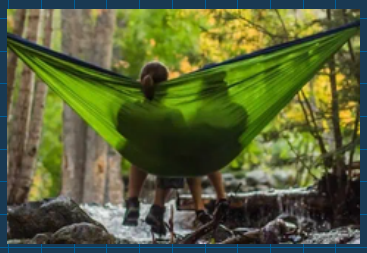
phn GOLD COAST
An Australian Government Initiative

CLINICAL COUNCIL MEETING

1 October 2026



INITIAL DISCUSSIONS

The Clinical Council meeting reinforced expectations for respectful, confidential and psychologically safe participation.

Reflections from GCPHN highlighted a growing focus on prevention, early intervention, integrated service delivery and stronger health literacy, with current planning centred on alcohol and other drug services and future work in mental health. Members also discussed ongoing access and system-navigation challenges in aged care and emerging disability reforms, noting GCPHN's role in connecting services and supporting regional partners despite limited influence over Commonwealth funding arrangements. Updates from the Community Advisory Council and Clinical Council emphasised the value of stakeholder engagement, the positive launch of the 2026–29 Strategic Plan and planned recruitment for 2027. The discussion also recognised the strong early response to the Northern Medicare Mental Health Centre, while identifying the need for clear referral, follow-up and continuity-of-care pathways, and noted that the Your Mood Moves With You campaign creative would be retained for future funding opportunities.

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Topic one: QI Toolkit and Clinical Audit Tool

DETAILS

To inform development of a practical quality improvement toolkit and clinical audit tool for general practice, focused on alcohol, smoking and vaping. Members were asked when clinicians raise substance use, what information and system prompts support earlier conversations, and how patients can be guided towards appropriate support before harmful patterns become entrenched.

KEY INSIGHTS

- Recording of alcohol, smoking and vape use is easiest at new-patient appointments, health assessments, mental health presentations and other key points in a patient's care.
- Triggers include acute injuries, major life events, bereavement, chronic conditions, abnormal pathology, cancer risk and consultations with secondary school-aged young people.
- Conversations should be tailored to the patient's presentation. When a patient is intoxicated or distressed, clinicians may need to gather essential information and write a note to revisit alcohol or drug use at a later consult.
- Records, previous consultation notes, cumulative pathology results and My Health Record can help identify patterns and earlier concerns. Practices also need regular data reviews to ensure alcohol, smoking and vaping information is current and recorded.
- Vaping must be asked about specifically because patients may not consider it smoking.
- Current clinical software (BP referenced) does not adequately capture vaping status, frequency or whether nicotine, cannabis or another substance is being used, limiting available data record and ease of follow-up. GPs may write a note about vaping use.
- Long-term familiarity with patients can make screening harder without a clear clinical trigger.
- Medicinal cannabis prescribing, particularly through online providers, requires stronger monitoring, communication and follow-up.
- Motivational interviewing, clear session-by-session guidance and progressive conversations can support change mindset and then behaviour.
- Health scares, impacts on family and friends, and financial costs were identified as common motivators to cessation. The urgency and approach should reflect the substance used and the associated clinical risk. Observed that generally people do not understand the full risks of alcohol consumption, including cancers.
- Health Pathways and local referral information are useful, but access barriers such as individual logins for clinicians into different systems may reduce use.

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Topic one QI Toolkit and Clinical Audit Tool (CONTINUED)

NEXT STEPS

- Develop the toolkit that clinicians can use around routine clinical triggers, to include practical conversation prompts, motivational techniques, follow-up guidance and clear referral pathways and patient education and other information resources.
- Include audit measures that support regular review and recording of alcohol, smoking and vaping status, while addressing current limitations in vaping data in clinical systems.
- Explore prompts within practice software and referral systems and make local guidance easier for clinicians to access.
- Include guidance on screening young people, reviewing medicinal cannabis use and adapting conversations according to the substance, patient readiness and level of risk. Discussion on what age would clinicians start to screen young people - general consensus either when in doctor's appointment without parent/carer or from 13/14 years.

Topic two Reducing Stigma

DETAILS

To identify practical ways to reduce shame and judgement associated with alcohol and other drug use so people feel safer seeking help earlier. The discussion considered workforce tools, public education communications, lived-experience stories, language, settings and models of care that can support open conversations in primary care and the community.

KEY INSIGHTS

- Conversations should be confidential, respectful and collaborative, using plain / non clinical language and caring prompts such as "I've noticed…" or "Is something going on?" rather than judgemental, authoritative or clinical language. Awareness and willingness to consider change should be recognised as progress.
- Members noted that requests for complete clinical records by life and income protection insurers may undermine confidence in confidentiality and record keeping around alcohol, smoking/vaping and other drug use, even where clinicians seek to limit disclosure.
- Culturally safe, holistic and wraparound care can make disclosure and follow-up easier. First Nations and multicultural communities may face additional barriers, and clinicians should ask respectfully rather than make assumptions. Mainstream services may not always have the wrap around MDT workforce needed to provide considered and coordinated support.
- Noted the level of alcohol use that is heavily normalised in Australia through social, sporting and family cultures, and many people may not recognise habitual drinking as harmful. Peer pressure can make declining alcohol difficult, so practical support in developing scripted responses may help patients manage social situations / exposures.
- Messaging should reflect everyday experiences rather than only severe dependence or crisis, including people who are working, parenting or socially connected. Tailored approaches may be needed for younger people, older people experiencing loneliness or isolation, multicultural communities and people affected by social or economic stress.
- Trusted relationships, peer support and continuity of care can normalise help-seeking. Potential settings include workplaces, construction sites, sporting clubs, schools, emergency departments and pre-employment health assessments.

NEXT STEPS

- Develop plain-language conversation prompts and practical scripts for clinicians, patients, families, friends and peers around harm minimisation and abstinence strategies.
- Use relatable lived-experience stories and messaging that normalise early help-seeking and show that support is appropriate before alcohol or drug use reaches crisis point.
- Explore culturally safe, multidisciplinary and peer-supported models that strengthen follow-up and realistic wraparound care.
- Target awareness activities through workplaces, sporting clubs, schools, health services and other community settings, with tailored resources for priority groups.
- Clarify how confidentiality and insurance-related disclosure should be explained so patients can make informed decisions about sharing sensitive information.

"Offering support - not judgement"

Reducing Stigma

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Topic three Naloxone

DETAILS

To explore clinician awareness and confidence in recommending take-home naloxone as part of routine safer opioid care. The discussion considered who should receive information, how families and household members can be supported, what clinical prompts would help, and how access through pharmacies can be better communicated.

KEY INSIGHTS

- Awareness of naloxone availability was extremely limited in the group, strongly indicating a need to educate clinicians before or concurrently with broader community promotion.
- Naloxone should be discussed with people taking regular or high-dose opioids, including prescribed opioids, and with people who may be exposed to opioids in their home or other environments.
- Families and household members should know how to recognise an opioid overdose, where naloxone is kept and how to administer it in an emergency, including for accidental overdose or ingestion by another person.
- Routine prompts could support conversations, including alerts when opioids are prescribed, Primary Sense notifications, QScript prompts at relevant oral morphine equivalent thresholds and pharmacy prompts when opioids are dispensed.
- Participating pharmacies can provide take-home naloxone without a prescription and free of charge, but this is not widely understood. Pharmacies could play a stronger role in routinely providing information or naloxone when dispensing opioids.
- Members noted that public messaging about harm minimisation and naloxone access can appear inconsistent with broader Queensland drug messaging, which may reduce awareness and acceptance.

NEXT STEPS

- Develop clear clinician education on naloxone, eligibility, access, availability and how to raise it as part of usual opioid care.
- Provide simple information for patients, families and household members on recognising overdose and using naloxone.
- Explore potential to develop medication prompts in Primary Sense, QScript, prescribing systems and pharmacy dispensing workflows.
- Strengthen clinical and public communication that naloxone is available without a prescription and free through participating pharmacies.
- Align clinical and public messaging so naloxone is presented as a practical emergency medicine and standard harm-minimisation measure.

Topic four Fetal Alcohol Spectrum Disorder

DETAILS

To identify local needs and opportunities for a fetal alcohol spectrum disorder (FASD) grant application focused on improved screening, diagnosis and place-based support. Members considered current service gaps, the role of primary care, priority populations and potential partnerships.

KEY INSIGHTS

- Assessment capacity on the Gold Coast is limited, with long waits (12-18 months) and restrictive pathways where prenatal alcohol exposure cannot be formally confirmed. Children in out-of-home care and families experiencing domestic violence, socioeconomic disadvantage or cultural and language barriers may be particularly affected.
- Clinicians reported gaps in confidence and skills in recognising, screening and diagnosing FASD at a practice level. Multidisciplinary specialist input remains key, and while primary care can support early identification, referral coordination and ongoing family care, they would be unable to effectively support diagnosis in general practice without allied health support.
- Routine developmental screening, including the three-year-old health assessment, may help identify concerns earlier. Screening should be considered for children with developmental, cognitive, motor, executive functioning or emotional regulation difficulties.
- Children and families need timely access to occupational therapy, speech pathology, psychology, parent and carer support, peer support and navigation through assessment, NDIS and other services—even where a formal diagnosis is delayed or unavailable.
- Prevention and education about alcohol use during pregnancy were identified as priorities. Any local model should be culturally safe, build on existing antenatal, AOD, paediatric, child development, education and family services, and avoid duplicating specialist capability.
- It was specifically noted that parents and carers are often in significant need of support.

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Topic four Fetal Alcohol Spectrum Disorder (CONTINUED)

NEXT STEPS

- Assess the grant streams and develop a feasible local proposal focused on prevention, earlier screening, navigation and family / carer support.
- Consider mapping existing assessment and referral pathways, clarify who can complete each diagnostic component, and identify opportunities to reduce delays and bottlenecks.
- Explore screening prompts and clinician guidance for the three-year-old health assessment and other developmental presentations.
- Engage priority communities and potential partners, including First Nations and multicultural organisations, out-of-home care, maternity, AOD, paediatric, education, child protection and primary care services.
- Consider a nurse navigator, peer-support or similar coordination role, alongside practical resources and culturally appropriate infographics for clinicians and families.

Topic five AOD Needs Assessment

DETAILS

To review and update the AOD Health Needs Assessment in preparation for anticipated changes to Commonwealth funding arrangements. Members were invited to test whether the current data reflects local clinical experience, identify gaps requiring further investigation and suggest priority stakeholders and services for consultation.

KEY INSIGHTS

- Emergency department and hospital presentation figures may understate AOD-related harm, particularly when substance use is not recorded in injury presentations. The scope of hospital data, including whether private hospitals are captured, requires clarification.
- Changes in access to prescribed cannabis may have affected reported illicit drug-use trends and should be examined in the updated analysis.
- Consultation should include harm-minimisation and early-intervention services such as the Chill Out Zone, Safe Spaces and headspace, as well as sporting clubs, schools and other settings where alcohol use may be common or culturally normalised.
- Members identified limited access to affordable inpatient detoxification on the Gold Coast, alongside gaps in continuity, psychosocial support and peer support throughout recovery.
- Lower-intensity, discreet and accessible options are needed for people with emerging concerns who do not identify with specialist AOD services. Relatable storytelling, virtual psychology and messaging-based support may encourage earlier engagement.
- Further analysis should examine differences in service use between men and women, possible overlap with mental health presentations, and population-based rates rather than total numbers alone.

NEXT STEPS

- Assess emergency department and hospital data with Gold Coast Health, including data coverage, coding practices and the inclusion of private hospitals.
- Assess how medicinal cannabis classification and access may have influenced illicit drug-use trends.
  Seek updated and more nuanced population-based data and analyse service access patterns by gender and presentation type.
- Consult harm-minimisation, early-intervention, youth, sporting and community services to capture experiences not reflected in existing datasets.
- Explore options for affordable detoxification, sustained psychosocial and peer support, soft-entry services and virtual access models.