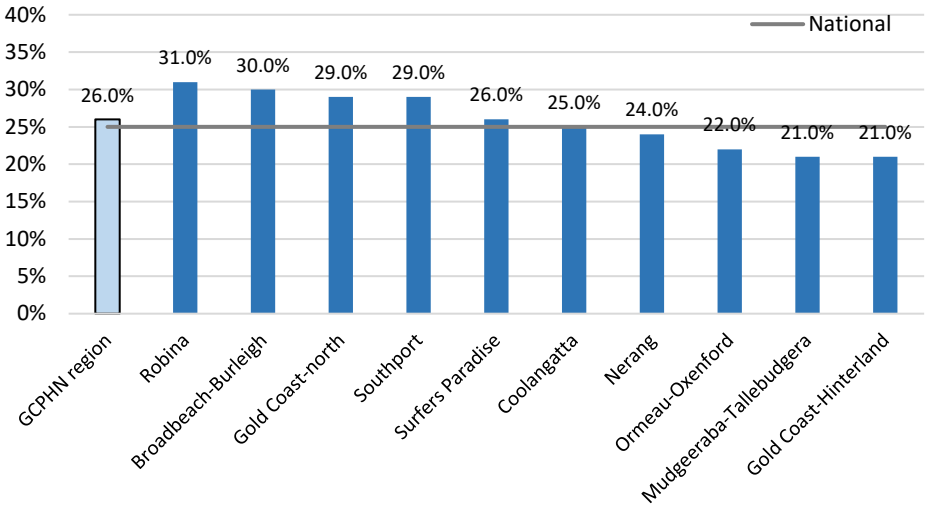
In 2016 in Queensland, 77% of infants were receiving only breast milk at discharge from hospital, 16% received breastmilk and infant formula, and 7% were receiving only infant formula.

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 25).

[68] Australian Institute of Health and Welfare. (2023). *Health of mothers and babies*, AIHW, Australian Government.

Figure 25. 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

11.3 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[69].

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%. GCPHN's and national rates have decreased from 2015 to 2020.

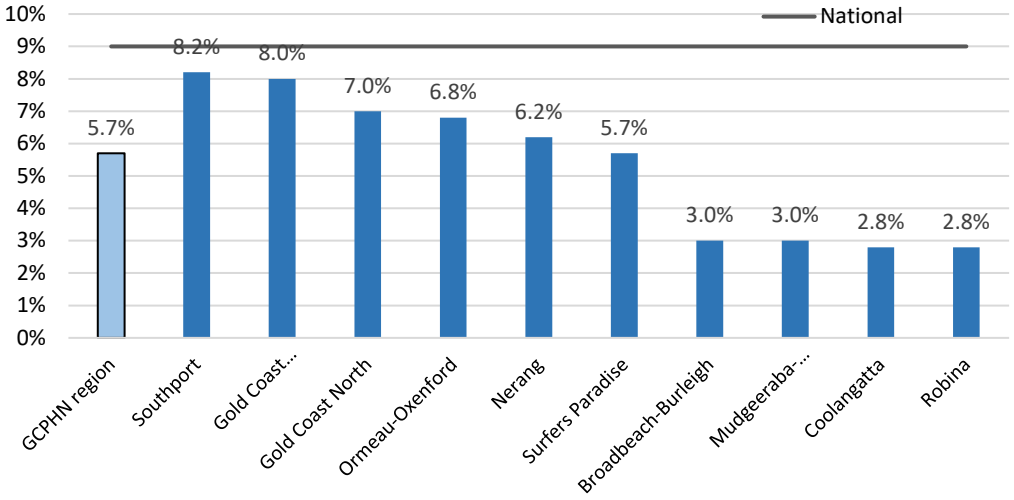
11.4 Smoking during pregnancy

Smoking during pregnancy 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%).

As seen in Figure 26, 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%.

[69] Goldenberg, R. L., & Culhane, J. F. (2007). Low birth weight in the United States. *American Journal of Clinical Nutrition*, *85*(2), 584–590.

Figure 26. 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.

11.5 Substance use during pregnancy

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 2019 National Drug Strategy Household Survey indicated[70]:

Nearly two thirds of women abstained from alcohol while pregnant, up from 56% in 2016. 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).

11.6 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[71].

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[72]). 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),
- were smokers,
- came from lower income households,
- were overweight or obese, or
- had an emergency caesarean section.

[70] Australian Institute of Health and Welfare. (2020). *National Drug Strategy Household Survey 2019*. Canberra: AIHW.
[71] Deloitte Access Economics. (2012). *The cost of perinatal depression in Australia – Final report*. Post and Antenatal Depression Association.
[72] Australian Institute of Health and Welfare. (2011). *2010 Australian National Infant Feeding Survey: indicator results*. Canberra: AIHW.

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 women with a coded postnatal depression. Of these, 80% were aged 25 to 44 years old.

11.7 Psychological Services Program

The Psychological Services Program, commissioned by the GCPHN, 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.

From July 2021 to June 2022 there were 235 referrals and 849 sessions delivered targeting children.

11.8 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)[73] .

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.

Younger mothers under 20 years of age were less likely to breastfeed (65 % exclusively breastfed at discharge) and more likely to use instant formula (11%)[74], compared to mothers aged 20 or more.

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

While the percentage of Aboriginal and Torres Strait Islander women in the GCPHN region who smoked is higher than among non-Aboriginal and Torres Strait Islander women, it's lower compared to the national rate of 45.2%.

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.

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%.

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 6).

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.

[73] Australian Institute of Health and Welfare. (2018). Teenage mothers in Australia 2015. Canberra: AIHW.
[74] Department of Health. (2016) *Queensland infant feeding survey 2014: current results, sociodemographic factors, and trends.*

11.10 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.

11.11 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[75].

11.12 Australian Early Development Census

The Australian Early Development Census (AEDC) provides a national measurement to monitor Australian children's development.

The AEDC has been completed by children from 2009 and there have been five censuses in this time.

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

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 rates (24.7% and 13.2%, respectively).

From 2018 to 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.

[75] Queensland Health (2018). *The health of Queenslanders 2018: Report of the Chief Health Officer Queensland.*

Table 58. 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

11.13 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.

11.14 Service system in GCPHN region

Service	Number	Distribution	Capacity
General Practices (Antenatal visits)	210	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), and progress of the mother, including emotional state • Monthly antenatal visits until week 28, fortnightly from week 30 to 36 and weekly thereafter • Hospital visits usually occur for an initial assessment and then at weeks 32 and 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.
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.
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 • Bedwetting program • Indigenous health workers
School interventions	111	State schools through Gold Coast	• State schools offer support and other services for children while they are in state schools
Paediatricians	32	Across the Gold Coast, 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, Helensvale, Nerang, Labrador, Robina, Palm Beach	• Health advice for infants from birth to four years. • Home visiting by referral • Breastfeeding clinic, practical assistance • Parent education groups .
Community immunisation clinics, Gold Coast Health	6	Helensvale, Carrara, Upper Coomera,	• 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.

		Burleigh, Robina and Southport	
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.
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	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.

11.15 Consultations

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 those.
    - 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.
    - 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.

12. PERSISTENT PAIN

KEY FACTS:

- Persistent pain is often linked to chronic musculoskeletal conditions, which have a slightly lower prevalence in the GCPHN region compared to national rates.
- The rate of opioid dispensing across Gold GCPHN region is above the national rate.
- Rate of prescriptions dispensed for opioid medicines is above the national rate on the GCPHN region and has been increasing in recent years.
- GCPHN region's rate of people with musculoskeletal system diseases is slightly below the national rate.
- Endometriosis affects 1 in 7 girls and women, yet it takes on average 7 years to be diagnosed.

LOCAL HEALTH NEEDS:

- There are high rates of musculoskeletal conditions in Southport, Coolangatta, Ormeau-Oxenford, and Gold Coast-North.
- Less than a third of GCPHN population with a musculoskeletal condition had GP a management plan in the last year.

SERVICE ISSUES:

- Pain management frequently focuses on medication.
- 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.
- There is a lack of multidisciplinary primary care services for endometriosis and pelvic pain.

12.1 Background

Persistent pain is any pain that lasts beyond normal healing time after injury or illness - generally three to six months. It is a common and complex condition, and can range 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[76]. 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 hospitalizations.

12.2 Prevalence

Measuring how many people have chronic pain in Australia is difficult. 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[77]. Persistent pain increased with increasing age, to almost one in four adults (24%) aged 85 and over. If this rate was 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, the number of people seeing GPs for persistent pain are increasing. Between 2006-2007 and 2015-2016, the rate of GP visits for chronic back pain or unspecified chronic pain were managed during the visit increased by 67%, representing about 400,000 more encounters[2].

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

[76] Pain Australia. (2019c). *The cost of pain in Australia.* Canberra: Deloitte Access Economics.
[77] Australian Bureau of Statistics. (2017). *Survey of Health Care, Australia 2016.* ABS cat. No. 4343.0. Canberra: ABS.

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[78] predicated the following:

- 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 by 58% and 50%, 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.

12.2.1 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. This was slightly lower than the national rate of 29.9 per 100 people.

Of the 166,059 residents in the GCPHN region living with a musculoskeletal condition, 72,906 (about 44%) 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 population growth and the increase in the average age of the population[79].

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[80].

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[81].

12.2.2 Local data

Analysing data extracted from GCPHN's PATCAT system as of March 2022, of the 587,244 active patients, 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 with a coded musculoskeletal

[78] Arthritis and Osteoporosis Victoria. (2013). *A problem worth solving.* Elsternwick: Arthritis and Osteoporosis Victoria.
[79] MBF Foundation. (2007). The High Price of Pain: The Economic Impact of Persistent Pain in Australia. Access Economics.
[80] Schofield et al. (2012) Quantifying the productivity impacts of poor health and health interventions, University of Sydney.
[81] National Health Survey. Australian Bureau of Statistics, 2017-2018.

condition. Table 59 shows the prevalence of different types of musculoskeletal conditions, including inflammatory arthritis, bone disease, osteoporosis, and osteoarthritis of all active patients.

Table 59. GP patients with coded musculoskeletal condition as of March 2022

	Number	Rate
All GP patient population	587,244	
Patients with a coded musculoskeletal condition	92,914	16%
Inflammatory arthritis	12,174	13%
Musculoskeletal other	21,479	23%
Bone disease	72,488	78%
Osteoporosis	31,347	34%
Osteoarthritis	52,982	57%

12.2.3 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.

12.3 Lower back pain

It is estimated that 70-90% of people will suffer from lower back pain in some form at some point in their life[82]. Back problems include a range of conditions linked to the bones, joints, connective tissues, muscles, and nerves of the back. Australian Bureau of Statistics 2017-2018 National Health Survey[83] estimated that around 4 million Australians (16% of the population) have back problems.

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 those, 53% were by females and 47% were by males. 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%).

12.4 Endometriosis

Endometriosis is a chronic inflammatory condition where endometrial like tissue exists in other parts of the body[84]. Endometrial tissue lines the uterus and responds to hormones released by the ovaries, however tissues that exist outside of the uterus also respond to hormonal fluctuations, triggering bleeding in areas it should not occur. This process causes chronic pain in females who suffer with this condition, with severity typically increasing at times of menstruation. Inflammation and scaring can lead to separate pelvic organs joining together due to painful adhesions caused by endometriosis[85]. Characteristics involve chronic pelvic pain, heavy periods commonly accompanied by mild to severe pain, discomfort when going the bathroom and infertility in women.

Endometriosis has been referred to as the 'missed disease' due to its unclear aetiology and inconsistencies in its diagnosis and management[86]. The average time for an Australian woman to be

[82] Australian Institute of Health and Welfare. (2023). *Back problems.* Cat. No. PHE 231. Canberra: AIHW.
[83] Australian Bureau of Statistics. (2017-18). National Health Survey: First Results methodology.
[84] Bulun, S. E., Yilmaz, B. D., Sison, C., Miyazaki, K., Bernardi, L., Liu, S., et al. (2019). *Endocrine Reviews*, 40(4), 1048–1079.
[85] AIHW (2019). Endometriosis in Australia: prevalence and hospitalisations. Canberra: AIHW.
[86] Hudson N. (2022). The missed disease? Endometriosis as an example of 'undone science'. Reproductive biomedicine & society, 14, 20-27.

diagnosed with endometriosis is around 7 years. Due to this, the true prevalence of endometriosis is difficult to determine. It is currently estimated that endometriosis affects 1 in 7 girls and women, which means that there are over 830,000 individuals living with endometriosis in Australia. Further, in 2016/17, there were around 34,200 endometriosis-related hospitalisations in Australia[85].

Endometriosis is reported to cost Australian society between $7.4 and $9.7 billion annually with two-thirds of these costs attributed to a loss in productivity with the remainder, approximately $2.5 billion being direct healthcare costs[19].

12.5 COVID-19 and persistent pain

Throughout the outbreak of COVID-19, many Gold Coast 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 start of the COVID-19 pandemic.

12.6 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[87].

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[88] 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[89] 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 musculoskeletal condition, over 50% had been prescribed pain relief medication. Table 60 gives a

[87] Pain Australia. (2016). Prevalence and the Human and Social Cost of Pain, Pain Australia Fact Sheet 2.
[88] Australian Commission on Safety and Quality in Healthcare, The First Australian Atlas of Healthcare Variation.
[89] Alcohol and Drug Foundation. (2016). Is there a pill for that? The increasing harms from opioid and benzodiazepine medication.

breakdown of medications prescribed and uptake of GP Management Plan (GPMP) and Team Care Arrangements (TCA) care plans in the past 12 months.

Table 60. People with a musculoskeletal condition, prescribed medication and management, Gold Coast, 2022

	Number	Rate
All active patients	587,244	
Patients with a coded musculoskeletal condition	88,098	15%
Prescribed pain relief medication	48,748	55%
Prescribed musculoskeletal medication	30,610	35%
GPMP in the last year	54,751	61%
TCA in the last year	52,115	58%

Note: 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.

12.7 Opioid prescriptions

Codeine has historically been Australia's most used opioid[90]. 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[91]. For further information on opioids please see the Alcohol and other drugs needs assessment.

Clients may present to a pain management program for assistance for opioid reduction to support their GPs recommendation.

Statistics from the Pharmaceutical Benefits Scheme (PBS) indicate that 65,681 prescriptions (per 100,000 population) for opioids were filled across the GCPHN region in 2016-2017, up from 59,939 in 2013-2014 (an increase of 9%). The rate was higher in the GCPHN region compared to national rate.

Table 61 provides a breakdown of opioid prescriptions dispensed across GCPHN's SA3 regions. The region with the highest rates of opioid prescription per 100,000 people use was Southport.

[90] Degenhardt, L., Gisev, N., Cama, E., Nielsen, S., Larance, B., & Bruno, R. (2016). The extent and correlates of community-based pharmaceutical opioid utilisation in Australia. Pharmacoepidemiology and drug safety, 25(5), 521–538.
[91] Lalic, S., Ilomäki, J., Bell, J. S., Korhonen, M. J., & Gisev, N. (2019). Prevalence and incidence of prescription opioid analgesic use in Australia. *British journal of clinical pharmacology, 85(1), 202–215*.

Table 61. Age-standardised rate of PBS opioid prescriptions per 100,000 people, Gold Coast, 2016-2017

Region	2016-2017
National	58,595
Gold Coast SA4	65,681
Broadbeach-Burleigh	61,740
Coolangatta	64,090
Gold Coast- North	69,981
Gold Coast Hinterland	68,729
Mudgeeraba-Tallebudgera	66,132
Nerang	68,019
Ormeau-Oxenford	69,950
Robina	54,078
Southport	77,673
Surfers Paradise	58,214

Source: ACSQHC, Australian Atlas of Healthcare Variation

12.8 Unnecessary treatments and surgical interventions

Concerns have been raised about potentially ineffective and unnecessary treatments, such as medical imaging for chronic back pain and surgical interventions for osteoarthritis. 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 PwC predicted annual savings to the MBS because of dis-incentivising unnecessary imaging for chronic low back pain to be over $100 million.

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.

12.9 Service system in GCPHN region

Services	Number	Distribution	Capacity discussion
General Practice	210	Across GCPHN, majority in coastal and central areas	• 857 GPs in the GCPHN region.
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. • There is currently a wait time of around 4-5 weeks. • Increasing demand—more GPs referring into the program each year. • Past evaluations show increased ability to perform everyday activities, a significant reduction in medications, and 78% reduction in hospitalisations.
Interdisciplinary Persistent Pain Centre, Gold Coast Health	1	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	Southport	• Fee-for-service, rebate 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	Southport	• Multi-disciplinary team including pain and rehab specialists, OTs, pharmacists, 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	Benowa; services John Flynn Private Hospital (Tugun) and GC 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/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 of chronic pain. • Information available for health professionals.
Supporting Kids in Pain (SKIP) program	1	Based in Brisbane with outreach on Gold Coast	• Not-for-profit organisation, free 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.
Endometriosis and Pelvic Pain Clinic	1	Benowa	• Offers multidisciplinary primary care services for endometriosis and pelvic pain.

12.10 Consultations

Attendees at the Collaborating for Better Pain Management event for GPs and allied health professionals held by GCPHN in June 2017 expressed a need 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.

13. CHRONIC DISEASE

KEY FACTS:

- Many chronic conditions can be prevented or managed by addressing common modifiable risk factors.

HEALTH NEEDS:

- 43.1% of Gold Coast adults have at least one chronic condition.
- Rate of potentially preventable hospitalisations in the GCPHN 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 GCPHN region with chronic obstructive pulmonary disease and asthma are above the national rate.
- Chronic disease risk factors for people aged 18+ in the GCPHN region was above the national rate for high blood pressure, smoking, inadequate fruit intake, and harmful alcohol intake.

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.
- 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.

13.1 Prevalence of chronic diseases

Many chronic 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. 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.

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 priority.

The proportion of adults who reported having a long-term health condition in the GCPHN region in 2017-18 was lower than the national average (43.1% and 50.1%, respectively). The GCPHN's rate has decreased from 45.6% in 2015-16.

Table 62. Prevalence of chronic diseases, by type and SA3 region, 2017-2018

Region	Diabetes Mellitus		Heart, stroke and vascular disease		COPD		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	4,332	9.8

Source: PHIDU, social health atlases by primary health networks. ASR - age-standardised rate) per 100 people

- The largest number of people living with chronic diseases live in the SA3 areas of Ormeau-Oxenford, and Gold Coast North.
- The rate of diabetes mellitus, and heart, stroke and vascular diseases was lower than the national rate in all SA3 regions.
- The rate of chronic obstructive pulmonary diseases was above the national rate.
- The rate of asthma in the GCPHN region was comparable to the national rate.

13.2 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.

In 2020-2021, around 2.7 million Australians (11% of the total population) self-reported as having a diagnosis for asthma[92].

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) and more likely to describe themselves as having poor health compared with people without asthma (7.4% and 3.0%, respectively).

Analysis of GCPHN's PATCAT data shows that as of March 2022, of the 587,244 active patients, 9.3% (n=54,572) had a coded asthma diagnosis.

13.3 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 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 for the mother and the baby.

In 2018, the proportion of people in the GCPHN region aged 18 years and over registered in the National Disability Services with Type 2 diabetes 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.

Data extracted from GCPHN's PATCAT show that as of March 2022, 5.0% (n=29,166 of 587,244 active patients) had a coded diagnosis of diabetes (Table 63 shows the prevalence of each type of diabetes).

[92] Australian Institute of Health and Welfare. (2023). *Asthma*.

Table 63. Patients with coded diagnosis of diabetes, March 2022

	Number	%
Total population	587,244	
Patients with a diagnosis of diabetes	29,166	5.0%
Diabetes type 1	2,804	9.6%
Diabetes type 2	22,771	78.1%
Gestational diabetes	4,244	14.6%

Source. GCPHN PATCAT

13.4 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, being overweight or obese, and impaired glucose regulation – are modifiable.

One in three Australians have an increased risk of CKD. Risk factors for developing CKD include:

- Diabetes, high blood pressure
- heart problems (heart failure or heart attack) or have had a stroke
- having smoked or being a current smoker
- being obese with a body mass index (BMI) 30 or higher
- being 60 years or older
- being of Aboriginal or Torres Strait Islanders origin

In 2017-18, the proportion of people in the GCPHN region hospitalised with CKD was 1,517 per 100,000 people, which was above the national rate of 1,480 per 100,000 people[93].

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[2].

Based on GCPHN's PATCAT system as of March 2022, of the 587,244 active patients, 1.3% (n=7,517) had a coded CKD diagnosis. Further, 39.5% (n=231,868) had a recorded risk factor for CKD (Table 64).

Table 64. Patients with a risk factor recorded for CKD, Gold Coast, March 2022

Measure	Number	%
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 aged>30	5,273	2.3%

[93]AIWH 2021. Geographical variation in disease: diabetes, cardiovascular and chronic kidney disease.

13.5 Cardiovascular disease

Cardiovascular disease (CVD) is a major cause of disease and death in Australia. 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.CVD is preventable in many cases, as several of its risk factors are modifiable:

- overweight and obesity
- tobacco smoking
- high blood pressure
- high blood cholesterol
- insufficient physical activity
- poor nutrition
- diabetes

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%. 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[93].

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.

Table 53 displays risks of cardiovascular event for general practice patients on the Gold Coast (obtained through Primary Sense tool). The CVD risk is calculated based on the Framingham Risk Equation[94], which uses 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.

As of August 2022, there were 191,872 active patients that were calculated as being at risk of a cardiovascular event in the next five years.

Table 65. Five-year risk of cardiovascular event, Gold Coast, August 2022

Measure	Number	%
Total Population	653,578	
Target Population	191,872	29.4%
High Risk > 15%	15,104	7.9%
Medium Risk 10 - 15%	22,209	11.6%
Low Risk < 10%	124,136	64.7%
Automatic High Risk	30,405	15.9%

Source. Primary Sense (159 practices)

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

[94] Refer to Appendix 2 for definition.

chronic condition in which short episodes of chest pain can occur periodically when the heart has a temporary deficiency in its blood supply.[95]

Data extracted from GCPHN's PATCAT system shows that as of March 2022, of the 587,244 active patients, 3.4% (n=20,015) had a diagnosis of coronary heart disease.

13.6 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[96].

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.

13.7 Chronic disease and mortality

In 2015-2019, chronic diseases accounted for four out of five leading causes of death in the GCPHN region:

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).

Age-standardised rate of deaths due to coronary heart disease in GCPHN region was 56.1 per 100,000 persons, which was below the national rate (59.8 per 100,000). Gold Coast-North SA3 region had the highest rate (72.0 per 100,000 people), while Gold Coast Hinterland had the lowest (32.4 per 100,000).

13.8 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 prevalence of modifiable risk factors for chronic diseases are shown in Table 66.

[95] Australian Institute of Health and Welfare. (2023). *Heart, stroke and vascular disease: Australian facts*.
[96] Australian Institute of Health and Welfare. (2023). *COPD*.

Table 66. Chronic disease risk factors (age-standardised rate per 100 people), Gold Coast regions, 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	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	51
Gold Coast - North	23.3	27.6	17.4	17	62.7	52.5
Gold Coast Hinterland	23	33.9	12.9	21.4	63.9	51
Mudgeeraba-Tallebudgera	23.4	30.1	12.6	19	61.2	53
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
Robina	23.7	29.3	15.6	17.7	62.3	53
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

- Rates of obesity, smoking and harmful alcohol intake are comparable or higher for the GCPHN region than national levels, but lower for physical inactivity.
- Rates of high blood pressure and obesity are particularly high in Ormeau-Oxenford.

13.9 Utilisation of health services

13.9.1 General practices

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. 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 67 provides data from Medicare Australia on the number of chronic disease management items claimed by GPs in the GCPHN region in 2020-21.

The GCPHN region's rate in 2020-21 was 47.7 services per 100 people, which was above the national rate of 40.4. In GCPHN, the rate has increased by 37.5% in the last 5 years.

Gold Coast-North SA3 region had the highest rate of MBS services for GP chronic disease management (59.5 per 100), while Nerang had the lowest rate (42.5 per 100).

Table 67. MBS services for GP chronic disease management plan, 2020-21

Region	GP chronic disease management plan (rate per 100 people)
National	40.4
Gold Coast	47.7
Broadbeach - Burleigh	51.0
Coolangatta	49.1
Gold Coast - North	59.5
Gold Coast Hinterland	51.3
Mudgeeraba - Tallebudgera	42.7
Nerang	42.5
Ormeau - Oxenford	43.5
Robina	48.3
Southport	49.0
Surfers Paradise	44.5

Source: AIHW analysis of Department of Health, Medicare Benefits claims data 2014–15, 2015–16, 2016–17, 2017–18 and 2018-19.

13.9.2 Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPH) are hospital admissions that potentially could have been prevented by timely and adequate healthcare in the community. 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.

PPHs are categorised into three groups: chronic, acute, and vaccine-preventable.

Table 68 shows that in 2019-20, 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 68. Rate of potentially preventable hospitalisations for selected chronic conditions per 100,000 people, national and Gold Coast, 2019-20

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
COPD	161	195
Diabetes complications	185	195
Hypertension	80	43
Iron deficiency anaemia	309	227
Rheumatic heart disease	14	15

Source: AIHW 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20.

13.10 Service system in GCPHN region

Services	Number	Distribution	Capacity discussion
General practices	210	Clinics are spread across the GCPHN region; most in coastal / central areas	GPs do preparation of chronic disease management plans, team care arrangements, medication prescribing/management, health checks, plan reviews.
Special interest general practices	24	Spread throughout the GCPHN region	These practices offer only 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.
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, 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 fully funded.
Diabetes Queensland	2	Helensvale and Robina	• Self-referral. Free to those with a Medicare card. • Targets newly diagnosed—new registration on national diabetes patient register will trigger an invite.
Other private and NGO services	Various	Various	• 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 and outcomes of these services.
Community Health Services Gold Coast Health	3	Robina Health Precinct Southport Health Precinct Helensvale Community Centre	

13.11 Consultations

The information presented herein has been collated from various sources including: 2017 GCPHN Primary Care Opinion Survey, GCPHN Primary Health Care Improvement Committee, liaising with general practice staff, and GCPHN Community Advisory Council.

The community and service system stakeholders recognised 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.

Community capacity and development

Many factors impact 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 suggested 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, however, some patients may be reluctant to have health assessments because they don't see the immediate value or may be unwilling to prioritise a health assessment over work and other family commitments, when they don't feel unwell or have concerns.

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.
- 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 (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 reported 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 identify 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 osteoarthritis.

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.
- 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)

GCPHN utilised the Community Advisory Council as an engagement mechanism to discuss emerging issues relating to chronic disease in the 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 patient lost in the system.

  Focus on a holistic team approach to managing chronic illness is needed, and peer mentors or advocates to walk alongside chronically ill people.

14. FAMILY AND DOMESTIC VIOLENCE

KEY FACTS:

- 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 family and domestic violence (FDV) compared to the total Queensland, the number of reported FDV-related incidents has increased in recent years.
- Family and domestic violence can have severe consequences on child development.
- People who experience domestic violence have higher rates of mental health issues.
- Women experience violence at much higher rates than men.

LOCAL HEALTH NEEDS:

- Several health issues are linked to exposure to partner violence, such as:
    - depressive disorder
    - anxiety
    - sufficient self-harm
    - alcohol use disorders

SERVICES ISSUES:

- Many mental health clinicians do not have specialised knowledge of domestic violence dynamics and services for domestic violence perpetrators are limited.
- Out-of-pocket cost may limit access to services for victims of domestic violence.
- 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.
- Not many mental health clinicians have a high degree of understanding of domestic violence issues.

14.1 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.

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.

It affects people of all ages and from all backgrounds, but primarily women and children. Victims often display including behavioural, emotional, and cognitive-functioning problems as a result.

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

14.1.1 Contributing factors

Many factors contribute to and influence family, domestic and sexual violence[97]. These elements relate to victims and offenders and include relationship dynamics, families and communities and geographic and political environments[98]. 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[99].

14.2 Prevalence

The Australian Bureau of Statistics' 2016 Personal Safety Survey estimated that 2.2 million Australian adults have been victims of physical behaviour and/or sexual violence from a partner[100].

A study completed in South Australia interviewed a 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[101].

[97] European Commission. (2010). Domestic Violence Against Women Report. Special Eurobarometer 344. Brussels: EC.
[98] Australian Bureau of Statistics. (2013). *Defining the Data Challenge for Family, Domestic and Sexual Violence.* Cat no. 4529.0.
[99] Edleson, J. L. (2019, August 1). *Children's witnessing of adult domestic violence*. SAGE Journals.
[100] Australian Bureau of Statistics. (2017). Personal Safety, Australia, 2016. ABS cat. no. 4906.0.
[101] Grande, E. D., Hickling, J., Taylor, A., & Woollacott, T. (2003). Domestic violence in South Australia: a population survey of males and females. *Australian and New Zealand journal of public health*, *27*(5), 543–550.

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[7].

14.2.1 Hospitalisations for assault

In 2016-2017, 29% of the 21,400 hospitalisations for assault injuries in Australia were a result of FDV. In 66% of cases, the offender was reported as a spouse or domestic partner.

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 (67.0 per 100,000) and lowest for women aged 65 and over (2.2 per 100,000). Amongst males, hospitalisations were higher for assaults committed by family members compared to spouse or domestic partner.

Hospitalisations of women assaulted by a spouse or partner continued 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.

14.2.2 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[102,103].

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:

- 0.3% of all deaths (n=223)
- 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[104].

14.3 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[105]. The removal from land and cultural dispossession over the past 200 years have resulted

[102] Ayre, J., Lum On, M., Webster, K., Gourley, M., & Moon, L. (2016). Examination of the burden of disease of intimate partner violence against women in 2011: Final report. Sydney: ANROWS.
[103] 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*Lancet390*(10100), 1345–1422.
[104] AIHW (2019). *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015*..
[105] Closing the Gap Clearinghouse. (2016). Family violence prevention programs in Indigenous communities. Canberra: AIHW.

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[106].

Aboriginal and Torres Strait Islander adults are disproportionately affected by family violence. Statistics show that 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.
- Aboriginal and Torres Strait Islander males were 27-times more likely to be hospitalised for family violence as non-Indigenous.

14.4 Domestic violence among LGBTIQAP+

Until recently, intimate partner violence within LGBTIQAP+ relationships was largely unacknowledged and limited research was available on this topic. The Australian Research Centre for Health and Sexuality conducted a national demographic and health and welling survey of 5,476 LGBTIQAP+ people and found that around 28% of male-identifying respondents and 41% female-identifying respondents reported having been in an abusive relationship[107].

Another study by the Australian Research Centre for Health and Sexuality[108] of 390 LGBTIQAP+ respondents in Victoria found that just under a third had been subject to abuse by their same-sex partner:

- 78% of the abuse was psychological and 58% involved physical abuse,
- women were more likely than 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.

14.5 Elder abuse

Elder abuse takes a myriad of forms, including psychological abuse, financial abuse, physical abuse, sexual abuse, and often a combination of these.

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 (among women only) is the 2014 Australian Longitudinal Study of Women's Health[109] found that 8% of elderly aged 85-90 had experienced being exposed to abuse, with name calling and put-downs being the most common forms, and around 20% persons aged 75 and more had experienced neglect.

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[110]. The calls were mostly in relation to female

[106] AIHW (2018). *Family, domestic and sexual violence in Australia, 2018*. Cat. no. FDV 2. Canberra: AIHW.
[107] 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, La Trobe University 2006.
[108] 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 & Society, La Trobe University 2008.
[109] Australian Longitudinal Study on Women's Health. (2014). 1921-26 cohort: Summary 1996-2013. Callaghan, NSW & Herston, Qld.
[110] 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.

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. 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.

14.6 Technology

As outlined in the Domestic and Family Violence Protection Act 2012, 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[111]. Technology can create a sense of the perpetrator's presence and aims to isolate, punish and humiliate their victims.

14.7 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 an 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.

14.8 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 in recent years.

Table 69. Rate of offences by domestic violence indicator per 100,000 people, Gold Coast, 2019

Type of offence	Rate per 100,00
Assault	284
Grievous assault	<5
Serious assault	119
Serious assault (other)	24
Common assault	138
Sexual offences	11
Rape and attempted rape	7
Other sexual offences	<5
Other offences against the person	51
Kidnapping and abduction	<5
Stalking	6
Life endangering acts	39

Source: Queensland Police Service

[111] Woodlock, D. (2017). The Abuse of Technology in Domestic Violence and Stalking. *Violence Against Women,* 23(5), 584–602.

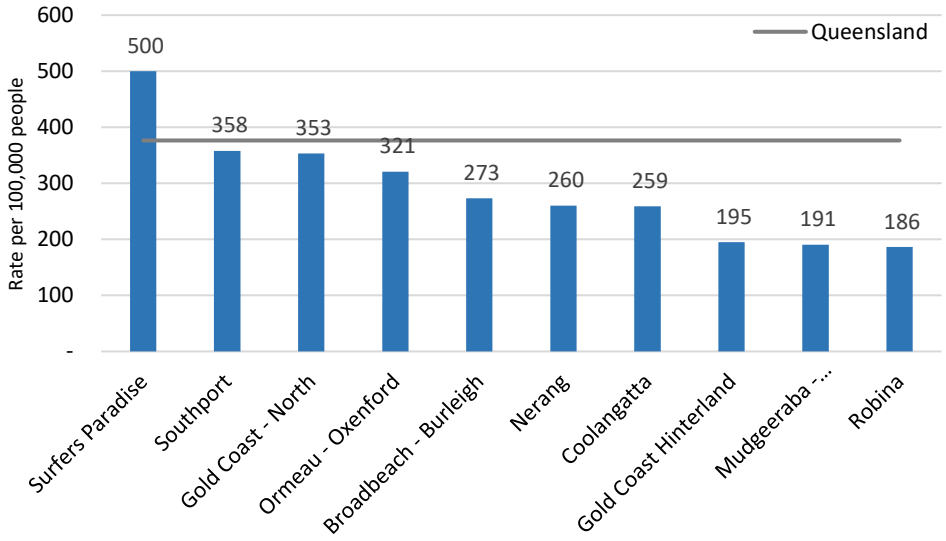
14.9 Domestic violence – police and private applications

Police can apply for a Domestic Violence Order (DVO) where they reasonably believe that there is sufficient reason to act and there is sufficient evidence to determine that the aggrieved person requires protection.

A private application for a DVO 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.

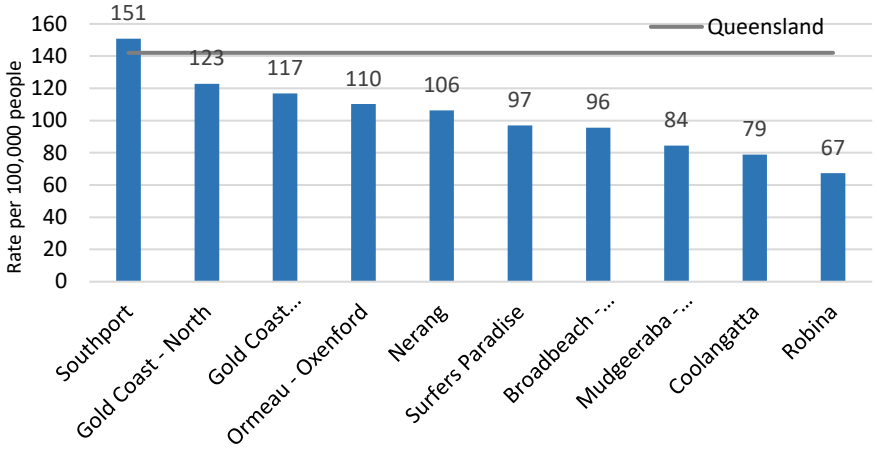
In 2020, there were 1,973 police applications and 689 private applications for DVOs. Figures 27 and 28 display rates of police and private DVO applications across GCPHN SA3 regions.

Figure 27. Domestic Violence Orders – police applications, Gold Coast SA3 regions, 2020



Source: Queensland Police Service

Figure 28. Domestic Violence Orders – private applications, Gold Coast SA3 regions, 2020



Source: Queensland Police Service

14.10 Service system in GCPHN region

Services	Number	Distribution	Capacity
Domestic Violence Prevention Centre (DVPC) Gold Coast	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	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	1	Gold Coast	Supports women and their children from culturally and linguistically diverse backgrounds affected by domestic and family violence.
DV Connect Womensline	Phone	Australia wide	Telephone hotline for women, their children and pets experiencing domestic violence. It offers emergency transport and accommodation as well as crisis counselling and interventions.
Elder Abuse Helpline (Qld)	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	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	Phone	Australia wide	This service from No to Violence offers assistance, information and counselling to help men who use family violence.

Mensline Australia	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	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	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.

14.11 Consultations

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) 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.

15. MENTAL HEALTH

KEY FACTS:

- In 2020/21, 76,131 patients visited a GP for mental health concerns on the Gold Coast.
- 65% increase in GP-provided mental health services in the last 6 years.
- 19% of the Gold Coast population has prescribed medication for mental health.
- GPs prescribe 86% of mental-health related medications.
- 25% of patients with frequent presentations to the ED have a mental health issue.
- 11,000 presentations per year to Gold Coast ED for mental and behavioural disorders.

HEALTH NEEDS:

- Increasing demand for all mental health services.
- In 2022, the following groups were prioritised as underserviced groups:
- 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, and financial hardship.
- Primary care providers often lack the confidence and skills to support people with severe mental illness or in suicidal crisis.
- Some patients may need ongoing support (for example, for living with personality disorders) but do not meet criteria for supports designed for severe and complex mental illness, or are not eligible for assistance through the NDIS.
- Increasing rate of women diagnosed with perinatal depression.
- People who experience domestic violence have higher rates of mental health issues.

SERVICE ISSUES:

- Mental health and aged care related issues are often treated in isolation to each other.
- Limited information sharing between providers due to confidentiality and legal concerns.
- GPs are unclear about available services and how at access them due to the evolving mental health system.
- Presentations to hospital mental health services due to gaps in community supports options.
- Limited supports are available for people in mental health crisis who end up in ED.
- Intersections between different sectors present challenges for continuous care.

15.1 Prevalence

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. In addition, it found that:

- One in seven adult Australians (15%) have experienced depression in their lifetime[112]. This is equivalent to 61,295 Gold Coast residents.
- One quarter of adult Australians (26.3%) have experienced an anxiety disorder. This is equivalent to 107,471 Gold Coast residents.
- An estimated 15% of adult Australians will experience an affective disorder, while 26.3% will experience an anxiety disorder. Applying these rates to the Gold Coast population, 62,183 will experience an affective disorder and 109,029 will experience an anxiety disorder.

Another insight into the mental health and wellbeing of Australians is provided through measures of psychological distress (described as unpleasant 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%)[113.]
- Applying the above figure to the 2021 census Gold Coast population, 83,301 Gold Coast adults are currently experiencing high or very high levels of psychological distress.

15.1.1 Children and youth

Findings from the Young Minds Matter Survey (2016-2017) indicated that 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[114].

Gold Coast PHN's general practice data, obtained through PATCAT, show that in March 2022, of the 100,451 patients 0 to 17 years, 6.3% (n=6,339) had a coded mental health diagnosis. Of those, 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.

[112] ABS National Survey of Mental Health and Wellbeing: Summary of Results, 2007
[113] Australian Bureau of Statistics. (2018). National Health Survey: First Results 2017-18. Canberra: ABS
[114] Goodsell B, Lawrence D, Ainley J, Sawyer M, Zubrick SR, Maratos J (2017). Child and Adolescent Mental health and educational outcomes. Perth: Graduate School of Education, The University of Western Australia

Table 70. Patients aged 0 to 17 with a mental health diagnosis, Gold Coast, March 2022

	Number	Percent
Patients aged 0 to 17	100,451	
Patients with a mental health diagnosis	6,339	6.3%
Patients with anxiety	6,023	95.0%
Patients with depression	1,261	19.9%
Patients with current prescribed mental health medication	2,075	34.1%
Patients with who claimed a MHTP in the last 12 months	4,168	68.5%
Patients who claimed a MHTP review in the last 12 months	1852	30.4%

Note: an individual may have more than one diagnosis.

15.1.2 Adults

Data extracted through PATCAT from Gold Coast general practices show that in March 2022, 88,166 or 24.0% of patients aged 18 to 64 had a mental health diagnosis. The most common diagnoses included anxiety and depression.

Of those, 57,048 (64%) also had a current mental health medication. Table 71 highlights mental health management of these patients.

Table 71. Patients aged 18 to 64 with a mental health diagnosis, Gold Coast, March 2022

	Number	Percent
Patients aged 18 to 64	367,032	
Patients with a coded mental health diagnosis	88,166	24.0%
Patients with anxiety	68,360	77.5%
Patients with depression	49,917	56.6%
Patients with schizophrenia	2,490	2.8%
Patients with bipolar	3,762	4.3%
Patients with dementia	134	0.2%
Current prescribed mental health medication	57,048	64.0%
Mental health treatment plan (MHTP) in the last 12 months	46,861	55.7%
MHTP review in the last 12 months	16,764	20.0%

Note: an individual may have more than one diagnosis.

15.1.3 Older adults

Data extracted from Gold Coast PHN's PATCAT system show that in March 2022, 18.5% (n=22,152) of patients aged 65 and over, had a coded mental health diagnosis. Of those, 13.0% had a mental health treatment plan in the last 12 months.

Table 72. Patients aged 65 and over with a coded mental health diagnosis, Gold Coast, March 2022

	Number	Percent
Active patents 65 year and over	119,766	
Patients with a coded mental health diagnosis	22,152	18.5%
Patients with anxiety	13,572	61.3%
Patients with depression	14,478	65.4%
Patients with schizophrenia	361	1.6%
Patients with bipolar	610	2.8%
Patients with dementia	3,446	15.6%
Patients with a mental health treatment plan (MHTP) in the last 12 months	5,337	13.0%

Note: an individual may have more than one diagnosis.

15.2 Medications for mental health

A 2014 report by the National Mental Health Commission reported that in the past 10 years, the use of medication to treat mental illness has increased by 58% in Australia[115], which has the second highest per capita antidepressant consumption of all OECD countries[116].

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

In 2018-2019[117], 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% by psychiatrist and 4.5% by non-psychiatrist specialist. 70.9% of all prescribed medication were antidepressants.

The majority of 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%).

[115] National Mental Health Commission (2014): The National Review of Mental Health Programmes and Services.
[116] OECD (2011). Health at a Glance 2011: OECD Indicators.
[117] Mental health services in Australia, Australian Institute of Health and Welfare, 2021.

Table 73. Patients and mental health-related prescriptions, GCPHN, 2018–19

Patients		Prescriptions	
Number	% of total population	Number	Rate per 1,000
118,406	1,002,660	19.0	1,612.2

Source: PBS/RPBS data maintained by the Department of Health and sourced from DHS.

Table 74. Patients and mental health-related prescriptions, 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.

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 with 198,447.

Gold Coast-North had the second largest number of patients prescribed a mental health medication (n=15,337), the second largest number of prescriptions with 137,295, and the largest rate of patients prescribed a mental health medication (21.9%).

15.3 Mental health services in primary care

15.3.1 Child, youth and families' mental health

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).

15.3.2 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).

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 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).

15.3.3 Older persons' mental health

Older people in the GCPHN region are considered those aged 65 years or more, however, since 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, older persons in this population group are 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.

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. 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

GCPHN acknowledges that some of these systemic problems will need to be resolved at a national level and this will take time.

15.3.4 General practitioners

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.

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.

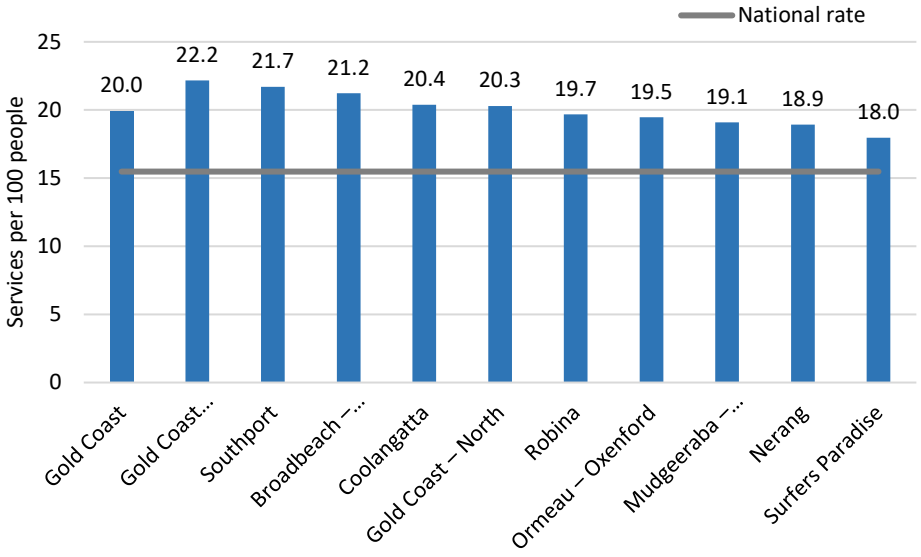
Table 75. GP mental health services per 100 people, Gold Coast, 2013-14 to 2020-21

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.

- In 2020-21, 76,131 Gold Coast residents saw a GP for a mental health-related service which led to 129,860 services[118].
- 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.

Figure 29. GP 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.

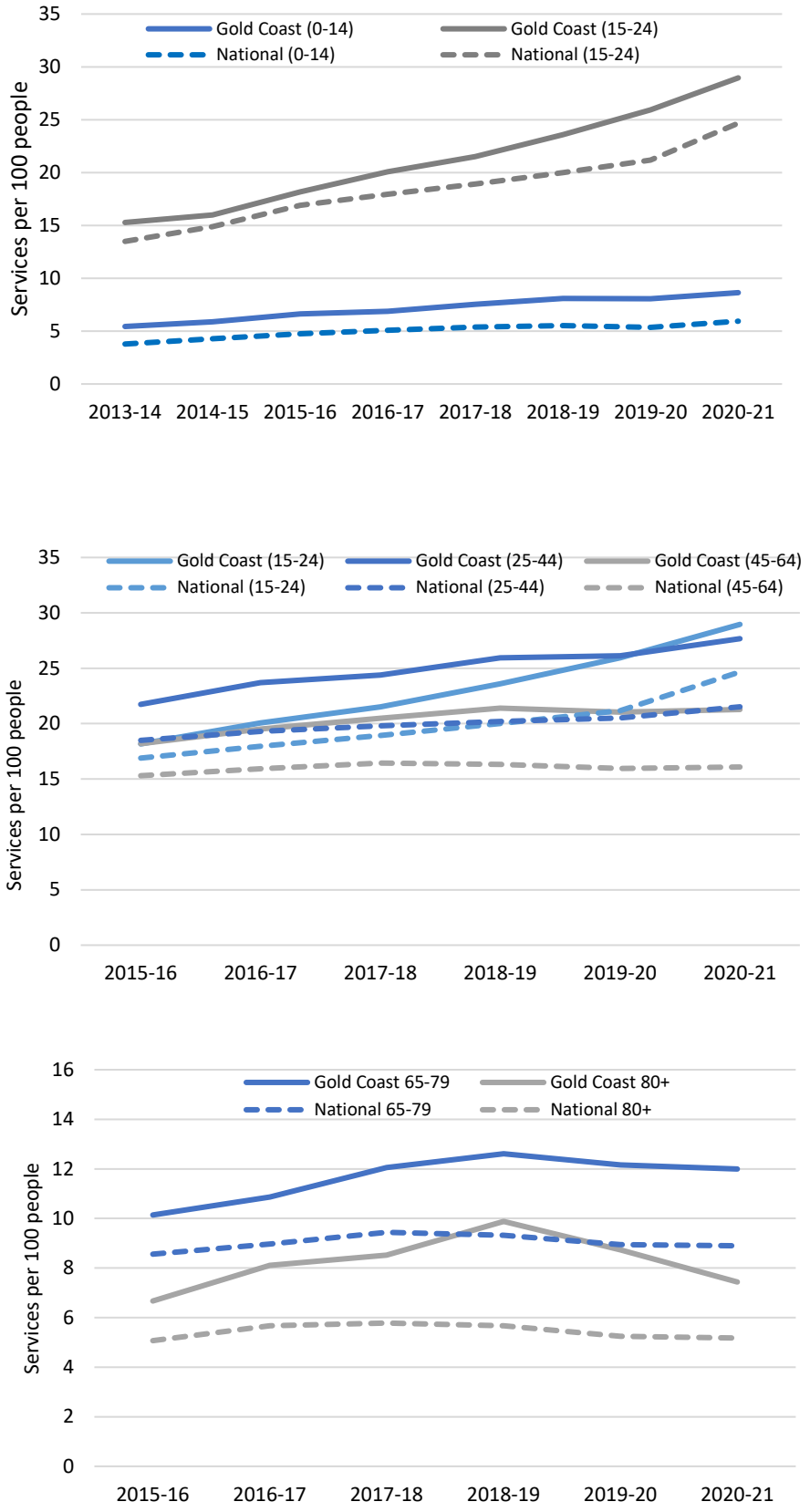
All Gold Coast SA3 regions were above the national rate in 2020-21 for claiming GP Mental Health MBS services. Gold Coast Hinterland SA3 region had the highest rate (22.2 per 100 people) while Surfers Paradise had the lowest rate (18.0 per 100 people). Ormeau-Oxenford had the highest number of services claimed in the same period (30,640).

AIHW analysis of 2020-2021 MBS data show the following rates for GP mental health services:

- Aged 0-14: above the national rate (8.4 vs 5.9 per 100 people)
  - 7,656 residents saw a GP for mental health concern, leading to 10,166 consultations.
- Aged 15-24: above the national rate (28.9 vs 24.7 per 100 people)
  - 14,122 residents saw a GP for mental health concern, leading to 23,803 consultations.
- 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.
- Aged 65-79; above the national rate (12.0 vs 8.9 per 100 people)
  - 5,639 residents saw a GP for mental health concern, 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 saw a GP for mental health concern, leading to 2,001 consultations.

[118] Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data.

Figure 30. General Practitioner mental health services per 100 people, national and Gold Coast, by age group, 2013-14 to 2020-21



Source: AIHW analysis of Department of Health, Medicare Benefits claims data.

15.3.5 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 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 76 shows that 20,755 Gold Coast residents had a consultation with a psychologist, leading to 98,596 consultations in total.

Table 76. Clinical psychologists services per 100 people, number of patients and number of services, Gold Coast, 2013-14 to 2020-21

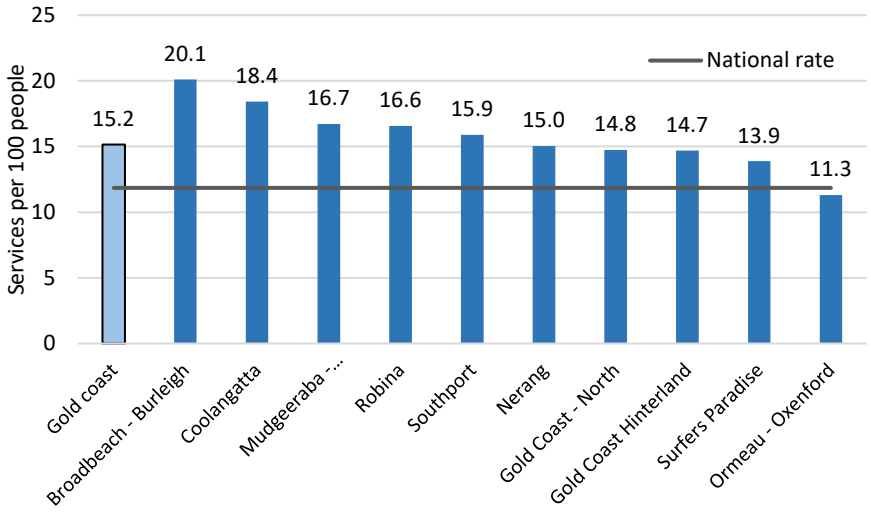
Year	Number of patients	Number of services	Services per 100 people
2013-14	12,144	52,027	9.4
2014-15	13,146	56,791	10.1
2015-16	15,214	64,842	11.3
2016-17	16,283	68,665	11.6
2017-18	17,790	74,999	12.4
2018–19	19,101	80,083	12.9
2019-20	19,990	85,793	13.5
2020-21	20,755	98,596	15.2

Source: AIHW analysis of Department of Health, Medicare Benefits claims data.

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 31. Clinical Psychologists services per 100 people, Gold Coast SA3 regions, 2020-21

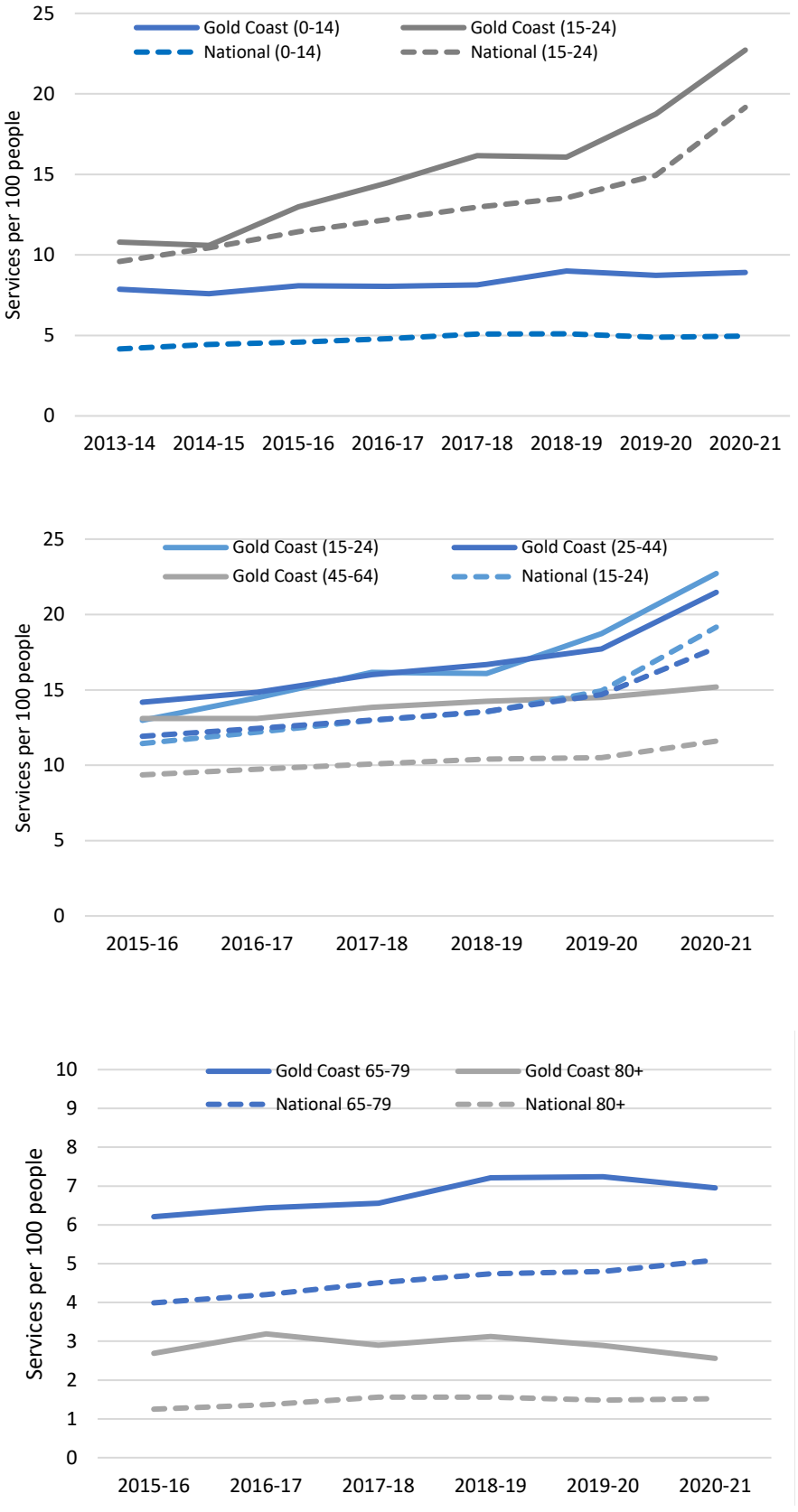


Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population.

The GCPHN region's rate for clinical psychologists' services across different age groups in 2020-2021 were:

- Aged 0-14: above the national rate (8.9 vs 4.9 per 100 people)
    - 2,354 residents saw a clinical psychologist, leading to 10,483 consultations.
- Aged 15-24: above the national rate (22.7 vs 19.2 per 100 people)
    - 3,819 residents saw a clinical psychologists, leading to 18,676 consultations.
- 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.
- Aged 65-79; above the national rate (7.0 vs 5.1 per 100 people)
    - 1,247 residents saw a clinical psychologist, leading to 5,807 consultations.
- Aged 80 years and over; above the national rate (2.6 vs 1.5 per 100 people)
    - 186 residents saw a clinical psychologist, leading to 690 consultations.

Figure 32. Clinical Psychologists services per 100 people, national and Gold Coast, by age groups, 2013-14 to 2020-21



Source: AIHW analysis of Department of Health, Medicare Benefits claims data

15.3.6 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 65). In 2020-21, 15,507 Gold Coast residents had a consultation with a psychiatrist, leading to 54,332 consultations in total.

Table 77. 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.

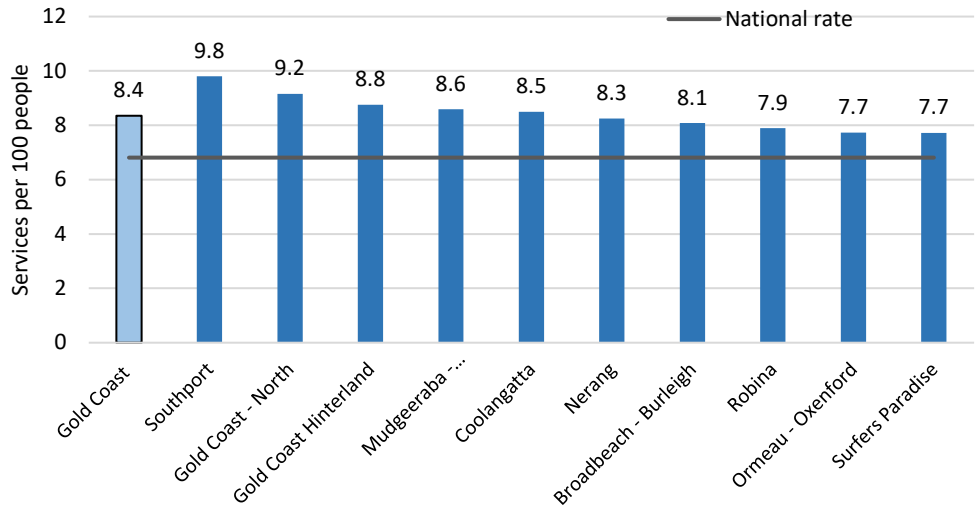
The GCPHN region's rates for psychiatry services in 2020-21 by age groups were:

- Aged 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.
- 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.
- 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.
- 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.

All GCPHN SA3 regions were above the national rate in 2020-2021 for claiming psychiatry services (Figure 31). Southport SA3 region had the highest rate (9.8 per 100 people) while Ormeau-Oxenford

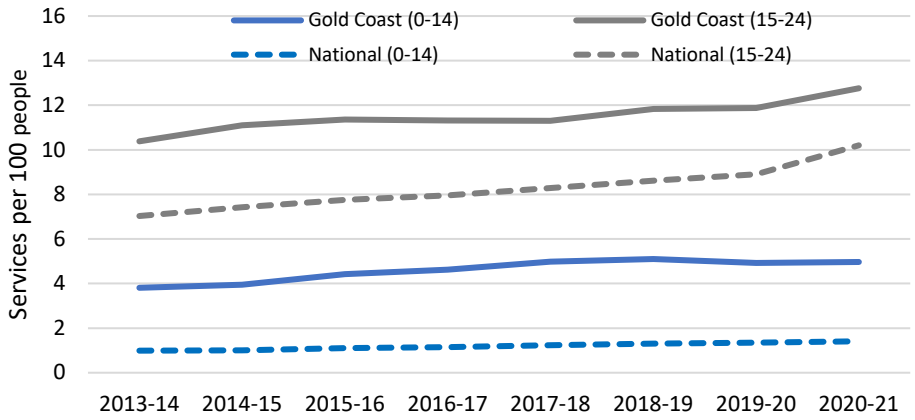
and Surfers Paradise had the lowest rate on the Gold Coast (7.2 per 100 people). Although Ormeau-Oxenford had the lowest rate of services per 100 people, it had the highest number of actual services among Gold Coast SA3 regions with 12,178 claimed services.

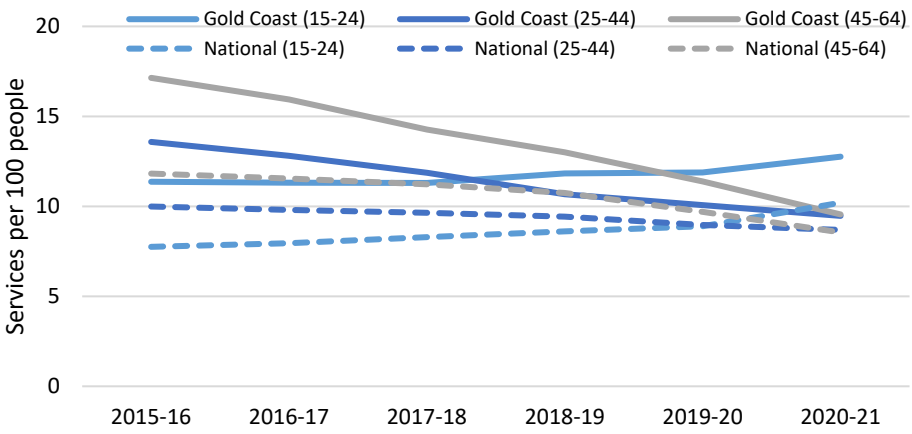
Figure 33. Psychiatrist's services per 100 people, Gold Coast SA3 regions, 2020-21

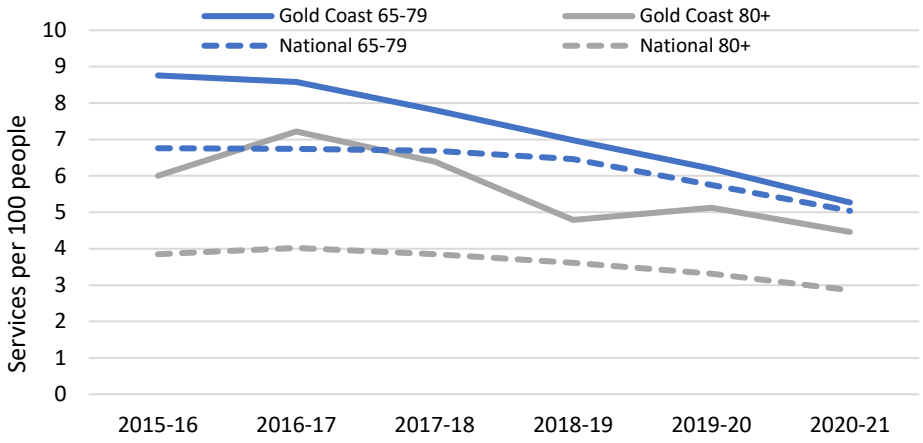


Source: AIHW analysis of Department of Health, Medicare Benefits claims data; and Australian Bureau of Statistics, Estimated Resident Population.

Figure 34. Psychiatrist services per 100 people, national and Gold Coast, by age groups, 2013-2014 to 2018-2019







Source: AIHW analysis of Department of Health, Medicare Benefits claims data.

15.4 Mental health services in hospitals

15.4.1 Emergency Department

In 2019-2020, there were 76,131 presentations to the Gold Coast Emergency Departments for mental and behavioral disorders.

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.

15.4.2 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 78. Overnight admitted mental health-related population rates of separations, bed days, psychiatric care days, and procedures, with and without specialised psychiatric care, GCPHN, 2018-19

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
6,742	108	96,757	1,556	83,540	1,343	16,657	268

Source: National Hospital Morbidity Database.

Among Gold Coast SA3 regions, 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 79).

Table 79. Mental health-related 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

15.5 High-risk groups

15.5.1 People from culturally and linguistically diverse backgrounds

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 can increase the risk of mental illness.

The prevalence of mental health and wellbeing issues is higher among people born in Australia (19.5% for males and 24% for females) than in people born overseas (17.7% for males and 19.9% for females)[119]. While the reasons are not clear it may relate to the fact that people who successfully migrate to Australia are 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 some immigrants, migration can be a source of trauma and refugees have been found to have high rates of mental health issues[120]. For example, rates of post-traumatic stress disorder, depression and anxiety were 3-4 times higher among Tamil asylum seekers than other immigrants. Further, Iraqi and sub-Saharan African refugees in Australia were found to have lower levels of mental health literacy compared with the general Australian population.

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.

Gold Coast is an identified area of settlement by the Department of Home Affairs for humanitarian entrants. 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[121].

Most permanent residents entering Gold Coast under the offshore humanitarian program are residing in Gold Coast-North and Southport, which are the two lowest socioeconomic status regions on the Gold Coast.

15.5.2 LGBTIQAP+ community

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[122].

While Australian and international research provide evidence that raises significant concern about mental health outcomes and suicidal behaviours among LGBTIQAP+ 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.

[119] ABS. (2007). National Survey of Mental Health and Wellbeing: Summary of Results 2007.
[120] Shawyer, F., Enticott, J. C., Block, A. A., Cheng, I. H., & Meadows, G. N. (2017). 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*, 1-12.
[121] Compiled by PHIDU (2016) based on the ABS Census of Population and Housing.
[122] Australian Human Rights Commission (2014). Face the facts: lesbian, gay, bisexual, trans and intersex 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.

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[123]. 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, which is more than triple the rate of adult heterosexual Australians (6%)[124]. 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].

Since 2010, the National Drug Strategy Household Survey (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[125]. Suicide and self-harm also have a disproportionate impact among the LGBTIQAP+ community.

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.

15.5.3 People at risk of homelessness

Quantifying the prevalence of mental illness among homeless populations is difficult, and estimates have varied considerably. A 2020 AIHW report on mental health services in Australia identified the prevalence of mental health issues among homeless people accessing specialist homelessness services. This report that around 30% of 241,966 specialist homelessness services clients aged 10 years and over had a current mental health issue. In addition, around 28,000 (about 1 in 10) of specialist homelessness services clients aged 10 years and over reported problematic alcohol and/or drug use.

In 2021, there were 1,828 homeless people on the Gold Coast, a rate of 28.4 per 10,000[126]. This was lower than the Queensland rate of 43.2 per 10,000. However, within the Gold Coast, Southport exceeded the state rate of homelessness with 63.7 persons per 10,000. Two other GCPHN regions had rates above that of the broader Gold Coast were Surfers Paradise (41.3 per 10,000) and Broadbeach – Burleigh (32.0 per 10,000). Service providers report that this is likely to be an under-representation of the true numbers.

15.5.4 Vulnerable children

Mental disorders are more common in children living in families experiencing various forms of socioeconomic disadvantage, including low household income, parental unemployment, and family breakup. 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.

[123] Private Lives 2. (2012) The second national survey of the health and wellbeing of GLBT Australians.
[124] ABS National Survey of Mental Health and Wellbeing (2007) Summary of Results 2007 p 32.
[125] Australian Institute of Health and Welfare. (2020) National Drug Strategy Household Survey 2019. Drug Statistics series no. 32.
[126] ABS. (2011). Census. Gold Coast (SA4). Quick Stats.

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[127].

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[130].

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[128].

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 80).

Table 80. Developmentally vulnerable children, 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.

15.5.5 Children in care

Children (children subject to Child Safety orders) 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.

- 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 are likely to have poorer mental health as well as physical and developmental health, than their peers:
    - more than half (54%) have emotional or behavioral problems
    - 14% have abnormal growth
    - 45% aged 10-17 years have moderate/ high health risks associated with substance use

[127] Felitti, V. J., Anda, R. F., Nordenberg, D et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American journal of preventive medicine, 14(4), 245-258.
[128] 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.

- 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)

15.5.6 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[129]. 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[130]). 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 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.

15.5.7 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:

[129] Deloitte Access Economics. (2012). the cost of perinatal depression in Australia – Final report
[130] Australian Institute of Health and Welfare, 2010 Australian National Infant Feeding Survey

- 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.

15.6 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 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[131]. An increasing number of people delay visits to GPs and psychologists because of cost consideration.

[131] Australia Bureau of Statistics, 2020. Patient Experiences in Australia, Summary of Findings.

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 Islander people,
- Culturally and Linguistically Diverse people (CALD),
- 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,
- Women experiencing perinatal depression,
- People with eating disorder,
- Men linked to family court,
- Victims of family or domestic violence, and
- Veterans.

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.

15.7 Types of services

15.7.1 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 complement 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.

The demand on services as evidenced by presentations to general practice for anxiety and depression increased from 2019 to 2021. 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.

15.7.2 Low intensity interventions

Depression and anxiety are the leading global causes of burden of disease in young people and contribute to considerable illness burden across the lifespan[132]. Effective prevention and early intervention can significantly reduce disease burden by halting, delaying, or interrupting the onset and progression of depression and anxiety[133]. Less than half of Australians with depression or anxiety seek help from a health professional, thus missing opportunities for intervention[134].

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[135].

[132] Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, et al. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study. *The Lancet 382*(9904):1575-86
[133] Muñoz RF, Cuijpers P, Smit F, et al (2010). Prevention of major depression. *Annual Review of Clinical Psychology 6*:181-212.
[134] Whiteford HA, et al (2014). Estimating treatment rates for mental disorders in Australia. Australian Health Review. 2014;38(1):80-85.
[135] Australian Government Department of Health. Low intensity mental health services for early intervention.

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 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)[136].

15.7.3 National Psychosocial 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[137].

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.

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.

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.

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. 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.

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

[136] Australian Bureau of Statistics, 2016, Gold Coast (SA 4), Quick Stats
[137] Project Air Strategy for Personality Disorders (2015). Treatment Guidelines for Personality Disorders 2nd Ed. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

- 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

15.7.4 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.

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.
- 29% were self-referred, 28% were referred by community agencies and 17% by public sector mental health service.

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%). At the point of 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.

The most common primary mental health diagnoses among PIR participants were mood disorder (48%), followed by schizophrenia, schizotypal and delusional disorders (22%).

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
- 65 participants (33.0%) - National Psychosocial Support Program
- 29 participants (14.7%) - Continuity of Support Program

15.7.5 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 81. 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.

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 shows that by presentations to general practice for anxiety and depression, which flow onto community mental health services, significantly increased from 2019-2020 to 2020-2021. 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.

15.7.6 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.

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 these 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.

15.7.7 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[138]. 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[139].

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.

15.7.8 Mental health services in Residential Aged Care Homes

There is evidence that RACH 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[140].

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.

[138] Eysenbach, G. (2001). What is e-health? *Journal of medical Internet research, 3*(2), e833.
[139] Richards, D., & Richardson, T. (2012). Computer-based psychological treatments for depression: a systematic review and meta-analysis. *Clinical psychology review, 32*(4), 329-342.
[140] Australian Institute of Health and Welfare 2015. Australia's welfare 2015. Canberra: AIHW

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.

15.7.9 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[141].

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.

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)[142].

[141] 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.
[142]Services Australia. Medicare Item Reports.

15.7.10 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.
- 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[143].

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[144].

15.8 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 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 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

[143] 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
[144] National Mental Health Commission (2014). The National Review of Mental Health Programmes and Services. Sydney.

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.

15.9 Impact of COVID-19 on mental health

The potential for COVID-19 to impact mental health and wellbeing was recognised early in the pandemic[145]. 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[146].

15.9.1 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.

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 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.

15.9.2 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.

15.9.3 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 per 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

[145] WHO (World Health Organization) 2020a. Substantial investment needed to avert mental health crisis.
[146] NMHC (National Mental Health Commission) 2020. National mental health and wellbeing pandemic response plan

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.

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[147].

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.

[147] Yourtown and the Australian Human Rights Commission 2020.

- Victorian children and families require higher levels of social and psychological support.

15.9.4 COVID-19 Recovery Service

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 the pandemic. 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.

15.10 Service system in GCPHN region

ALL POPULATIONS

Services	Number	Distribution	Capacity discussion
General Practice	210	Distributed across the Gold Coast, majority located in coastal and central areas	857 GPs on the Gold Coast.
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 GCPHN region.
Gold Coast Health Inpatient services	5 (Acute Adult (16-65), Older Persons (65+, 16 beds) and an Extended Treatment Unit (16 bed) at Robina. Acute Adult unit (16-65) in Southport.	4 in Robina, 1 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).
Gold Coast Health Community services	4	Southport, Palm Beach and outreach	Includes Mobile intensive rehabilitation team, older persons mental health, Continuing Care Teams, Eating Disorder Service.
Gold Coast Health Consumer and Carer consultants	1	Across all Gold Coast Health locations as needed	Team comprising consumer and carer peer consultants
Private mental health facility	2	1 in Currumbin and 1 in Robina	Comprehensive private mental health facilities equipped to support people with severe and complex needs).

Psychosocial service funded by GCPHN	2	Plus Social, Crossing Paths Carer Support Program, 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	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	5	headspace, Kids Helpline, beyondblue, eheadspace, ReachOut	Online Services. Public awareness knowledge of these services would drive uptake/demand and could bridge gap between services. 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.
Phone Services	3	Kids Helpline, Beyond Blue, Headspace	
Online Counselling	2	beyondblue online chat headspace online chat	
Information and referral helplines and websites	9	MindHealthConnect, Mi networks, SANE Australia, beyond blue, ReachOut.com, R U Ok? Black Dog Institute, Mental Health Online, Commonwealth Health Website	

eTherapy: information and referral helplines and websites	57	online programs recommended through MindHealth Connect to promote eTherapy and self-care	
NewAccess (Beyond Blue)	Online	Phone, online or in person	Coaching low intensity CBT.
Psychologists	633	Across the Gold Coast, with the majority located in coastal and central areas	Psychologists can be a point of referral for individuals.

CHILDREN AND YOUTH SPECIFIC SERVICES:

Services	Number	Distribution	Capacity discussion
headspace (12-25 years)	2	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.
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.
Lighthouse Youth Enhanced	1	Southport	Provides trauma informed, recovery orientated clinical care coordination and specialised treatment for young people aged 12-18.
Wesley Kids	1	Robina – Southport (children 5-11 years)	
Coaching	Reachout	Phone coaching for parents and carers of 12- to 18-year-olds.	
Gold Coast Health inpatient services, ages 0-25 years	3	Robina has 2 - child and youth and acute young adult aged 18-25 years. Southport has 1 acute unit for ages 16-65 years	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.
Gold Coast Health community services, ages 0-25 years	8 (Child and Youth Mental Health Service, Evolve therapeutic services, child and youth access, perinatal infant mental health, early psychosis, continuing care teams (18+), eating disorder service (18+), acute care	2 CYMHS clinics (Robina and Southport), Early Psychosis (Robina), rest outreach.	

	treatment team (18+).		
Community based mental health NGO services	5	1 in Southport, 1 in Burleigh, 3 outreach to all of Gold Coast.	
Community NGO services	8	3 in Southport, 2 in Arundel, 1 in Labrador, 1 in Miami, 1 in Robina, 1 in Burleigh	NGO providers who provide counselling services or refer into specific youth mental health services.
Fetal Alcohol Syndrome Disorder (FASD) clinic	1	Gold Coast Health service	
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	In Primary, Secondary, and Special schools across the GCPHN region with a wellbeing professional providing a service.	
GP Pilot in schools	5 schools participating	Across the Gold Coast	

OLDER ADULTS SPECIFIC SERVICES:

Psychological Services in Residential Aged Care Homes (RACHs)	1	Change Future's attend in person at each RACH	The Psychological Services in RACH program offers structured psychological therapies that support people with mental health needs living in residential aged care.
Southern Gold Coast 60 & Better Program Inc	1	Elanora to Palm Beach	Community service that offers social connectedness, activities, support services and advance care planning support for those over the age of 65.

15.11 Consultations

Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services

Consultations were held throughout 2020 between Gold Coast Health and Gold Coast Primary Health Network in the development of a Gold Coast Joint Regional Plan, which identified several issues pertaining to people experiencing mental health concerns:

Child, youth and families' mental health

- 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.
- 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, their health needs are not always met due to an absence of a dedicated health care coordinator. 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.
- 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.

Adult mental health

- A range of structured psychological interventions are available in the 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.
- 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.

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.
- Limited access to assessment and treatment by public sector geriatricians.
- 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 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 on and loneliness, however activities in the community that support inclusion/connection on may not be targeted or inclusive of older people and their needs.

Severe and complex mental illness

Consultations identified numerous priority areas for supporting people with severe and complex mental illness on the Gold Coast:

- 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.

- There is significant lack of services in the Northern Corridor (Pimpama and Ormeau):
    - 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.

    - Since COVID, GPs in the Northern Corridor are attending to mental health issues for 20-30% of daily practice.
- GP's awareness of and referral to local services, including online, self-help, low intensity services, can have a significant positive impact on recovery.
- 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".
- People with intellectual disability, autism and acquired brain Injury are often not able access disability services for mental health support. Some private psychologists do not feel confident or have skills to provide support to these people.

Severe and complex mental illness

- 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.
- The emergence of increased ease of access to low-cost methamphetamine present a big problem.
- 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.
- GPs report that they deliver increased number of consultations due to significant lack of allied health service availability in the GCPHN region.

Child, youth and families' mental health

- Services and support for children who are undergoing gender transitioning or who identify early as LGBTIQAP+ are sparse.
- 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 children under the age of 10 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.

- 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.
- 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 / 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.

Labrador Child Safety Service Centre Transition to Adult team reported that:

- 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.
- Cheaper drugs are preference. Marijuana is not seen by young people as a problematic drug.
- 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

Older people

- Older people often need assistance with physical and mental health, with coordination of medical appointments and understanding their medications, and 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.
- Data from COVID recovery service 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).
- 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 support.

People from CALD backgrounds

- 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 are needed on the Gold Coast to ascertain needs.

People at risk of homelessness

- 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 identified 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.

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. Gold Coast City Council 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.
- There is a need for more bulk billing psychologists and psychiatrists.

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.
- 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.

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.

People from CALD backgrounds

- 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.
- Asylum seekers often 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.

Child, youth and families' mental health

Children themselves were not engaged in providing direct feedback. Dialogue occurred with young people, 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, 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.
- There 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.
- Assessments from multiple health services - all are different, all require significant input. Need for streamlining these questionnaires.

People at risk of homelessness

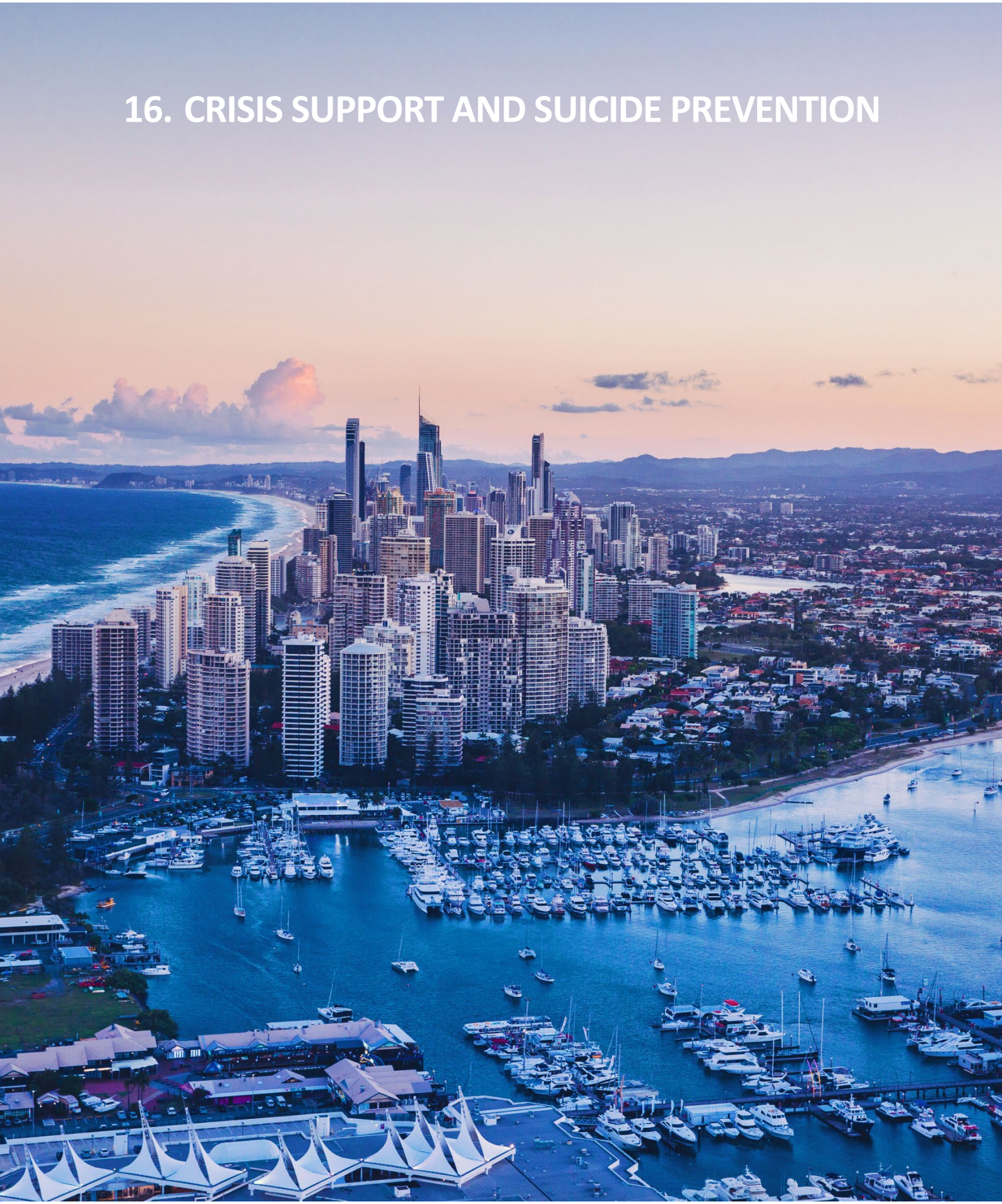
- Consumer journey mapping indicated that for homeless people with mental health conditions, often contact with a trusted staff member was the thing that put them on a trajectory to recovery in addition to finding accommodation and taking the step of seeking treatment.
- As similarly identified by the 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.

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.

16. CRISIS SUPPORT AND SUICIDE PREVENTION



KEY FACTS:

- Gold Coast Primary Health Network (GCPHN) suicide rate is consistent with the average Queensland, but higher than the national rate.
- Males account for 75.0% of deaths by suicide on the Gold Coast.
- Mental illness, including depression, and trauma are associated with a large portion of suicide attempts.
- Services that support people struggling with relationship and family breakdowns, financial problems and bereavement are essential elements of the suicide prevention system.

LOCAL HEALTH NEEDS:

- Suicidal people often visit primary care providers in the weeks or days before suicide but often their suicide risk is not identified.
- LGBTIQAP+ communities, Aboriginal and Torres Strait Islanders, and culturally and linguistically diverse communities have elevated risk of suicide.
- Limited supports are available for people in distress who end up in Emergency Department.

SERVICE ISSUES:

- When challenges occur during a crisis, it is often at the points of intersection between different sectors.
- 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.

16.1 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 do not go on to end their lives, however, previous self-harm is the strongest predictor of death by suicide. Therefore, monitoring of intentional self-harm is key to suicide prevention.

As can be seen in Table 82, in 2021/22, GCPHN region was below the Queensland rate per 100,000 people for all intentional self-harm for all age cohorts except females aged 65 years and over.

Table 82. Number and rate of intentional self-harm hospitalisations, Gold Coast and Queensland, 2021-22

		Gold Coast	Queensland	Gold Coast	Queensland
		Number		Rate per 100,000 people	
Male	0-24	61	883	61.6	104.9
	25-44	83	1173	95.9	168.0
	45-64	44	614	55.9	96.6
	65+	22	203	41.5	49.4
	All ages	210	2873	66.2	111.1
Female	0-24	235	2746	245.6	343.9
	25-44	113	1620	122.8	225.4
	45-64	86	919	101.9	139.2
	65+	36	248	59.8	54.6
	All ages	470	5533	141.4	210.3

Source. Data tables: 2021–22 National Hospital Morbidity Database—Intentional self-harm hospitalisations

16.2 Deaths by suicide

In 2021, there were 3,144 deaths by suicide in Australia – an average of about 9 per day. The age standardised rate was 12.0 deaths per 100,000 population, which is down from 13.2 in 2017.

The release of the 2017-2021 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 16,137 deaths (12.6 per 100,000) in Australia. Suicide was the 8th leading cause of death on the Gold Coast in the same period with 470 deaths (14.5 per 100,000)[148].

During 2019-2021, there were 258 suicides in the GCPHN catchment area, accounting for a rate of 12.7 per 100,000 people[177]. This was below the total Queensland rate of 15.5 per 100,000 persons during the same period.

Table 83 shows that Surfers Paradise had the highest rate of deaths by suicide between 2017 and 2021. Although the age-standardised rate of deaths by suicide identified Ormeau-Oxenford as the fourth rated in the region, it accounted for the highest number of deaths by suicide (n=103).

[148] Australian Institute of Health and Welfare. (2021). *Mortality Over Regions and Time (MORT) books 2015-2019.*
[177] S Leske, G Adam, A Catakovic, B Weir and K Kõlves, *Suicide in Queensland: Annual Report 2022*, AISRAP, Griffith University.

Table 83. Suicides in Gold Coast SA3 regions, 2017–2021

	Number of deaths	Age-standardised rate (per 100,000 people)
Gold Coast SA4	447	14.5
Ormeau - Oxenford	103	15.0
Nerang	54	14.9
Southport	50	14.2
Gold Coast - North	48	13.1
Surfers Paradise	47	18.5
Broadbeach - Burleigh	46	12.4
Coolangatta	46	15.6
Robina	32	11.6
Mudgeeraba - Tallebudgera	27	15.3
Gold Coast Hinterland	17	-

Source. AIHW (2021. MORT (Mortality Over Regions and Time) books: Statistical Area Level 3 (SA3), 2017–2021. Canberra: AIHW.

16.2.1 Suicide rates by age and gender

In 2021, more than half of all deaths by suicide (53%) in Queensland occurred in people aged 30–59 with 1,653 deaths, 24% of suicide deaths occurred in people aged 60 and over, and 22% occurred in people aged 15–29. Suicide was the leading cause of death among people aged 15–44 in 2021.

Between 2019 and 2021 in the Gold Coast PHN region, 71.3% of suicide deaths were by males, and 28.7% by females.

16.2.2 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[149].

Of the 756 suicides reported in 2021 in Queensland. Aboriginal and Torres Strait Islander individuals living in Queensland had 57 deaths accounting for 7% of all suspected suicides by Queensland residents[150]. The age group of 20-29 had the highest number of suspected suicides (28) 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 HNA chapter on Aboriginal & Torres Strait Islander health and wellbeing).

[149] Australian Bureau of Statistics. (2018). *Causes of Death, Australia*. ABS.
[150] S Leske, G Adam, A Catakovic, B Weir and K Kõlves, *Suicide in Queensland: Annual Report 2022*, AISRAP, Griffith University.

16.2.3 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[151] .

Of the 756 suicides reported in 2021 in Queensland, 24 (3.2% 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[3] . 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[152].

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[153]. 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[154].

16.2.4 Culturally and linguistically diverse 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.

16.3 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.

Data from the Australian Institute for Suicide Research and Prevention[8] identified the prevalence of life events among people who died by suicide (2016-2018). Financial problems were the most frequently recorded life event (16.8%), followed by bereavement (16.5%), and family conflict (15.0%).

Table 84. Adverse life events experienced by those dying by suicide in Queensland, 2016 to 2018

Adverse life event	Number	%
Financial problems	398	16.8
Bereavement	395	16.5
Family conflict	356	15.0
Pending legal matters	270	11.4
Work/school problems (not financial)	267	11.3

[151] Suicide Prevention Australia (2009). Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities
[152] Rosenstreich, G. (2013). LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance: Sydney.
[153] Robinson, KH., Bansel, P., Denson, N., Ovenden, G., Davies, C. (2014) Growing Up Queer: *Issues Facing Young Australians Who Are Gender Variant and Sexuality Diverse*, Young and Well Cooperative Research Centre.
[154] Cook, A., Winter, S., Strauss, P., Lin, A., Wright Toussaint, D., & Watson, V. (2017). Trans Pathways: The mental health experiences and care pathways of trans young people: Summary of results.

Recent or pending unemployment	232	9.8
Child custody dispute	129	5.4
Interpersonal conflict	127	5.4
Childhood trauma	132	5.6
Sexual abuse	103	4.4

16.4 Impacts of COVID-19

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.

Table 85 shows the year-to-date comparisons for suicides from January to July in 2020, which was comparable to 2019.

Table 85. 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, I., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. AISRAP.

16.5 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 were completed and discharged, 19% were admitted, 16% were 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%).

16.6 Available services in Gold Coast

16.6.1 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, those experiencing suicidal crisis.

From July 2021 to June 2022 there were 1,056 referrals to the Adult Suicide Prevention 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.

16.6.2 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).

16.6.3 Suicide Prevention Pathway

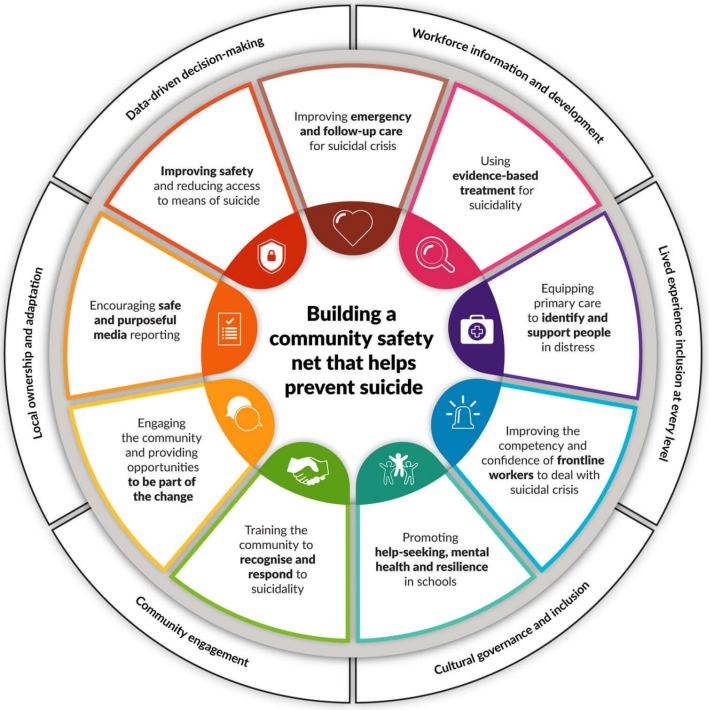
The Gold Coast Mental Health and Specialist Services Suicide Prevention Pathway assists patient's recovery from suicidal thoughts and behaviors. Between January and November 2019, there was a total of 1,681 placements on the Suicide Prevention Pathway (on average, 153 placements per month). This represented a total of 1,498 persons (average of 136 per month). Of these people, 84.2% were aged 18 years and over.

16.6.4 Community approach to suicide prevention

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, a Suicide Prevention Leadership Group was formed in August 2019 as part of the Joint Regional Planning process. 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 37. 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:

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.

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.

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.

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.

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.

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 is limited evidence around which programs are most effective and relevant to local stakeholders.

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.

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.

- 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.

16.6.5 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[155], 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.

[155] Action Alliance Crisis Service Task Force. (2016). Crisis Now, Transforming Services Within Our Reach.

The Gold Coast Crisis Reform Framework was developed[156] 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.
- 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.
- 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, and lived experience principles.

[156] Queensland Health. (2020) Gold Coast Crisis Reform: A Strategic Approach to Transforming Mental Health Crisis Care.

16.7 Service system in GCPHN region

Services	Number	Distribution	Capacity discussion
Gold Coast Health crisis helpline 13 MH CALL	1 phone hotline for the Acute Care Treatment (ACT) Team	Available 24hrs	Dedicated suicide prevention services on the Gold Coast appear to be limited; however, a number of mental health services provide information and referral advice on suicide prevention. Gold Coast PHN needs assessment indicated a need for non-clinical suicide prevention services such as Gold Coast Community Support Program to service 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). 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.
Emergency Departments (ED)	5	Southport and Robina (public); Southport, Benowa and Tugun (private)	
The Way Back Support Service -	1	Adults 18 years or older that have presented or been discharged from either Robina or Gold Coast University Hospital following a suicide attempt or suicidal crisis.	
Crisis helplines	5 (Lifeline, Suicide Call Back Service, Mensline, Kids Helpline, 13YARN)	24-hour, 7-day telephone services. Public knowledge of these services would drive uptake/demand.	
Counselling helplines and websites	12 (Mensline, Kids Helpline, Open Arms, QLife, Carers	Online and telephone services	

	Australia, eheadspace, 1800 Respect, Relationships Australia, SANE Australia, ReachOut, BeyondBlue, Counselling Online, Child abuse prevention service)		
Crisis Stabilisation Unit (CSU) Robina Hospital	1		Accessible via contact with public hospitals in Robina and Southport and through the 13 MHCALL hotline.
Gold Coast Community Support Program (GCCSP)	1		• Self-referrals from community can be made via 01 5569 1850 or online. • Referrals accepted from General Practitioners and community groups and organisations for individuals living in Gold Coast.
Psychosocial service funded by GCPHN	2	Plus Social, Crossing Paths Carer Support Program, 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.

16.8 Consultations

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,
- Crisis Reform Strategy, and
- Suicide Prevention Community Action Plan.

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 providers

- 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 users

- 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.

17. ALCOHOL AND OTHER DRUGS

KEY FACTS:

- Alcohol, cannabis, and amphetamines are the most common drugs of concern.
- Lifetime risky alcohol consumption on the Gold Coast = 21.7% (national: 16.8%).
- Recent illicit drug use on the Gold Coast = 22.0% (national: 16.8%).
- 2019/20: 901 ED presentations for mental and behavioural disorders due to use of alcohol, acute intoxication.
- Coolangatta has the highest rate of drug and alcohol hospitalisations on the Gold Coast
- Southport has the highest rate of opioid prescriptions on the Gold Coast.

HEALTH NEEDS:

- High demand and limited AOD service options, particularly in the northern Gold Coast.
- High levels of opioid dispensing across Gold Coast.

SERVICE ISSUES:

- Challenges in recruiting AOD health workers that identify as Aboriginal and Torres Strait Islander.
- Financial costs, childcare responsibilities, and housing costs present barriers to accessing residential rehabilitation.
- Limited availability of suitable service options to support older population.
- Limited availability of withdrawal management services access to residential rehabilitation.
- GPs need access to timely and accurate information about capacity to connect people to suitable AOD services.
- Limited delivery of AODs services outside of business hours.
- Inefficient transitions between services, particularly from inpatient to community-based services.
- Variability in GPs' capacity to identify and manage AOD issues.

17.1 Prevalence

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.

17.2 Alcohol

Lifetime risk of harm related to alcohol consumption is defined as people consuming more than 2 standard drinks per day on average over a 12-month period[157]. While consumption at levels of lifetime risk have trended downward for Australia in recent years, in 2019 Gold Coast had higher proportions of people consuming alcohol at lifetime risky levels than the national average (Table 86). While the national rate has decreased from 2016 to 2019 of risky alcohol consumption, the Gold Coast percentage has remained the same.

Table 86. 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

Gold Coast PHN's general practice data (sourced from PATCAT) indicates that as of March 2022 of the 486,761 aged 18 years and over, 13% (n=65,646) 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).

17.2.1 Alcohol use across the life span

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.

[157] National Health and Medical Research Council. (2020) Australian Guidelines to Reduce Health Risks From Drinking Alcohol.

This is not reported back to the individual's GP and the individual does not disclose this information to their GP either.

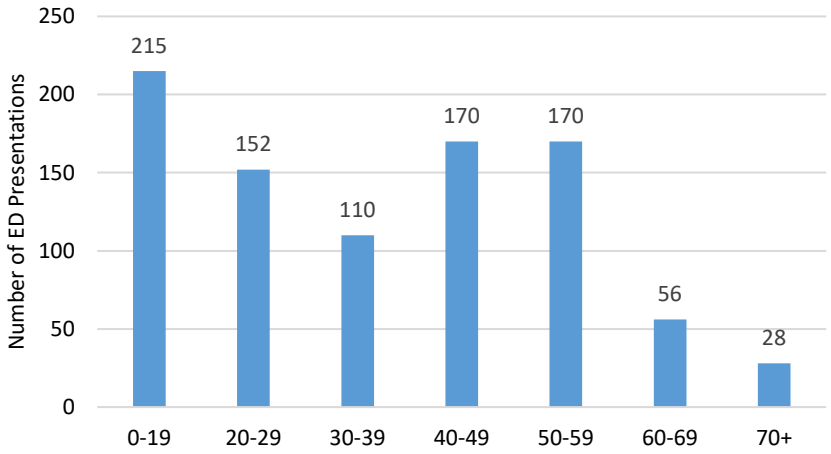
Younger people are now more likely to abstain from alcohol than they were 18 years ago. The proportion of people in their 20s abstaining from alcohol increased from 8.9% in 2001 to 22% in 2019[158].

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 and 8.8% of people aged 70 and more surpassed the single occasion guideline at least monthly.

17.2.2 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 regions with the largest number of presentations included Southport, Labrador, and Surfers Paradise.

Figure 38. 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 broader Gold Coast rate, three of these areas had rates above the national figure, with the highest recorded in Coolangatta (245) (Table 87).

[158] Australian Institute of Health and Welfare. (2020). National Drug Strategy Household Survey 2019. Canberra: AIHW.

Table 87. Drug and alcohol related hospitalisations per 100,000 people, Gold Coast SA3, 2014-15

Region	Hospitalisations per 100,000 people
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: AIHW National Hospital Morbidity Database 2014–15; and ABS Estimated Resident Population 30 June 2014.

17.3 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[159]. 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. Codeine is an opioid in the same family of compounds as opioids such as morphine, methadone and heroin.

Pharmaceutical opioids are responsible for 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[160]. 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.
- Where opioid use exceeds, or is expected to exceed 12 months, the patient need to seek a second opinion to approve ongoing prescriptions.

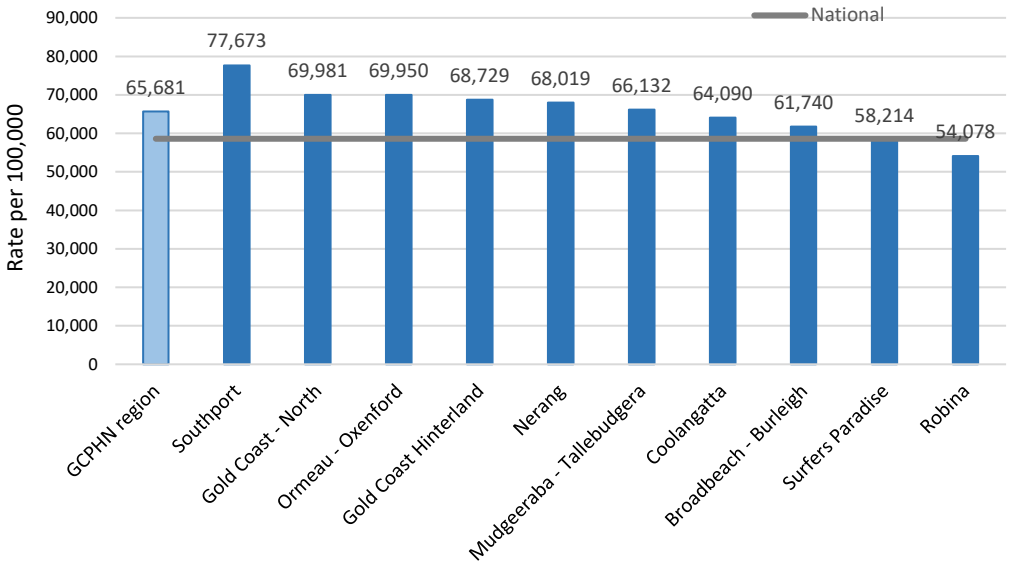
The number of opioids dispensed through the Pharmaceutical Benefits Scheme (PBS) increased fifteen-fold over the twenty years from 1992, reaching 7.5 million in 2012. Almost half the

[159] Australian Institute of Health and Welfare. *National Drug Strategy Household Survey 2016: preliminary findings*.
[160] Australian Institute of Health and Welfare. (2018). *Opioid harm in Australia: and comparisons between Australia and Canada*.

prescriptions for opioids from general practice are to treat chronic pain[161], however, evidence does not support using opioids for this condition[162].

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 39. PBS prescriptions dispensed for opioid medicines, Gold Coast SA3 regions, 2016-17



Source: Australian Atlas of Healthcare Variation, 2018

17.4 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),
- 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 2019, 22.0% of people reported recent illicit drug use among Gold Coast residents, which was above the national rate of 16.8%.

The National Drug and Strategy Household Survey, the leading survey on drug use patterns, attitudes and behaviours in Australia, showed that in 2019[163]:

- 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,

[161] Alcohol and Drug Foundation. (2016) Prevention research: is there a pill for that?
[162] Australian Commission on Safety and Quality in Health Care. (2015) Australian Atlas of healthcare Variation. Chapter 5 opioid medicines.
[163] Australian Institute of Health and Welfare. (2020). *National Drug Strategy Household Survey 2019*. Canberra: AIHW.

- 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.

This survey also found that across PHNs there was wide variation in the use of tobacco, alcohol, and illicit drugs in 2019. Gold Coast PHN was among the top five 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%).

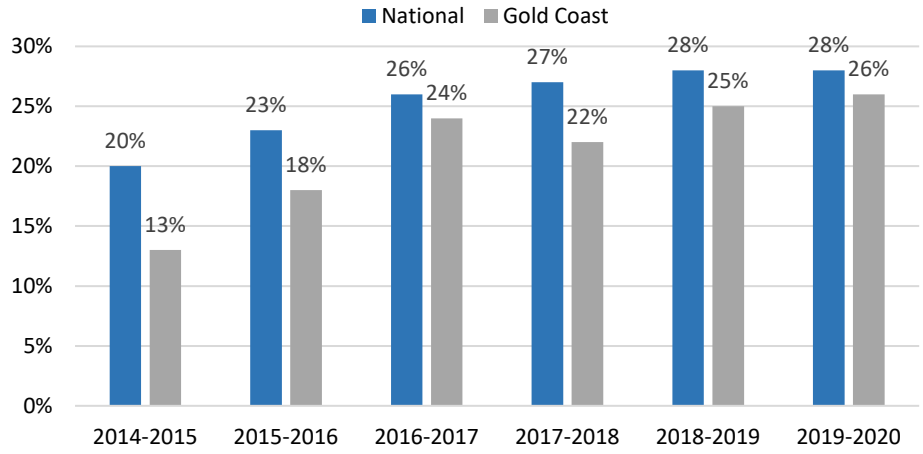
Table 88. High risk levels of alcohol and drug use, Gold Coast and national, 2019

	Exceeded lifetime alcohol risk guideline [a]	Exceeded single occasion alcohol risk guideline[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.

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 40).

Figure 40. Closed treatment episodes for amphetamines, Gold Coast and national, 2014-2015 to 2019-2020



AIHW: Alcohol and other drug treatment services, 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.

17.5 People with a dual diagnosis

Dual diagnosis is a term used to describe when a person is experiencing 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[164,165]:

- 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.
- 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.

17.6 Drug-induced deaths

Drug-induced deaths can be directly attributable to drug use, as determined by toxicology and pathology reports. 2018 Australian Institute of Health and Welfare analysis of the national mortality database showed:

- 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).
- 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).
- Opioids were present in nearly two-thirds of drug-induced deaths (64.5% or 1,123 deaths).
- The most common substance present in drug-induced deaths in 2018 were benzodiazepines, identified in 883 deaths (51%)[166].

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[167].

[164] Alcohol and Drug Foundation (2021). Understanding Dual Diagnosis (internal document) .
[165] Victoria State Government (2017). VicHealth. Dual Diagnosis.
[166] Australian Institute of Health and Welfare. National Mortality Database.
[167] Penington Institute. (2021). Australia's Annual Overdose Report 2021.

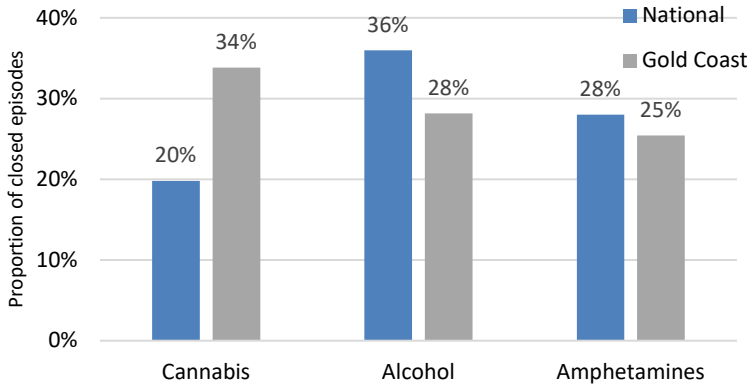
17.7 Utilisation of health services

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 41)[168].

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.

Figure 41. Treatment episodes for clients receiving treatment for drug use, Gold Coast and national, 2018-19



[168] Australian Institute of Health and Welfare. (2020). *Alcohol and other drug treatment services in Australia 2018–19*. Canberra: AIHW.

17.8 Service system in GCPHN region

Service	Number	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 within Gold Coast Health focusing on frequent presentations. • 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.
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 Sunday Morning, Youth substance abuse service, national drug and alcohol services directory)	Online and telephone services. Public knowledge of these services and connectivity capacity would drive uptake/demand	
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 (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	

17.9 Consultations

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 consultations 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 providers

- 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 users

- 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.

18. OLDER PEOPLE

KEY FACTS:

- Older adults on Gold Coast visit GPs more frequently than the national average.
- Gold Coast's older adults report better health and wellbeing and lower levels of disability than in other regions.
- In 2020, 9,044 Gold Coast residents had dementia.
- 3,044 older people in Gold Coast were using home care packages.
- Most common reason for GP visit by people aged 65 is hypertension.
- Estimated 26,000 older adults on Gold Coast have depression or anxiety.
- 6,789 people aged 65+ consult a GP for mental health concerns per year.
- 16.7% of older adults on the Gold Coast need assistance with core activities.
- 9,287 potentially preventable hospitalisations for people aged 65+ per year.

HEALTH NEEDS:

- Increased ED presentations and hospitalisations due to falls and wounds in older people.
- High prevalence of older people with frailty.
- Support for families and carers for people with dementia is needed.
- High levels of isolation and loneliness among older people on the Gold Coast.

SERVICE ISSUES:

- Aged care staff lack understating of the language of the aged care system.
- Long wait times for appropriate home-based support and/or aged care services.
- Slow adoption of digital health solutions by RACFs.
- Unnecessary and lengthy hospital admissions due to staffing issues and insufficient beds in RACHs.
- Lack of support in navigating complex aged care system.
- Limited culturally appropriate services for culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander older people.
- Clinical coordination tools and processes for patient-centred care for older adults are needed.
- Limited capacity for coordinated palliative and end-of-life care in RACHs.
- Limited number of registered nurses working in aged care.
- Slow uptake of COVID-19 vaccination for RACF residents and staff.
- Limited uptake of Advanced Care Plans, and lack of confidence and skills to provide palliative care at residents' place of choice.
- Limited access to public sector geriatricians.

18.1 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. The number of older adults aged 65 years

and over residing in the Gold Coast is forecast to double by 2030 which will account for over 20.2% of the total Gold Coast LGA population[169].

Table 89 provides a breakdown of the older adult population in by age group.

Table 89. 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

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.

18.1.1 Aboriginal and Torres Strait Islander population

There are 2,431 people aged 50 years and over (the age of eligibility for Aboriginal and Torres Strait Islander people to enter the public-funded aged care system) identifying as Aboriginal and Torres Strait Islander reside on the Gold Coast. 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 90).

[169] Gold Coast City Council, Social Planning and Research Reports.

Table 90. Number 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)

18.1.2 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.

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[170]. 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.

18.2 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, 66,893 Gold Coast residents aged 65 years and over were receiving an age pension. This accounts for 60.5% of the older population, which is slightly lower than the national level of 61.8%. This finding aligns with the lower levels of socio-economic disadvantage observed within the wider Gold Coast population relative to other regions.

Table 91 outlines the number and proportion of age pensioners within the GCPHN region.

[170] Gold Coast City Council Community Profile (2016). Gold Coast City migration by age.

Table 91. Number and proportion of age pensioners, Gold Coast SA3 regions, 2021

Region	Number of age pensioners	Age pensioners among all persons aged 65+ (%)
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

18.3 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)[171]. 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)

18.4 Prevalence of diseases

Data on disease prevalence were sourced from Gold Coast PHN's Primary Sense tool. 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 were due to diabetes. Anxiety and/or depression accounted for 35,137 presentations.

Prevalence of 10 most common diseases among GP-presenting older adults is shown in Table 92.

[171] Australian Institute of Health and Welfare. *Mortality Over Regions and Time (MORT) books: 2015-2019.*

Table 92. 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

Source: Primary Sense, n=159 Gold Coast general practices

18.4.1 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.

Table 93 shows hospitalisations for heart failure on the Gold Coast in 2017-18.

Table 93. 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

18.4.2 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.

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. 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.

18.4.3 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 disability is defined as someone that needs help or supervision always or sometimes to perform core activities of self-care, mobility and/or communication.

Table 94 outlines the 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 RACH, non-self-contained residences, and psychiatric hospitals).

The figures show high proportions of older adults living with high care needs in Southport and Robina, with high numbers of older adults living with high care needs in Gold Coast-North.

Table 94. People with a profound or severe disability aged 65 years and over, Gold Coast SA3 regions, 2016

SA3 Region	Number	% of all persons aged 65+
Gold Coast SA4	15,753	16.6%
Broadbeach - Burleigh	1,815	13.8%
Coolangatta	1,833	16.1%
Gold Coast - North	2,519	17.3%
Gold Coast Hinterland	393	11.8%
Mudgeeraba - Tallebudgera	647	15.8%
Nerang	1,570	17.0%
Ormeau - Oxenford	2,123	17.5%
Robina	1,670	20.7%
Southport	2,191	22.6%
Surfers Paradise	992	10.9%

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

older Gold Coast population needing assistance). Ormeau – Oxenford and Gold Coast North have the largest number of people aged 65 years and over need assistance with core activities.

Table 95. 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-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

18.5 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. 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%)[172,173].

Approximately 450,000 Australians currently live with a chronic wound, directly costing the Australian healthcare system around AU$3 billion per year. 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].

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[174]. 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%)

[172]Graves, N., & Zheng, H. (2014). The prevalence and incidence of chronic wounds: a literature review. *Wound Practice & Research 22*(1).
[173]Graves, N., & Zheng, H. (2014). Modelling the direct health care costs of chronic wounds in Australia. *Wound Practice & Research22*(1).
[174] Gold Coast Health, Emergency Department presentations, 2021-22.

- 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.

18.6 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[175,176].

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[177]. 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 96 has been extracted from Primary Sense for 155 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 – Oxenford SA3 has the highest overall number of patients with a frailty flag (n= 1321).

[175]Kojima, G. (2015). Frailty as a predictor of future falls among community-dwelling older people: a systematic review and meta-analysis. *Journal of the American Medical Directors Association*, *16*(12), 1027-1033.
[176]Tom, S. E., Adachi, J. D., Anderson Jr, F. A., Boonen, S.,... & GLOW Investigators. (2013). Frailty and fracture, disability, and falls: a multiple country study from the global longitudinal study of osteoporosis in women. *Journal of the American Geriatrics Society*, *61*(3), 327-334.
[177] Torpy, J. M., Lynm, C., & Glass, R. M. (2006). Frailty in older adults. *jama*, *296*(18), 2280-2280.

Table 96. Patients aged 65 years and over with a frailty flag, Gold Coast region, July 2022

Postcode	SA3 of the post codes	Number of patients aged 65+ with a frailty flag	Proportion of patients aged 65+ with frailty flag
4215	Gold Coast North	595	3.9%
4212	Ormeau - Oxenford	545	4.9%
4220	Broadbeach - Burleigh	474	3.4%
4216	Ormeau - Oxenford/Gold Coast North	472	4.8%
4211	Gold Coast Hinterland	420	3.9%
4221	Coolangatta	412	8.5%
4217	Surfers Paradise	365	3.9%
4218	Broadbeach - Burleigh	266	3.0%
4214	Southport	245	4.0%
4209	Ormeau - Oxenford	228	3.6%
4226	Robina	184	3.0%
4225	Coolangatta	178	3.9%
4227	Robina	168	4.6%
4210	Gold Coast Hinterland	140	3.3%
4272	Gold Coast Hinterland	137	7.4%
4223	Coolangatta/Mudgeeraba - Tallebudgera	128	4.8%
4224	Coolangatta	84	4.6%
4208	Ormeau - Oxenford	76	3.0%
4271	Gold Coast Hinterland	72	7.0%
4213	Gold Coast Hinterland	54	2.7%
4230	Robina	51	3.7%
4270	Gold Coast Hinterland	31	4.9%
4275	Gold Coast Hinterland	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. Patients are attributed to the postcode of the general practice, not their residence.*

18.7 Mental health

Good mental health is one of the key factors associated with healthy ageing[178]. 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

[178] Kane, R. L. (2005). What's So Good About Aging? *Research in Human Development*, *2*(3), 103-114.

able to make a contribution to his or her community"[179] – as well as has 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. These factors may lead to social isolation and/or loneliness, loss of independence and increased psychological distress.

It has been estimated that between 10 to 15% of older adults experience depression and about 10% experience anxiety[180]. 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, it can be estimated that 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.

18.8 Contributing factors

18.8.1 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[181]) 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[182].

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. 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.

18.8.2 Low literacy levels

Health literacy relates to how people access, understand and use health information in ways that benefit their health[183]. 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)[184]. Applying this prevalence to the local Gold Coast older adult population, over 74,000 people are estimated to have low literacy skills.

People with low health literacy are more likely to have worse health outcomes, such as:

- lower engagement with health services, including preventive services such as cancer screening[185],
- higher hospital re-admission rates[186], and

[179] World Health Organization. (2004). *Promoting mental health: Concepts, emerging evidence, practice: Summary report*..
[180] Haralambouse et al. (2009). *Depression in older age: A scoping study.* National Ageing Research Institute (NARI) funded by Beyond Blue.
[181] Peplau, L. A., & Perlman, D. (1982). Loneliness: A sourcebook of current theory, research, and therapy.
[16] Beer, A., et al. (2016). Regional variation in social isolation amongst older Australians. *Regional Studies, Regional Science*, *3*(1), 170-184.
[183] Australian Institute of Health and Welfare. (2022). *Health literacy.*
[184]Australian Bureau of Statistics (2013). Older Australians have lower levels of literacy and numeracy (media release).
[185]Kobayashi, L. C., Wardle, J., & 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), 100–105.
[186] Mitchell, S. E., Sadikova, E., Jack, B. W., & Paasche-Orlow, M. K. (2012). Health literacy and 30-day postdischarge hospital utilization. *Journal of health communication*, *17 Suppl 3*, 325–338. 3

- lower ability to self-manage care[187].

18.8.3 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.

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[188], 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. Neglect has been experienced by about 20% of women from ages 70-75 to 85-90 years.

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[189].

18.8.4 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%[192]. 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[190].

18.9 Dementia

18.9.1 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'[191].

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.

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.

[187]Geboers, B., de Winter, A. F., Spoorenberg, S. L., Wynia, K., & Reijneveld, S. A. (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.

[188] *Australian Longitudinal Study on Women's Health. (2014). 1921-26 cohort: Summary 1996-2013. University of Newcastle and the University of Queensland.*

[189] Robinson, E., & Adams, R. (2008). Housing stress and the mental health and wellbeing of families.

[190] Dementia Australia. (2022), Mild Cognitive Impairment.

[191] Australian Institute of Health and Welfare. (2023). *Dementia in Australia.*

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[192].

18.9.2 Prevalence

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%).

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[193]. This will be a 195% increase from 2020.

Table 97 shows the number of people living in the GCPHN region living with dementia grouped into Statistical Area Level three regions (SA3).

Table 97. 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.

[192] Livingston ,G., Sommerlad A., Orgeta, V. et al. (2017) 'Dementia prevention, intervention, and care'. *The Lancet*, 390:2673–2734.
[193] Alzheimer's Australia Qld. *Projections of dementia prevalence and incidence in Queensland 2011-2050.*

18.9.3 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 number of dementia related hospitalisations in the region has increased by over 24% in the last three available reporting years (Table 98).

Table 98. 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)

18.9.4 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[194].

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[195]. 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[196].

[194] Hustey, F. M., & Meldon, S. W. (2002). The prevalence and documentation of impaired mental status in elderly emergency department patients. *Annals of emergency medicine*, *39*(3), 248–253. 7

[195] Meldon, S. W., Mion, L. C., Palmer, R. M., Drew, B. L., et al. (2003). A brief risk-stratification tool to predict repeat emergency department visits and hospitalizations in older patients discharged from the emergency department. *Academic emergency medicine*, *10*(3), 224–232.

[196] Queensland Health. (2019) Care for The Older Person In Emergency.

18.9.5 Deaths due to dementia

Dementia was the second leading cause of death on the Gold Coast in 2015-19, accounting for 1,697[197] 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).

18.9.6 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.

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. In addition, antipsychotic medications were dispensed to about one-fifth (21%) of the 64,600 people who had scripts dispensed for dementia-specific medication[198].

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.

18.9.7 Residential Aged Care Facilities

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[199].

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.

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[200].

18.9.8 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 99, for people with dementia aged under 80, the number of services used by people in residential aged care was similar to the number of services used by people who were living in the community. From age 80

[197] Australian Institute of Health and Welfare. (2023). *Mortality Over Regions and Time (MORT) books*.
[198] AIHW (2023). *Dementia in Australia: Prescriptions dispensed for dementia-specific medications—data tables, 2021,*
[199] Australian Institute of Health and Welfare. (2021) *Gen Aged Care Data.*
[200] Australian Institute of Health and Welfare. (2021) D*ementia in Australia- aged care services*.

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.

Table 99. 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	MBS services - number	MBS services – rate per 1,000
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[201]. This is likely due to the increasing number of co-existing health conditions and more complex health needs as people age.

18.9.9 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. 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[202].

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.

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.
- One in two experienced financial impacts since taking on the role[203].

[201] Australian Institute of Health and Welfare. (2021). Dementia in Australia: GP, Specialist and other Healthcare Services- data tables.
[202] Tookey, S., Greaves, C. V., Rohrer, J. D., Desai, R., & Stott, J. (2022). Exploring experiences and needs of spousal carers of people with behavioural variant frontotemporal dementia including those with familial FTD (fFTD): a qualitative study. *BMC geriatrics*, *22*(1), 1-11.
[203] Australian Institute of Health and Welfare. (2021) *Dementia in Australia: 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[204].

18.10 Utilisation of health services

18.10.1 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 100).

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 100. Potentially preventable hospitalisations for people aged 65+, national and Gold Coast, 2019-20

	Gold Coast	National
Total acute	3,117	2,471
Total chronic	5,522	5,014
Total vaccine preventable	721	710
Total potentially preventable	9,278	8,098

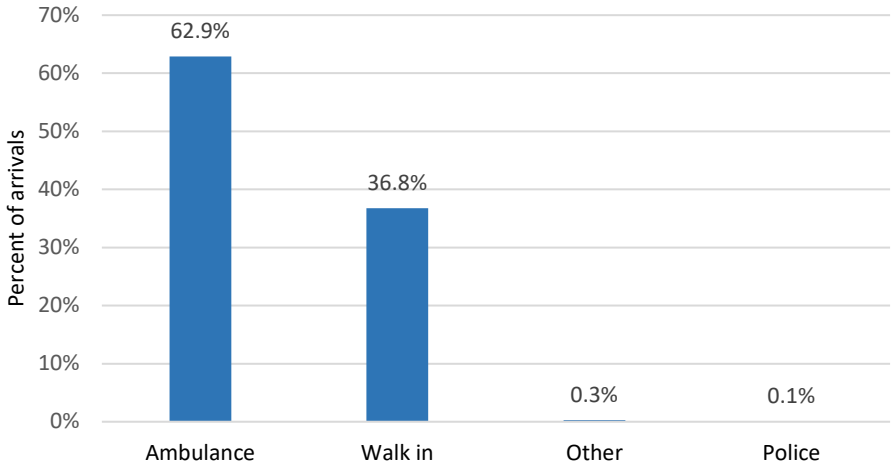
Source: AIHW 2022. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20.

18.10.2 Emergency Departments

People who do not have appropriate supports or aged care services in place may utilise Queensland Ambulance Service and hospital services more frequently. Figure 42 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.

[204] **B**rown, L., Hansnata, E., & La, H. A. (2017). Economic Cost of Dementia in Australia 2016-2056: Report prepared for Alzheimer's Australia.

Figure 42. Proportion of ED presentations for older adults 65+ in the GCPHN region, by arrival 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.

In 2021-22, the highest rates for more urgent presentations (Australian Triage Scale category 1-3) by older adults were 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 (Australian Triage Scale category 4 or 5) 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

18.10.3 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[205].

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"[206]. 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.

[205] Royal Commission into Aged Care Quality and Framework
[206] Aha (2015). Primary Healthcare Advisory Group: *Better Outcomes for People with Chronic and Complex Health Conditions*.

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 101. 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 101. 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

18.10.4 Prescribed medications

Dispensing rates under the 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 102 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.

Table 102. Rate of prescriptions for selected medications for people aged 65+, 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

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.

18.11 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[207]. 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[208].

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.
- 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[209].

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 March 2020. Work that supported this included:

[207] Rhee, J. J., Zwar, N. A., & Kemp, L. A. (2013). Why are advance care planning decisions not implemented? Insights from interviews with Australian general practitioners. *Journal of palliative medicine*, *16*(10), 1197–1204.
[208] Australian government Department of Health and Ageing, Canberra. (2011) *A national Framework for Advance Care Directives.*
[209] Detering, K. M., Buck, K., Ruseckaite, R., Kelly, H., Sellars, M., Sinclair, C., Clayton, J. M., & Nolte, L. (2019). Prevalence and correlates of advance care directives among older Australians accessing health and residential aged care services. BMJ open, 9(1), e025255. 5

- 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[210].

Table 103. Advance care planning documents uploaded to the Queensland hospital record, 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

18.12 Aged Care Services

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)[211].

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 can be 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, with more than two-thirds of people using aged care services do so from home.

[210] Office of Advance care Planning – Queensland Health Queensland Health. Office of Advance Care Planning.
[211] Australian Bureau of Statistics. (2018 edition). Queensland Government Population Projects: Population by age and Sex

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 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.
- **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.

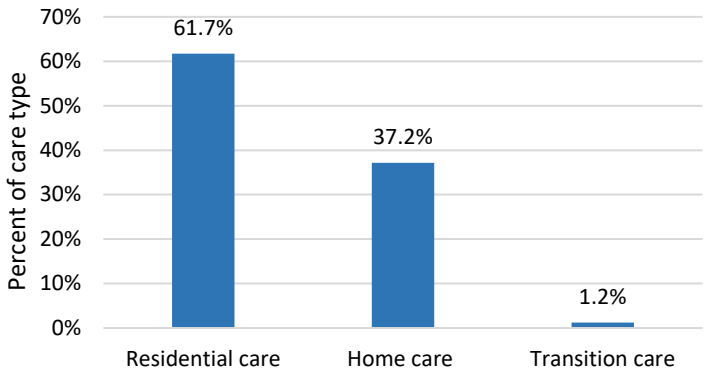
Table 104. Number of users and allocated places for South Coast region by care type and provider type, 2020

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 43). 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 43. 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)

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.

18.12.1 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[212]. 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 105. 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.

Table 105. Estimated waiting time for home care package on National Prioritisation Queue, December 2021

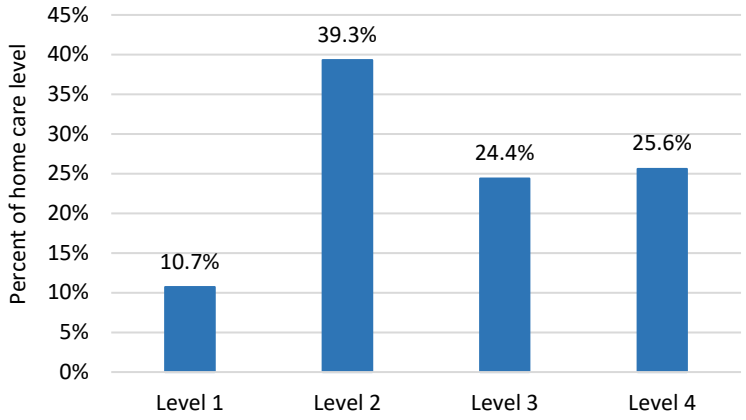
Package level	First package assignment	Time to first package	Time to approved package
Level 1	Level 1	3-6 months	3-6 months
Level 2	Level 1	3-6 months	6-9 months
Level 3	Level 1	3-6 months	6-9 months
Level 4	Level 2	6-9 months	6-9 months

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)[48]. 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 44 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 44. Proportion of all people using Home Care Services in South Coast aged care planning region, 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. 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.

[212] Department of Health. (2022), *Home care Packages Program data report: Data Report 2nd Quarter 2021-22 , October -December 2021.*

18.12.2 Residential aged care homes

A Residential Aged Care Home (RACH) 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 106. It includes a breakdown by demographic characteristics.

Table 106. 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	Under 65	30	90
	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.

Table 107 shows that over 82% of people who exited permanent residential aged care in 2020-21 did so due to death.

Table 107. Length of stay and exits from permanent residential care, 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 108 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 108. 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 by the fact 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.

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[213]. 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[214].

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[215]. 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,

[213]Jaul, E., Barron, J., Rosenzweig, J. P., & Menczel, J. (2018). An overview of co-morbidities and the development of pressure ulcers among older adults. *BMC geriatrics*, *18*(1), 305.
[214]Pagan, M., Trip, H., Burrell, B., & Gillon, D. (2015). Wound programmes in residential aged care: A systematic review. Wound Practice & Research: Journal of the Australian Wound Management Association, 23(2), 52–60. f
[215]Gold Coast Health. Emergency Department presentations, 2021-22.

- 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.

As seen in Table 109, Gold Coast has a higher number of GP attendances per RACH patient compared to the national rate. The number of GP RACH attendances increased from 122,830 in 2016-17 to 144,574 in 2020-21 (17.7% increase).

Table 109. 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[216].

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.

[216] Australian Institute of Health and Welfare. (2015). Australia's welfare 2015. Canberra: AIHW.

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.

18.13 Service system in GCPHN region

Services	Number	Distribution	Capacity discussion
General practices	210	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	857 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 RACHs.
Residential aged care homes	57	Spread from Ormeau to Coolangatta	• The RACHs 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: 57 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 RACH residents.
Specialist practices	236 services with 664 workers	Spread across Gold Coast; majority in coastal and central areas	• Many different specialists contribute to the care of older adults on the Gold Coast. • Specialists can range from cardiology, psychiatry, and oncology etc.

Hospital and Health Service (Gold Coast Health)		2 public hospitals - Southport and Robina Helensvale and Palm Beach Community Health Centres 3 private hospitals - 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+ provides 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 Homes (RACH) Acute Support Service (RaSS)	Available seven days a week from 7.30am until 6pm to support RACH 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, RACH 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 RACHs and GPs on behalf of GCHHS.

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)	1	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.
Older Persons Advocacy Network	1	National	OPAN offers free, independent and confidential support and information to older people seeking or already using Australian Government-funded aged care services across the nation, along with their families and carers.
End of Life Directions for Aged Services	1	National	End of Life Directions for Aged Care (ELDAC) is a national specialist palliative care and advance care planning advisory service. This service comprises a comprehensive website with resources to equip care providers with skills and information to help older Australians receive high-quality end of life care.
Aged and Disability Advocacy Australia	1	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.

18.14 Consultations

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
    - 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.

Australian Medical Association: Aged Care Survey Report

The Australian Medical Association 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.

19. PALLIATIVE CARE

KEY FACTS:

- Most Australians would prefer to die at home, but over half of deaths occur in a hospital.
- There is limited uptake of Advanced Care Plans.
- The effectiveness of palliative care has increased significantly over the last 10 years in relation to symptoms such as pain, fatigue, breathing problems and family or carer problems.

LOCAL HEALTH NEEDS:

- 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.

SERVICE ISSUES:

Consultation highlighted a range of issues that may be impacting the effectiveness of palliative care services to meet the needs of the Gold Coast community:

- 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,
- 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 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.

19.1 Background

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[217]. 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[218].

The Australian Government established the Royal Commission into Aged Care Quality and Safety in October 2018, which received numerous 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,
- 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 RACH,
- Access to multidisciplinary outreach service, and
- A new Aged Care Act that includes the right to access palliative care and end-of-life care.

19.2 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.

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[219], yet 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
- in patient's homes through primary care providers.

[217] Australian Commission on Safety and Quality in Health Care (2015). National Consensus Statement: essential elements for safe and high-quality end-of-life care.
[218] Department of Health (2019). National Palliative Care Strategy 2018. Canberra: Department of Health.
[219] Swerissen, H and Duckett, S., (2014). Dying Well. Grattan Institute: Melbourne.

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.

19.3 Palliative care delivered in 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.

Key points identified from admitted patient palliative care and other end-of-life care and hospital-based facilities:

- 83,430 palliative care-related hospitalisations were in public acute and private hospitals in Australia in 2018–19; 57.3% were for palliative care, and 42.7% 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.
- There has been a 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.
- In 38.4% of all hospitalisations during 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 anymore in 95% of Australian public hospitals.

19.3.1 Diagnoses in palliative care hospitalisation

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 other most frequently reported diagnoses for palliative care were cerebrovascular disease and heart failure and complications (4.3% and 3.1%, respectively), and for other end-of-life care, septicaemia and other ill-defined causes (4.9% and 4.8%, respectively).

Table 110 shows the numbers of Gold Coast Health palliative care-related hospital separations and associated bed days over the period 2014-15 to 2020-21.

Table 110. Palliative care-related separations and occupied bed days, Gold Coast, 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 are 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.

19.3.2 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 2018/19, just over a quarter (27.3%) of hospitals with a specialist palliative care inpatient unit in Australia were in New South Wales and Western Australia, with 11 in Queensland.

19.4 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.

19.4.1 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 last conducted in 2015-16. The main findings were:

- About 1 in 1,000 GP visits were palliative care-related.
- About 9 in 10 palliative care visits were by people aged 65 and over, and 4.8% by those aged under 55.

- Females accounted for a greater proportion of GP palliative care-related visits (53%) than males (47%), but there was no difference between the sexes (about 1 per 1,000 of GP encounters for both males and females).
- 1.3% of palliative care-related visits were by Indigenous Australians[220].

19.4.2 Medicare subsidised palliative services

The Royal Australian College of Physicians 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[221].

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[222].

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 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.

19.4.3 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 found 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.

[220] Britt, H., Miller, G. C., Henderson, J., et al. (2016). *General practice activity in Australia 2015–16*. Sydney University Press.
[221] RACP (Royal Australian College of Physicians). (2020). *Australasian Chapter of Palliative Medicine*.
[222] ANZSPM (2008). *Defining the meaning of the terms: Consultant Physician in Palliative Medicine and Palliative Medicine*.

The study also provided a variety of recommendations including:

- better definition of 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[223].

19.5 Palliative care in residential aged care homes

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 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[224].

19.6 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 palliative care workforce is not currently available for the GCPHN region.

In 2019, there were 292 palliative medicine physicians employed in Australia, 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.

19.7 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.

[223] 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.
[224] Australian Institute of Health and Welfare. (2023*). Palliative care services in Australia.*

- Nationally, the rate of subsidised palliative medicine specialist services provided in 2019-20 was 347 per 100,000 population.

19.8 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[225]. 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 :

- 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.
- More males (53.2%) underwent palliative care episodes than 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 cancer.

Patterns of national outcome data collected through PCOC from 2009 to 2016 show that:

- More patients are having palliative care commence within two days.
- 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.

[225] Australian Health Services Research Institute. *Palliative Car Outcomes Collaboration (PCOC)*. University of Wollongong.

19.9 Service system in GCPHN region

Services	Number	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 Health 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	857	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.

19.9.1 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)

19.10 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.

Community Advisory Council (2018)

In June 2018, GCPHN undertook engagement with 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.

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.

19.11 Appendix A: 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.

19.11.1 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, 23 practice managers), and by providing intensive support to six general practices to implement ACP processes in their practice and support the evaluation.

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.

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)

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).

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.

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 nurses.

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.

19.11.2 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.

19.11.3 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.

19.11.4 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.

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