phn
DARLING DOWNS
AND WEST MORETON
An Australian Government Initiative

Health Needs Assessment 2019 - 2021

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Local Integrated
Primary Health Care

1. Overview

The revision of the Darling Downs and West Moreton Primary Health Network (PHN) Health Needs Assessment (HNA) has provided the opportunity to expand on the foundational document developed in 2017 providing a comprehensive review of our region. Health is a dynamic environment, ever adjusting to ensure quality and safe provision of care and incorporating new and innovative models of care, research findings related to best practice and evidence-based interventions, and the needs of a growing and evolving population. Understanding the region's population, and health trends, deficits and risks can be both exciting and daunting but is nonetheless essential for regional, collaborative health planning.

The HNA has involved continued consultation with the region's residents, health care providers, community groups, hospital and health services, councils and universities. Focus of formal consultation has centred on the national priorities of Mental Health (including per- and poly-fluoroalkyl substances (PFAS), psychosocial measures, drought resilience, suicide prevention), Aboriginal and Torres Strait Islander health, alcohol and other drugs, workforce and aged care, as well as the population health segments of vulnerable populations, chronic disease and children and youth. Ongoing collaboration in the roll-out of the MyHealthRecord system has expanded digital health platform across the region.

Along with the Board, the West Moreton and Darling Downs Clinical Councils continue to provide expert clinical and community representative input into broadening the understanding of health and services and the gaps within the region.

Data from the existing HNA was updated where required and analysed to determine trends, changes and impacts with literature reviews undertaken to increase understanding of cause and potential solutions. Differences in data subset boundaries can prove difficult with many not providing SLA or SA2 level which may be difficult for focused community need identification. The review process discussed had no boundaries with the aim of an authentic search for the needs of the region.

Review and analysis of data, consultation and literature enabled a refinement and enhancement to the previous nine PHN priorities with this updated HNA defining 10 clear clinical priorities of the region.

1. MATERNAL AND INFANT HEALTH AND CHILD DEVELOPMENT

The most recent data has propelled this priority's status to very high with the PHN region having the second highest PHN ranked child and infant mortality rate. High levels of poverty throughout the region, with 1 in 4 children living in single parent families, and a rank of the 3rd highest proportion of low income welfare-dependent families, place our children at high risk for poor health outcomes. In particular, a large number of our Aboriginal and Torres Strait Islander children live in communities identified as having a number of markers for socio-economic disadvantage.

Mixed with the risks to our children is a the 2nd highest fertility rate for the nation and a teenage birth rate up to four times larger than the Queensland rate in particular communities. Although our children are more physically active than many other regions, a high percentage remain overweight or obese.

Regional child protection units have seen growing activity and the number of children in out-of-home care continues to increase with 49% identifying as Aboriginal and/ or Torres Strait Islander.

Literature reviews and consultation have highlighted potential models for reaching families to improve outcomes, however the high rate of child and infant mortality remains unanswered. Regional collaboration is required for further exploration into this concerning statistic.

2. PREVENTION AND MANAGEMENT OF CHRONIC CONDITIONS

The PHN region owns some disturbing data associated with risk behaviours and premature death rates related to chronic conditions. With the 4th highest proportion of obesity and highest ranking for physical inactivity, 80.8% of our region rate their health as excellent, very good or good. This is below all other Queensland PHNs.

High premature death rates align with areas of socio-economic disadvantage and prevalence of risk factors. Despite the benefits of cancer screening, the PHN ranks second last in National Cancer Screening Program participation.

There are difficulties in understanding prevalence rates of disease for Aboriginal and Torres Strait Islander people within our region. While nationally it is known that 79% of the gap in mortality is related to chronic conditions, at a local level inferences may be made for communities with larger Aboriginal and Torres Strait Islander populations although the accuracy of this application across the region is unknown.

Further understanding of mechanisms to decrease risk and prevent chronic conditions is required across the lifespan while regional partnership for innovative action guided by the Global Obesity Centre provides a promising option for improvement.

3. HEALTH FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Combined with the priorities discussed above is the knowledge of higher impacts of risk factors on our Aboriginal and Torres Strait Islander people and the higher proportion of population within the region. The region has the highest proportion of young people (0-19) and the lowest proportion of people aged 45 and over (out of total Aboriginal and Torres Strait islander population).

Limitations in the data examined have prevented further understanding of the trends over decades (to determine migration effect) along with the effect of causes of morbidity and mortality within the region, however will be a future focus to understand reasoning.

Chronic conditions, poverty, social determinants and history have significant impacts on morbidity, co-morbidity, mortality and social and emotional wellbeing of the Aboriginal and Torres Strait Islander population. Data available to the PHN do not describe population health categorisation for Aboriginal and Torres Strait Islander people, therefore National data and literature were utilised to assist in analysis.

4. WORKFORCE CAPACITY AND WELLBEING

Workforce influences service access and availability. Across the region and within all service types, concerns were expressed regarding service availability and access with and equal concern for shortages in workforce stemming from difficulties in retention and recruitment of staff, especially in rural areas, and an ageing health workforce.

New and innovative models for workforce growth and development, and recruitment and retention are the focus of collaborative research proposals across the region.

5. HEALTH FOR OLDER AUSTRALIANS

Australia's older generation continues to grow and 15% of the PHN region are aged 65 years and over while 0.8% of the population is Aboriginal and Torres Strait Islander people aged 50 years and over.

Wherever the home, care for older Australians includes healthy ageing and care for the conditions associated with ageing. Approximately half of people living in residential care have a diagnosis of dementia while there are a number of people cared for in their own homes with this diagnosis, resulting in a need for more support.

Supports are also required for palliative care, a care type mostly associated with older people while a new focus of anticipatory care (preparing for deterioration in condition) has evolved to assist with end of life planning options.

6. PRIMARY MENTAL HEALTH CARE

With high rates of anxiety and depression and deaths from suicide, mental health care is a high priority for the PHN. The implementation of stepped care will allow improved referral options across the region with e-referral and health service navigators enabling closer monitoring of wait times while ensuring appropriate priority for referrals.

As a drought affected area, much of the PHN region is under stress and a localised mental health response will be provided to affected communities. The Darling Downs and West Moreton Suicide Prevention Plans, along with the imminent Mental Health Plan will enable a region wide response.

National and state levels of data have been used with caution in projection to local communities.

7. DRUG AND ALCOHOL MISUSE

While there is ongoing community concern for the influence of alcohol and other drugs, the inability to quantify the depth and breadth of usage causes difficulty in understanding the reach within the community. Because of this, health care providers may not be sure of the need for intervention in every day practice.

Travel and transport remain a barrier for some people while an uncertainty about support and service provision may be inhibiting referral uptake and options. Further research to quantify the degree of usage has been suggested to assist in translation into understanding and resource allocation.

8. ACCESS AND INTEGRATED SERVICE DELIVERY

Improved access to health care may be achieved through supporting telehealth and may also alleviate the pressure of inadequate transport, particularly in rural areas, for people with disability and for people with complex health needs.

Increased uptake of HealthPathways will improve integration while improving referral pathways will increase awareness and access to outreach services.

9. HEALTH FOR PRIORITY POPULATIONS

Refugees have been identified as one of our vulnerable populations with support and care coordination required to extend beyond the initial screening and community introduction into ongoing care for a population that is at increased risk for chronic conditions and mental health impacts from a history of trauma.

Community support and rapid response for vulnerable people such as those experiencing homelessness or domestic violence is a focus for regional partnerships along with improving health literacy across the region.

Barriers associated with culture, language, health literacy, fear, finances require alternative models of care.

10. HEALTH PROMOTION AND PREVENTION STRATEGIES

Each of the above strategies require health promotion and prevention strategies although improving the region's interest in health cannot be underestimated in value.

Identifying high risk cohorts and their location is important in ensuring appropriate prevention education and events can be brought to the people. Being proactive and embedded in communities is hoped to raise the health profile and avoid risky behaviours which increase the risk of early mortality.

Through the development of this HNA, the PHN has been able to increase awareness of the risks to health amongst hospitals and health services, universities, community groups and other health care providers.

Through the comprehensive assessment that the HNA provides, the PHN will have the opportunity to enjoy meaningful partnerships across the community with the aim of impacting the improvement in quality of health. This may also enable sharing of alternative datasets to add further meaning to this assessment. The three-year HNA provides the PHN the ability to conduct purposeful planning across our region.

Maternal and Infant Health and Child Development

In 2011, the Australian Institute of Health and Welfare reported Australian children as generally faring well according to the 19 priority areas covering health status, risk and protective factors, early learning and care, and family and community environments. Queensland demonstrated poorer results on several indicators while Aboriginal and Torres Strait Islander children, children living in socioeconomically disadvantaged areas, and children living in remote areas experienced higher levels of risk.

There are significant populations of children and young people at risk of poor developmental outcomes including children born into poverty, children with mental health problems, children affected by homelessness as well as Indigenous children. In particular, the health and well-being of Aboriginal and Torres Strait Islander children and young people has been identified as being significantly worse than that of other Australians.

IMPACTS OF SOCIAL DETERMINANTS

Poor health outcomes linked to poverty and reduced life chances generally commence at birth and continue throughout the life cycle. However, there is now strong evidence that the biological and neurological development of an individual can be shaped by environmental conditions in the womb. If nutritional and hormonal conditions are suboptimal in the womb, adaptations can result in permanent alteration of the structure, physiology and metabolism of the offspring, thus laying a physiological basis for adult-onset disease such as metabolic disease and effects on cognitive development. Stressors, such as poverty in early childhood, can alter the programming of the immune system with changes being embedded in a manner that persists across the lifespan and makes the person more susceptible to the diseases of ageing. Alteration to key immune cells producing a chronic inflammatory state in the body can be caused by a harsh family climate characterised by conflict, a lack of warmth, inadequate parenting and household chaos. Psychosocial processes play an active role in health with a lack of sense of control triggering chronically activated inflammatory, hormonal and immunological responses leading to premature ageing and early onset of heart disease or cancer.

Important risk factors include: prenatal stress; difficult temperament; poor attachment; harsh parenting, abuse or neglect; parental mental illness or substance abuse; family disharmony, conflict or violence; low socioeconomic status; and poor links with community. Important protective factors include: easy temperament; at least average intelligence; secure attachment to family; family harmony; supportive relationships with other adults; and community involvement.

DARLING DOWNS AND WEST MORETON PHN REGION CHILDREN

Evidence of poverty and the potential for poor life chances are seen across the Darling Downs and West Moreton. The most current data for children of this region demonstrates:

- Greater percentage of infants and children (0-14 years) than all of Queensland
- An estimated 36,907 children in the Darling Downs and West Moreton PHN region living in low income, welfare dependent families. The proportion of children that this represents is 28.7%, which is higher than the Queensland proportion of 23.9%.

Table GHN3.1: Indicators of Low Income Families, 2016

Indicator of Low Income Families	PHN	Darling Downs	West Moreton	Qld	National
Single parent families with children aged <15 years	**25.7%** *(6th highest PHN Nationally)*	**24.7%**	**26.6%**	23.1%	20.4%
Jobless families with children aged less than 15 years	**15.9%** *(equal 5th highest PHN Nationally)*	**15.3%**	**16.5%**	12.8%	11.9%
Children aged less than 15 years in jobless families	**15.5%** *(3rd highest PHN Nationally)*	**14.7%**	**16.3%**	12.2%	11.5%
Children in families where the mother has low educational attainment	**22.4%** *(11th highest PHN Nationally)*	**21.9%**	**22.9%**	17.8%	17.0%

*(red: >10% higher than Qld rate; **bold**: >10% higher than National Rate)*

- The Darling Downs and West Moreton PHN region ranks the 3rd highest in proportion of low income welfare-dependent families (with children) in Australia, and the 6th highest in proportion of children in low income, welfare dependent families of all 31 PHNs in Australia.

Table GHN3.2: Welfare-Dependent Families, 2016

Indicator of Welfare-Dependent Families	PHN	Darling Downs	West Moreton	Qld	National
Low income, welfare-dependent families (with children) *(out of total families)*	**14.1%** *(3rd highest PHN Nationally)*	**12.7%**	**15.5%**	11.0%	10.1%
Children in low income, welfare-dependent families *(out of total children <16years)*	**28.7%** *(6th highest PHN Nationally)*	**27.2%**	**30.1%**	23.9%	22.5%

*(red: >10% higher than Qld rate; **bold**: >10% higher than National Rate)*

- Children and pregnant women can experience vulnerability, with evidence in our region of a high percentage who report lower socio-economic background with more behavioural health risk.
- High rates of smoking during pregnancy with the PHN rate of 19.9% as compared to the National rate of 12.3%

INFANT AND CHILD MORTALITY

Recent data has shown that the Darling Downs and West Moreton region has moved from 3rd highest to 2nd highest region for combined infant and child mortality rates.

Table GHN3.3: Infant and Young Child Mortality Rates – Top 5 PHN Regions 2014-16 and Comparison Rates for 2013-15

State	Rate (per 1,000 live births) 2013-15	Rate (per 1,000 live births) 2014-16
Northern Territory	7.9	7.6
Darling Downs and West Moreton	6.2	6.3
Western Queensland	6.3	6.1
Northern Queensland	5.7	5.3
Murrumbidgee (NSW)	4.6	5.3

Table GHN3.4: Infant Mortality Rates – Top 5 PHN Regions 2014-16 and Comparison Rates for 2013-15

State	Rate (per 1,000 live births) 2013-15	Rate (per 1,000 live births) 2014-16
Northern Territory	6.4	6.3
Darling Downs and West Moreton	5.3	5.2
Western Queensland	5.1	5.1
Northern Queensland	4.8	4.3
Tasmania	3.9	4.3

Table GHN3.5: Leading Underlying Causes of Death – Australia – 2014-2016

Rank	Under 1	1-14 years
1	Perinatal and congenital conditions	Land transport accidents
2	Other ill-defined causes	Perinatal and congenital conditions
3	SIDS	Accidental drowning and submersion
4	Spinal muscular atrophy	Brain cancer
5	Accidental threats to breathing	Other ill-defined causes

Reasons for high mortality rates need to be further explored although stakeholder consultation discussed the importance of maternal health in pregnancy (particularly nutritional and mental health but also smoking and alcohol) as a preventative factor for child health.

Table GHN3.6: Pregnancy Related Risk Factors 2014-16 and Comparison Rates for 2013-15

	Rate (2013-2015)		Rate (2014-2016)	
	PHN	National	PHN	National
Low birthweight babies, all women	5.3%	4.9%	4.5%	5.0%
Low birthweight babies, Aboriginal and Torres Strait Islander women	8.3%	10.6%	8.1%	10.4%
Smoking during pregnancy, all women	18.9%	11.0%	17.7%	10.4%
Smoking during pregnancy, Aboriginal and Torres Strait Islander women	49.3%	46.5%	47.6%	45.2%

While the national percentage of Aboriginal and Torres Strait Islander women giving birth to low birthweight babies has remained stable, there has been some marginal improvement across the Darling Downs and West Moreton ranking 4th lowest in rates of low birthweight babies.

Table GHN3.7: Low Birthweight Babies, Aboriginal and Torres Strait Islander 2014-2016

Primary Health Network area name	2012-2014 %	2013-2015 %	2014-2016 %
National	**10.6%**	**10.6%**	**10.4%**
Brisbane North (Qld)	6.7%	7.3%	8.0%
Brisbane South (Qld)	9.2%	9.2%	9.3%
Gold Coast (Qld)	11.5%	12.6%	9.6%
Darling Downs & West Moreton (Qld)	**9.5%**	**8.3%**	**8.1%**
Western Queensland	11.3%	11.7%	10.5%
Central Qld, Wide Bay & Sunshine Coast	8.6%	8.5%	8.3%
Northern Queensland	10.2%	10.0%	10.1%
SA4 (2011 local area name)			

Toowoomba (Qld)	10.8%	10.7%	10.6%
Ipswich (Qld)	9.9%	7.6%	7.1%

For infant mortality alone, the PHN ranked 4th highest across all PHN regions for 2011-2015 with a rate of 4.7 as compared to Queensland at 4.4 and the National rate of 3.5.

Table GHN3.8: Infant Death Rates (IDR) per 1,000 for Darling Downs and West Moreton (2011-2015)

West Moreton	Darling Downs
Ipswich - Central/ North Ipswich – Tivoli – 9.4	Stanthorpe/ Stanthorpe Region – 9.6
Bundamba/ Riverview – 6.8	Newtown/ North Toowoomba - Harlaxton/ Wilsonton – 7.8
Ipswich – East – 6.2	Warwick – 7.3
Gatton/ Lockyer Valley – West – 5.1	Balonne/ Goondiwindi/ Inglewood - Waggamba/ Tara – 6.5
Springfield - Redbank – North – 4.6	Kingaroy Region - North/ Nanango – 6.3

For children aged 1-4 (2011-2015), the PHN region ranked 8th highest for child mortality (this data is not available per SA2). The PHN rate was 21.4 (ASR per 100,000) compared to the Qld rate of 19.4 and National rate of 16.6.

For youth aged 15-24 years (2011-2015), PHN ranked 8th highest for mortality rates. The PHN rate was 51.2 compared to a Queensland rate of 42.8 and National rate of 37.4. Much higher rates are noted in the Darling Downs.

Table GHN3.9: Youth Mortality (ASR per 100,000) for Darling Downs and West Moreton (2011-2015)

West Moreton	Darling Downs
Esk/ Lake Manchester - England Creek/ Lowood – 101.7	Chinchilla/ Miles - Wandoan/ Roma/ Roma Region – 114.9
Brassall/ Leichhardt - One Mile – 60.4	Balonne/ Goondiwindi/ Inglewood - Waggamba/ Tara – 105.6
Bundamba/ Riverview – 58.3	Stanthorpe/ Stanthorpe Region – 95.4
Springfield - Redbank – North – 53.2	Kingaroy Region - North/ Nanango – 84.9
Churchill - Yamanto/ Raceview/ Ripley – 42.2	Clifton - Greenmount/ Southern Downs – 81.2

FERTILITY

Along with the high infant and young child mortality rates, is a high fertility rate for the region with Darling Downs and West Moreton ranking 2nd to Western Queensland (2011-2015) with a rate of 2.36. The teenage (aged 15-19 years) live birth rate is also higher than the Queensland rate with some SA2 areas having a rate as much as 4 times as high.

Table GHN3.10: Teenage Birth Rates for Darling Downs and West Moreton (2011-2015)

2016 Census	Total number of children ever born by aged 15-19's mother	Female Population aged (15-19 years)	Teenage birth rate (aged 15-19 years) per 1,000 females	SA2 with highest rate
Queensland	2,357	145,089	16.25	
PHN by SA2s	397	17,790	22.32	Kingaroy Region - North (69.60), Miles - Wandoan (60.61), Riverview (57.47), Chinchilla (55.56)

DEVELOPMENTALLY VULNERABLE

Children who score below the 10th percentile (in the lowest 10 per cent) of the national Australian Early Development Census (AEDC) population are classified as 'developmentally vulnerable'. These children demonstrate a much lower than average ability in the developmental competencies in that domain. In 2015, 17.9% children in our region were developmentally vulnerable on two or more domains as compared to 14.0% in Queensland and 11.1% in Australia. This was the 3rd highest ranking behind Northern Territory and Western Queensland.

Reviewing 15 child risk factors (see *Table GHN3.11)* across the Darling Downs and West Moreton revealed Darling Downs children experienced higher risk factors **(>10% difference**) in 5 areas and decreased risk in 1 area. West Moreton children were found to have evidence of higher risk in 3 areas and improved in 1. The highest areas were Redbank Plains (37.2%), Bundamba/ Riverview (23.4%), Ipswich East (23.2%), Darling Heights (22.0%), and Brassall/ Leichardt (21.3%)

Table GHN3.11: Child Risk Factors for Darling Downs and West Moreton

Child Risk Factors (Proxy Report)	Darling Downs (%)	West Moreton (%)	Queensland (%)
Live with current smoker in household	**29.8**	23.9	24.1
Obese	**9.5**	**9.7**	7
Overweight/ Obese	**27.9**	**28.0**	24
Overweight	**18.4**	**18.3**	17
Recommended Fruit	**66.0**	**63.6**	69
Recommended Vegetables	**6.5**	**3.2**	4
Discretionary foods consumed daily	**66.5**	**64.4**	64.3
Sufficient Physical Activity	**41.5**	**46.8**	42
Participated in organized sport in last year	**66.9**	**66.7**	73
1 year old fully vaccinated	92.9	93.1	92.4
2 year old fully vaccinated	90.5	**90.1**	90.2
5 year old fully vaccinated	93.5	93.7	92.4
Ave No. of teeth per child with untreated decay on presentation	1.65	1.5	1.4
Ave No. of teeth with decay experience per child	**2.8**	**2.4**	2.3
Prevalence of decay experience	**63.0**	54.3	55.4

Australian Early Development Census (AEDC) data are collected nationally every three years and provides a snapshot of how children are developing. The AEDC collects data on children in their first year of schooling across five domains through a teacher- completed instrument:

- physical health and well-being
- social competence
- emotional maturity
- language and cognitive skills (school-based)
- communication skills and general knowledge.

Darling Downs and West Moreton PHN children are more developmentally vulnerable than the Queensland rates across all five domains. Evidence supports that successes, health and emotional well-being have their origins in early childhood and if we get it right in the early years, we can expect to see children and youth thrive throughout school and their adult lives. Both nature and nurture (genes and environment) influence children's development. The quality of a child's earliest

environments and the availability of appropriate experiences at the right stages of development are crucial determinants of the way each child's brain architecture develops.

Families with low socioeconomic status often lack the financial, social, and educational supports that characterise families with high socioeconomic status. Poor families also may have inadequate or limited access to community resources that promote and support children's development and school readiness. Poor children are at greater risk than those from higher income families for a range of problems, including detrimental effect on IQ, poor academic achievement, poor socio-emotional functioning, developmental delays, behavioural problems, poor nutrition, low birth weight, and respiratory disease.

Good early child development programs involving parents or other primary caregivers of young children can influence how they relate to and care for children in the home, and can vastly improve outcomes for children's behaviour, learning and health in later life. Efforts to maximise a child's potential require a whole-of-community approach. Early detection of illness may be achieved through evidence-based screening measures via general practice with this targeted to population subgroups with a higher risk of disease prevalence or difficulty in accessing services. Child and family health nurses, Aboriginal health workers, social workers, community-based health workers and health educators may also provide care and support to children and their families.

One service delivery strategy that has been shown to have had positive effects on the behaviour and attitudes of parents is home visiting. Intensive home visiting programs typically target significantly disadvantaged children, parents and families and, as such, have the potential to improve the absolute position of these groups through improvements in a range of areas, including: parent confidence/competence; child abuse and neglect, and parent-child relationships. Evaluations of Australian home visiting programs have demonstrated their beneficial effects on a range of outcomes amongst significantly disadvantaged families, including the individual health behaviours and attitudes of parents, such as improvements relating to breastfeeding, improvements in parenting confidence and parenting style (e.g. significantly lower levels of anger and hostility), and improvements relating to obesity risk factors in early childhood.

Targeted telephone-based motivational smoking cessation interventions and holistic cessation support delivered to women in their own homes and through community outreach have demonstrated some promising results amongst low-income pregnant women in the US and the UK. For Aboriginal and Torres Strait Islander families, some promising strategies include: targeting male partners who smoke; tailoring interventions to local culture and providing culturally tailored support to quit smoking; delivering smoking cessation support through all antenatal providers; and involving other members of the community.

Parenting programs have also had some success in Australian amongst migrant and refugee families. A pre- and post-test study of a parenting program for African refugees and migrants living in Melbourne found that participation in the program was related to positive changes in parental expectations of children, views regarding corporal punishment, and restriction of children's access to food

BIRTH LOCATION

Perinatal Data Collection of mothers birthing in Queensland in 2015 displays birth location by usual residence of mother by HHS. Mothers from the Darling Downs gave birth at different HHS across the state at a rate of less than 1.5% per region. Mothers from West Moreton gave birth at differing

locations at a significantly higher rate: Metro North 3.37%, Metro South 5.84%, Darling Downs 6.18% and Mater Public 11.73%. Some of the variation in birth location may be explained by proximity to residence. Reasons for birthing at the Mater Public may be worthy of further review.

OUT OF HOME CARE

There is a strong case for investment in system improvement with the percentage of children in out-of-home care increasing every year by 6,827 (17%) from 30 June 2012 to 30 June 2016. As of 30 June 2016, there were 16,846 Aboriginal and Torres Strait Islander children in out-of-home care in Australia. The national rate of Aboriginal and Torres Strait islander children in out-of-home care was almost 10 times the rate for non-Indigenous children.

Of children on orders within North Ipswich at 4 July 2018, 61 per cent were guardianship or custody orders. Aboriginal and Torres Strait Islander children are significantly over represented within the population of children in alternative care of which 49 percent identified as Aboriginal and Torres Strait Islander children of which 23 percent had been placed according to the Aboriginal Child Placement Principle.

Table GSN10.1: Types of Orders vs Custody for Children in OOHC

Type of order	CSSC (438) n (%)	Who has custody?	Who has guardianship
Intervention with parental agreement (IPA)* 1 year	31 (.1%)	Parent	Parent
Short-Term custody (STC)	68 (23%)	Child Safety Services	Parent
2 years	199 (66%)	Child Safety Services	Child Safety Services

**out of scope to this project*

Table GSN10.2: Type of Care vs Indigenous Status

Type of placement	CSSC (218) n (%) Aboriginal & Torres Strait Islander	CSSC (135) n (%) Non-Indigenous
Foster care	154 (71%)	93 (68%)
Relative/kinship care	49 (23%)	16 (12%)
Residential care	15 (5%)	26 (19%)

Key features of this cohort of children and young people in out-of-home care including the following:

- Relatively even gender divide (53 percent were male, 47 percent female)
- Nearly 2 per cent were infants less than one year of age
- 17 percent were under 5 years of age
- 29 per cent were aged between 5 and 9 years
- 33 per cent were aged between 10 and 14 years
- 20 per cent were aged between 15 and 17 years

CURRENT SYSTEM RESPONSE

- The feedback gathered from interviews reflected an improving, but currently disconnected system of health services available to manage the complex needs of children and young people in out-of-home care. Many professions perceive that too much is demanded of them, but Child Support Officers are widely recognised as being overloaded and suffering burnout, leading to high turnover which in turn leads to discontinuity of care and loss of information/history about the child/young person in care.

- There was a common theme of improving the coordination between services, referral pathways and associated information chains such that children and young people in out-of-home care can be tracked across changes in residency, placement, CSO assignments. The absence of Child Health Passports and Medicare cards for children presenting at a new service was widely mentioned.
- Schools in Ipswich have taken some initiatives to support children and young people in out-of-home care and their health needs but report also suffering a lack of relevant departmental information and notification, relying on carers and behavioural observations.
- Staffing issues, wait lists and caseloads currently result in spill-over into less suitable services for care. Gaps in the fee structures for various services and eligibility criteria are perceived as a major disincentive to providing suitable care.
- A lack of awareness of the National Clinical Assessment Framework and trauma-informed care was widely acknowledged

COMMUNITY VOICES

Below is a summary of the most prevalent system issues that affect timely, quality and consistent health assessments.

General Practices	Medical and family history unknown	No suitable MBS structures with associated incentives	Availability of templates to conduct health	Difficulty navigating the health system, unsure of pathways, eligibility
Health	Medical and family history unknown	Quality of referrals poor, inappropriate	Screenings not performed to inform assessments	
Child Safety	Access to information	Staff turnover and placement changes	Lack of bulk-billed services	Difficulty in navigating the health system
Fostering Agencies	Limited trauma-informed practitioners	Barriers obtaining information	Waiting lists for bulk-billed services	Difficulty in navigating the health system
Residential Care	Lack of information/ documentation	Limited trauma-informed practitioners	Lack of bulk-billed services	Referral pathways not clear
Carers/ Kin	Lack of information to support decisions	Lack of financial support	Lengthy waiting lists	Difficulty in navigating the health system
Young People	Retelling story	Space needs to be nice and welcoming	Non-judgmental and friendly	
Parents	No information shared	No opportunity to be involved in decisions		

OPPORTUNITIES

Consultation suggested the following strategies to improve the health response to children in care:

- Models of assessment
  - Development of a model of care to guide process and improve coordination between services
  - Development of clear and efficient referral and management processes from Child Safety
  - Implement routine health screening and assessment of all children entering care
  - Formulation of health management plan – close relationship to the planning process / review
  - Identification of lead clinicians
  - Effective case management/responsibilities
  - Communication policies/processes between child safety and health services

- Appropriate/ standardised medical assessments – age specific
- Dedicated general practices to perform assessments
- Pre-booked / longer appointments with GP.
- MOU to clarify roles and responsibilities of health and child protection agencies
- Dedicated coordinator roles to bring a focus to health assessments
- Dedicated MBS item number for children in care

- Training and education
  - Training and education of National Clinical Assessment Framework
  - Development of a trauma-informed health practice framework
  - Development of a culturally safe, trauma-informed health approach and practice framework for service providers working with Aboriginal and Torres Strait Islander children in care

- Access to information
  - Development of a process to track health histories for continuum of care
  - Exploration and agreement on a local, shared documentation platform e.g. My Health Record
  - Development of an information gathering policy/process
  - Development of formal agreement to access medical and family history
  - Data-management to health information capability in ICMS / the ability to extract information for different stakeholders and purposes.

- Access to services
  - Identification of trauma-informed services
  - Exploration on a financial supportive model to support model of care
  - Formalising mechanisms to ensure priority access to health services that aligns with National Clinical Assessment Framework. e.g. 3 weeks standard consult; 3 months long consult (for Initial Assessment and comprehensive); GP follow up / continuity of care.
  - Identification of gaps and services within the localised out-of-home care health pathway
  - Encourage uptake and use of referral pathways e.g. HealthPathways
  - Identification of Specialist options to refer

REGIONAL CONSULTATION

- Strong need for more antenatal and prenatal services to be provided in rural communities, given the limited capacity of community health in such areas, to reduce the need for patients to travel to Toowoomba Hospital or be admitted as inpatients and to improve the health outcomes for mothers and babies alike
- Limited availability of midwives in the Darling Downs region, particularly in rural areas
- General need for more holistic support services to improve the health and wellbeing of expecting mothers prior to birthing, such as lactation support, dietetics and nutrition services
- Lack of outreach paediatric services, most notably to Cherbourg and Kingaroy, which have large paediatric population
- Greater need for paediatric training in the workforce to improve skills and capabilities, particularly for nurses
- Significant need for more school-based youth health nurses and paediatric nurses to administer early intervention care to prevent social and wellbeing issues
- The West Moreton Child Protection Unit has experienced accelerating activity with growth in numbers of child protection cases linked to the socio-economic demographic. The sustained

increases are of significance when taking into consideration additional resources available for at-risk families with the service holding the assumption that notifications would decrease with the implementation of packages.

- West Moreton Child Development Service has experienced a significant demand for child development assessment and intervention with children waiting much longer than their clinical category KPI. Accessing private providers for allied health management is not tenable for young families of this region.

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Prevention and Management of Chronic Conditions

Chronic diseases are the leading cause of ill health, disability and death in Australia. The effects of chronic disease can be profound, both on individual's health and wellbeing and on the health care system. The top three chronic diseases reported by Australians are cardiovascular disease (18%), mental health conditions (18%) and back pain and problems (16%).

Across the Darling Downs and West Moreton region, evidence demonstrates:

- High relative rates of mortality from diabetes.
- A high premature death rate in people aged 18 to 74.
- The region ranks in the top 7 for premature deaths related to diabetes, circulatory system and respiratory system diseases and their subsets.
- There are consistent areas in both the West Moreton and Darling Downs that experience these high premature death rates (see below table *GHN2.1*) with many of these aligning with areas of socio-economic disadvantage (see *GSN8: Social Determinants of Health*)
- Demonstrated high rankings and rates of potentially preventable hospitalisations (PPH) (see *GSN6: Workforce/ Services*)

HIGH RISK BEHAVIOURS AFFECTING MORTALITY AND MORBIDITY

Many chronic diseases share largely preventable behavioural and biomedical risk factors. Modifying these risk factors can reduce an individual's risk of developing a chronic disease and result in large health gains by reducing illness and rates of death.

Across the Darling Downs and West Moreton region, evidence demonstrates:

- The Darling Downs and West Moreton Primary Health Network (PHN) region overall reports a lower rate of harmful alcohol consumption of 16.1 (ASR – age standardised rate - per 100) and ranks 22nd (out of 31) when compared to other PHNs across Australia. While the Queensland (Qld) rate of 17.2 is higher than the region, a number of PHN communities report harmful alcohol consumption, which is between 10-25% greater than the Queensland rate. All of these areas lie within the Darling Downs region.
    - Clifton - Greenmount/ Southern Downs – 22.6
    - Chinchilla/ Miles - Wandoan/ Roma/ Roma Region – 21.1
    - Banana/ Biloela – 20.8
    - Millmerran/ Pittsworth/ Wambo – 20.0
    - Balonne/ Goondiwindi/ Inglewood - Waggamba/ Tara – 19.6
    - Middle Ridge/ Rangeville/ Toowoomba – East – 19.7
    - Kingaroy/ Kingaroy Region – South – 19.4
    - Crows Nest - Rosalie/ Jondaryan – 19.0
- The prevalence of obesity in men and women in the PHN region is 36.0 (ASR per 100) which is more than 10% higher than the Queensland rate of 32.1 and places the region as 4th highest obesity rate of all PHN regions. 16/31 PHN SA2 areas have rates >10% higher than the Queensland rate. The 5 areas with the highest rates are:
    - Kingaroy Region - North/ Nanango – 43.6
    - New Chum/ Redbank Plains – 42.7
    - Crows Nest - Rosalie/ Jondaryan – 41.9
    - Newtown/ North Toowoomba - Harlaxton/ Wilsonton – 41.8
    - Millmerran/ Pittsworth/ Wambo – 41.5

- Demonstrated high rates of obesity in children (aged 2-17) with a rate (8.8) >10% higher than the Qld rate (7.9) and the region ranking 4th highest of 31 PHNs in the prevalence of obesity in children with higher rates overall in the West Moreton.

Table GHN1.1: Highest areas of Obesity in Children Aged 2-17 for Darling Downs and West Moreton (2014-2015)

West Moreton	Darling Downs
New Chum/ Redbank Plains – 12.8	Newtown/ North Toowoomba - Harlaxton/ Wilsonton – 9.5
Bundamba/ Riverview – 11.7	Kilcoy/ Woodford - D'Aguilar – 9.3
Springfield - Redbank – North – 11.3	Drayton - Harristown/ Toowoomba – Central – 8.5
Brassall/ Leichhardt - One Mile – 10.8	Warwick – 8.5
Ipswich – East – 10.4	Crows Nest - Rosalie/ Jondaryan – 8.4

- The Darling Downs and West Moreton PHN **ranks 1st in Australia** for the lowest rate of physical inactivity (no or little activity in the previous week) with a rate of 74.6 (ASR per 100). The Qld rate is 67.9 while the national rate is 66.3. Slightly higher rates are seen in the Darling Downs.

Table GHN1.2: Highest areas of Lowest Rate of Physical Activity for Darling Downs and West Moreton (2014-2015)

West Moreton	Darling Downs
Lockyer Valley – East – 72.2	Balonne/ Goondiwindi/ Inglewood - Waggamba/ Tara – 73.6
New Chum/ Redbank Plains – 70.0	Clifton - Greenmount/ Southern Downs – 73.2
Bundamba/ Riverview – 69.7	Crows Nest - Rosalie/ Jondaryan – 72.9
Esk/ Lake Manchester - England Creek/ Lowood – 69.7	Banana/ Biloela – 72.7
Boonah/ Rosewood – 68.1	Kingaroy Region - North/ Nanango – 71.0

- The Estimated number of people aged 18 years and over who were current smokers (modelled estimates) for the PHN region is 18.7 (ASR per 100). This places the region as the 15th highest (out of 31 regions). The rate for all of Australia is 16.1 and Queensland is 17.0.
- 19.9% of women in the Darling Downs and West Moreton region reported smoking during their pregnancy (2012-2014). This is the 7th highest ranking for all PHNs in Australia. The Queensland rate is 14.2% while the rate for Australia is 12.3%.

Table GHN1.3: Highest areas of Smoking During Pregnancy for Darling Downs and West Moreton (2012-2014)

West Moreton	Darling Downs
Bundamba/ Riverview – 30.3	Kingaroy Region - North/ Nanango – 40.1
Brassall/ Leichhardt - One Mile – 26.0	Kingaroy/ Kingaroy Region – South – 25.7
Ipswich - Central/ North Ipswich – Tivoli – 27.6	Balonne/ Goondiwindi/ Inglewood - Waggamba/ Tara – 25.5
Lockyer Valley – East – 25.8	Warwick – 24.5
Ipswich – East – 25.4	Newtown/ North Toowoomba - Harlaxton/ Wilsonton – 22.6

The percentage of adults from the Darling Downs and West Moreton with self-reported excellent, very good or good health is 80.8%. This is lower than all PHN regions within Queensland with the closest, North Queensland, reporting a rate of 85.2%. 53.6% of the region's adults have reported a long-term health condition, the highest rate in the state. Again, North Queensland's rate is the

nearest to Darling Downs and West Moreton with 49.1%. Lifetime risky drinking demonstrated a **more than 10% better rate** than the state.

Table GHN1.4: Other Self-Reported Risk Factors (2016-2017)

Adult Risk Factors (Self- Reported)	Darling Downs (%)	West Moreton (%)	Queensland (%)
Recommended Fruit	55.3	55.3	57.0
Recommended Vegetables	8.1	7.0	7.1
Lifetime Risky Drinking	17.8	18.7	21.8

Of note is the region's death rate related to transport accidents in rural areas for people aged under 75 years – these include on and off roads.

Table GHN1.5: Avoidable Deaths from Transport Accidents People Aged 0-74 years (2011-2015)

PHIDU	Average annual ASR per 100,000			
2011-2015	PHN	QLD	Australia	PHN with the highest areas
Avoidable deaths from transport accidents aged 0 to 74 years	10.5	6.7	5.9	Balonne/ Goondiwindi/ Inglewood - Waggamba/ Tara (31.5), Kingaroy Region - North/ Nanango (25.2), Clifton - Greenmount/ Southern Downs (21.6)

OBESITY AND CHRONIC DISEASE

- Enhanced analysis by the Australian Institute of Health and Welfare (AIHW) found that being overweight or obese contributed to 7.0% of the disease burden in Australia in 2012
- Obesity is a recognised chronic disease, which also increases the risk of the development of serious and/ or chronic conditions such as heart disease, hypertension, diabetes mellitus, sleep apnoea, cancer and bone and joint disease such as osteoarthritis. Health can also be impacted by the psychosocial effects of obesity

Table GHN2.1: Premature Death Rates Related to Chronic Disease (2011-2015)

Disease (age 0-74 years) 2011-2015	PHN	Darling Downs highest 3 areas	West Moreton Highest 3 areas	Qld	National
Deaths from circulatory system diseases	**54.3** *(6th highest PHN Nationally)*	1. Kingaroy Region – North Nanango – 71.3 2. Balonne/ Goondiwindi/ Inglewood – Waggamba/ Tara – 69.4 3. Warwick – 66.7	1. Brassall/ Leichardt – One Mile – 92.7 2. Ipswich – Central/ North Ipswich – Tivoli – 86.0 3. Bundamba/ Riverview – 81.2	45.8	44.8
# ischaemic heart disease	**29.2** *(6th highest PHN Nationally)*	1. Kingaroy Region – North Nanango – 40.7 2. Warwick – 38.2 3. Drayton – Harristown/ Toowoomba – Central – 37.8	1. Brassall/ Leichardt – One Mile – 54.7 2. Ipswich – Central/ North Ipswich – Tivoli – 47.7 3. Bundamba/ Riverview – 39.8	25.3	23.5
# cerebrovascular diseases	**10.3** *(equal 3rd highest PHN Nationally)*	1. Newtown/ North Toowoomba – Harlaxton/ Wilsonton – 14.4 2. Balonne/ Goondiwindi/ Inglewood – Waggamba/ Tara – 13.8	1. Bundamba/ Riverview – 18.8 2. Brassall/ Leichardt – One Mile – 18.5 3. Ipswich East – 16.3	8.2	8.1

		3. Stanthorpe/ Stanthorpe Region – 13.7			
Deaths from respiratory system diseases	**19.7** *(7th highest PHN Nationally)*	1. Kingaroy Region – North Nanango – 29.5 2. Chinchilla/ Miles – Wandoan/Roma/ Roma Region – 24.3 3. Balonne/ Goondiwindi/ Inglewood – Waggamba/ Tara – 21.6	1. Ipswich – Central/ North Ipswich – Tivoli – 36.1 2. Brassall/ Leichardt – One Mile – 31.0 3. New Chum/ Redbank Plains – 29.5	15.8	15.0
# chronic obstructive pulmonary disease	**12.7** *(Equal 5th highest PHN Nationally)*	1. Kingaroy Region – North Nanango – 18.7 2. Balonne/ Goondiwindi/ Inglewood – Waggamba/ Tara – 17.6 3. Chinchilla/ Miles – Wandoan/Roma/ Roma Region – 14.8	1. Ipswich – Central/ North Ipswich – Tivoli – 25.7 2. New Chum/ Redbank Plains – 19.2 3. Bundamba/ Riverview – 18.7	10.0	8.8
Deaths from diabetes	**9.5** *(4th highest PHN Nationally)*	1. Balonne/ Goondiwindi/ Inglewood – Waggamba/ Tara – 15.8 2. Chinchilla/ Miles – Wandoan/Roma/ Roma Region – 14.0 3. Darling Heights – 12.8	1. Ipswich East – 20.1 2. Brassall/ Leichardt – One Mile – 20.0 3. Ipswich – Central/ North Ipswich – Tivoli – 19.1	6.9	6.0

*(red: >10% higher than Qld rate; **bold**: >10% higher than National Rate*

SOURCES

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Health for Aboriginal and Torres Strait Islander People

The Darling Downs and West Moreton PHN region has a larger proportion of Aboriginal and Torres Strait Islander people population than Queensland and this is a demonstrated vulnerable population for health outcomes. The region contains an Aboriginal and Torres Strait Islander community, Cherbourg. Cherbourg sits in the SA2 area Kingaroy – North/ Nanango and this SA2 area has been highlighted throughout this report for high rates of premature death rates related to chronic disease and low socio-economic risk factors

Regional consultation raised concerns regarding:

- Prevalence and morbidity/ mortality relating to chronic disease, child and maternal health, ears and hearing, sexual health and communicable and infectious diseases
- Socio-economic factors including overcrowding in households, lack of emergency accommodation, lack of food and financial assistance for patients transferred from their home/community to access health care
- Babies born to Aboriginal and Torres Strait Islander mothers were almost twice as likely to be of low birth weight (less than 2,500 grams) than babies born to non-Indigenous mothers (low birth weight can increase the risk of a child developing health problems)

LIFE EXPECTANCY AND CLOSING THE GAP

For the Aboriginal and Torres Strait Islander population born in 2010–2012, life expectancy was estimated to be 10.6 years lower than that of the non-Indigenous population for males (69.1 years compared with 79.7) and 9.5 years for females (73.7 compared with 83.1). Between 2005–2007 and 2010–2012, Indigenous life expectancy at birth for boys increased by 1.6 years and by 0.6 years for girls. Over the same period, the gap between Indigenous and non-Indigenous life expectancy narrowed by 0.8 years for males and 0.1 years for females.

The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 outlines the strategies to be employed to make health systems accessible, culturally safe and appropriate, effective and responsive for all Aboriginal and Torres Strait Islander people. The six leading drivers of the health gap between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders as cardiovascular disease, diabetes, chronic respiratory disease, cancers, injuries and mental disorders. Strategies to 'close the gap' encompass mothers and babies, children, youth, adults and older people, aiming to empower communities to increase their social and emotional well-being and retain a strong connection to country and culture

Aboriginal and Torres Strait Islander people form 4.5% of the Darling Downs and West Moreton population with 5.1% of the Darling Downs region and 4.1% of the West Moreton region. While the region does contact dedicated Aboriginal and Torres Strait Islander areas such as Cherbourg, the region ranks 10th nationally for this proportional statistic, while Queensland's total proportion is 4.0% and Nationally it is 2.8%.

Table IHHN1.1: Aboriginal Population as a Proportion of Total Population, PHN

	PHN	Darling Downs	West Moreton	Qld	National
Aboriginal population as proportion of total population	4.5% *(equal 10th highest PHN Nationally)*	5.1%	**4.1%**	4.0%	2.8%

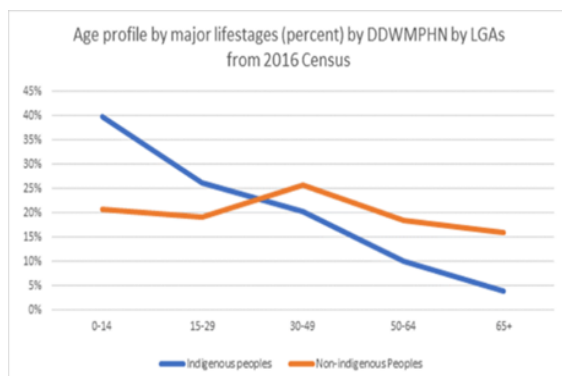
*(red: >10% higher than Qld rate; **bold**: >10% higher than National Rate)*

Table IHHN1.2: Areas with Highest Proportion of Aboriginal and Torres Strait Islander Population (2016)

West Moreton	Darling Downs
Brassall/ Leichhardt - One Mile – 6.9%	Kingaroy Region - North/ Nanango – 12.6%
Bundamba/ Riverview – 6.1%	Balonne/ Goondiwindi/ Inglewood - Waggamba/ Tara – 8.0%
Ipswich - Central/ North Ipswich – Tivoli – 5.4%	Newtown/ North Toowoomba - Harlaxton/ Wilsonton – 6.4%
Ipswich – East – 5.2%	Chinchilla/ Miles - Wandoan/ Roma/ Roma Region – 6.0%
Lockyer Valley – East – 4.7%	Warwick – 5.9%

The age profile of Aboriginal and Torres Strait Islander people across the region demonstrates a lower proportion of elderly with a high proportion of children and youth; this is consistent for all areas across the region. Of note, Aboriginal and Torres Strait Islander people account for less than 1% of all permanent residential care and 4% of people in home care.

The comaprison graph of the non-indigenous population shows a fairly level distribution over the age-span.



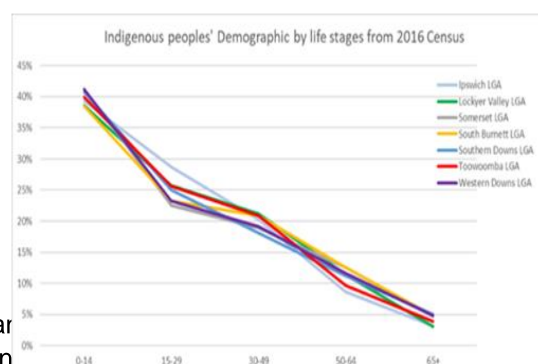
The areas with highest proportions of Aboriginal population within the DDWMPHN region are:

- Kingaroy Region – North/ Nanango – 12.6%
- Balonne/ Goondiwindi/ Inglewood – Waggamba/ Tara – part a – 8.0%
- Brassall/ Leichardt – One Mile – 6.9%
- Newtown/ North Toowoomba – Harlaxton/ Wilsonton – 6.4%
- Bundamba/ Riverview – 6.1%

These areas reflect some of our most financially vulnerable (see *GSN8: Social Determinants of Health*) and areas of high rates of premature deaths related to chronic disease

The DDWMPHN region ranks 1st of all PHN regions in the proportion of Aboriginal and Torres Strait Islander people within the age groups up until age 19. From age 20 the proportion drops to 18th highest and from 45 years of age, the region has the lowest proportion of Aboriginal and Torres Strait Islander people.

Further understanding of the trends over decades (to determine migration effect) along with the effect of causes of morbidity and mortality within the region, are required to understand the reasoning.



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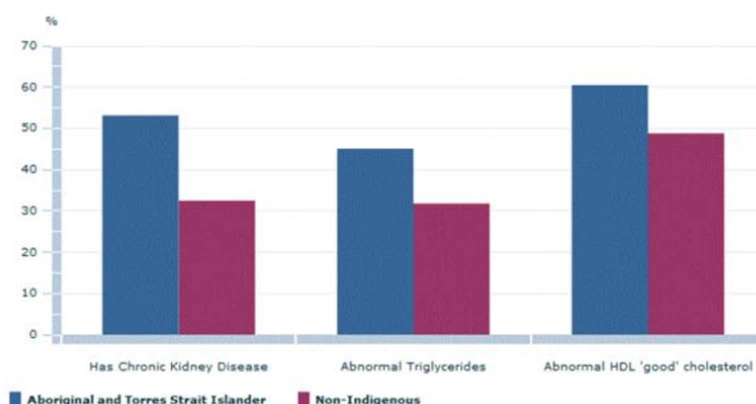
target is to be met in 2031. For the Aboriginal and Torres Strait Islander population born in 2010–2012, life expectancy was estimated to be 10.6 years lower than that of the non-Indigenous population for males (69.1 years compared with 79.7) and 9.5 years for females (73.7 compared with 83.1). Between 2005–2007 and 2010–2012, Indigenous life expectancy at birth for boys

increased by 1.6 years and by 0.6 years for girls. Over the same period, the gap between Indigenous and non-Indigenous life expectancy narrowed by 0.8 years for males and 0.1 years for females.

Circulatory diseases were the leading broad cause of Indigenous deaths for the period 2008-2012 (26%), followed by cancer (20%), external causes (15%), endocrine, metabolic and nutritional disorders (9%), respiratory diseases (8%) and digestive diseases (6%). While 79% of the gap in mortality is due to chronic disease, four groups of chronic conditions account for about two-thirds of the total gap in mortality between Indigenous and non-Indigenous Australians: circulatory disease (24% of the gap), endocrine, metabolic and nutritional disorders (21%), cancer (12%), and respiratory diseases (12%). There have been significant improvements in the Indigenous mortality rate from chronic diseases, particularly from circulatory diseases since 1998.

Diabetes, cardiovascular disease and chronic kidney disease are all risk factors for each other and often occur together in the same individual. Co-morbidity between these conditions was more common for Aboriginal and Torres Strait Islander people than for non-Indigenous people in 2011–13. Diabetes in particular had very high co-morbidity with kidney disease, with around half (53.1%) of all Aboriginal and Torres Strait Islander people with diabetes also having signs of kidney disease. This was higher than the corresponding rate for non-Indigenous people with diabetes (32.5%). Aboriginal and Torres Strait Islander people with diabetes were also more likely than non-Indigenous people with diabetes to have indicators of cardiovascular disease, including high triglycerides (45.1% compared with 31.8%) and lower than normal levels of HDL (good) cholesterol (60.5% compared with 48.8%).

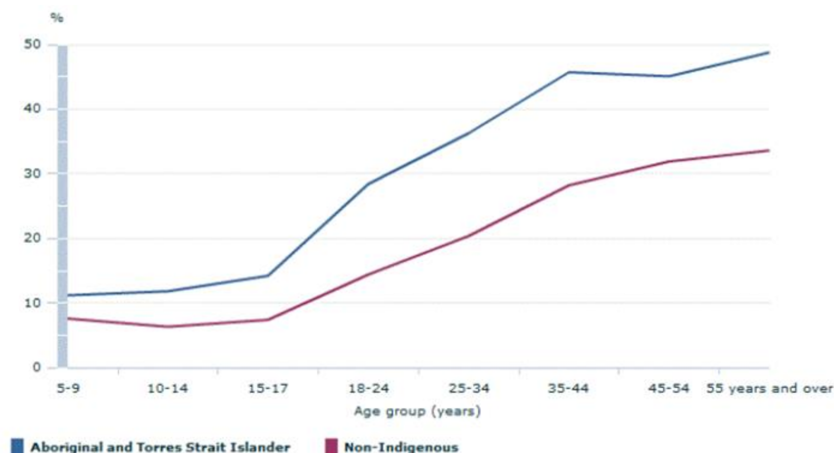
Persons Aged 18 Years and Over with Diabetes – Proportion with Abnormal Test Results by Indigenous Status, 2011-13



Obesity rates remained high among Aboriginal and Torres Strait Islander adults in 2012–13, with four in every ten (39.8%) being obese. After taking age differences into account, Aboriginal and Torres Strait Islander adults were one and a half times as likely as non-Indigenous Australians to be obese (rate ratio 1.6). Obesity, in turn, was strongly associated with the chronic disease biomarkers. Being obese increased the risk of abnormal test results for nearly every chronic disease tested for in the survey,e.g. Aboriginal and Torres Strait Islander adults who were obese were seven times as likely as those who were of normal weight or underweight to have diabetes and nearly five times as likely to have high triglycerides.

Aboriginal and Torres Strait Islander people who were obese were still more likely than non-Indigenous people who were obese to experience chronic disease. They were more likely to have

risk factors for cardiovascular disease, including lower than normal levels of HDL (good) cholesterol (49.1% compared with 35.8%) and high triglycerides (37.4% compared with 25.3%). They were also more likely to have diabetes (17.2% compared with 11.2%) and chronic kidney disease (20.1% compared with 12.9%). This may be partly explained by the earlier incidence of obesity in the Aboriginal and Torres Strait Islander population, particularly for children and young adults.



Persons Aged 5 Years and Over – Proportion who were Obese by Age and Indigenous Status, 2011-13

While there were improvements in mortality from cancer in the non-Indigenous population between 2001 and 2012, this did not occur in the Indigenous population, leading to a significant increase in the mortality gap due to cancer for both males and females. Some health interventions under Closing the Gap, especially population health interventions, have a long lead time before measurable impacts are seen. For instance, smoking rates may take five years to impact on heart disease and up to 30 years to impact on cancer deaths. Improvements in educational attainment will take 20 to 30 years to impact on early deaths from chronic disease in the middle years when most deaths for Indigenous Australians occur.

For the Aboriginal and Torres Strait Islander population born in 2010–2012, life expectancy was estimated to be 10.6 years lower than that of the non-Indigenous population for males (69.1 years compared with 79.7) and 9.5 years for females (73.7 compared with 83.1). Between 2005–2007 and 2010–2012, Indigenous life expectancy at birth for boys increased by 1.6 years and by 0.6 years for girls. Over the same period, the gap between Indigenous and non-Indigenous life expectancy narrowed by 0.8 years for males and 0.1 years for females.

CHILDREN

Aboriginal and Torres Strait Islander children (aged 0-14) make up 8.3% of the PHN's total children (0-14) population.

Table IHHN3.1: Areas of highest proportion of Aboriginal and Torres Strait Islander Children (aged 0-14) of total children (aged 0-14) Population for Darling Downs and West Moreton (2016)

West Moreton	Darling Downs
Balonne/ Goondiwindi/ Inglewood - Waggamba/ Tara – 17.2%	Kingaroy Region - North/ Nanango – 32.0%
Brassall/ Leichhardt - One Mile – 16.6%	Newtown/ North Toowoomba - Harlaxton/ Wilsonton – 17.5%
Bundamba/ Riverview – 15.0%	Warwick – 15.7%

Ipswich - Central/ North Ipswich – Tivoli – 14.5%	Drayton - Harristown/ Toowoomba – Central – 13.3%
Ipswich – East 12.3%	Chinchilla/ Miles - Wandoan/ Roma/ Roma Region – 12.8%

Indigenous children have higher rates of death and hospitalisation due to injury than non-Indigenous children and are over-represented in the child protection, youth justice and homelessness systems.

- Injury hospitalisation rates for Indigenous children aged 0–14 in 2011–12 were around 1.5 times as high as for non-Indigenous children (AIHW: Pointer 2014). The death rate due to injuries was 3 times as high for Indigenous children as for non-Indigenous children in 2009–2013 (15 and 5 deaths per 100,000 population respectively) (AIHW 2015a).
- Indigenous children aged 0–12 were almost 7 times as likely to be the subject of a substantiation of a notification for child abuse and neglect in 2013–14 as other children. Over time, substantiation rates for Indigenous children have increased from 35 to 45 per 1,000 children between 2007–08 and 2013–14. Although a real change in the incidence of abuse and neglect may contribute to this change, increased community awareness and changes to policy, practice and legislation are also contributing factors.
- Indigenous children aged 10–14 were 36 times as likely to be in detention in the youth justice system on an average day in 2013–14 compared with non-Indigenous children.
- In 2013–14, 32% of specialist homelessness services clients aged 0–14 were Indigenous (excludes those for whom Indigenous status was not stated); however, Indigenous children accounted for only 5.6% of children in the total 0–14 population.

There are significant populations of children and young people at risk of poor developmental outcomes including children born into poverty, children with mental health problems, children affected by homelessness as well as Indigenous children. In particular, the health and well-being of Aboriginal and Torres Strait Islander children and young people has been identified as being significantly worse than that of other Australians.

While the national percentage of Aboriginal and Torres Strait Islander women giving birth to low birthweight babies has remained stable, there has been some marginal improvement across the Darling Downs and West Moreton ranking 4th lowest in rates of low birthweight babies.

Table GHN3.6: Low Birthweight Babies, Aboriginal and Torres Strait Islander 2014-2016

Primary Health Network area name	2012-2014 %	2013-2015 %	2014-2016 %
National	**10.6%**	**10.6%**	**10.4%**
Brisbane North (Qld)	6.7%	7.3%	8.0%
Brisbane South (Qld)	9.2%	9.2%	9.3%
Gold Coast (Qld)	11.5%	12.6%	9.6%
Darling Downs & West Moreton (Qld)	**9.5%**	**8.3%**	**8.1%**
Western Queensland	11.3%	11.7%	10.5%
Central Qld, Wide Bay & Sunshine Coast	8.6%	8.5%	8.3%
Northern Queensland	10.2%	10.0%	10.1%

SA4 (2011 local area name)			
Toowoomba (Qld)	10.8%	10.7%	10.6%
Ipswich (Qld)	9.9%	7.6%	7.1%

DISABILITY

- 1 in 4 Aboriginal and/ or Torres Strait Islander people reported living with disability in Australia in 2015
- Higher rates of disability were experienced across all age groups when compared to non-indigenous people
- Around 1 in 3 people with disability have profound or severe disability
- Around 3 in 5 people with disability needed assistance with at least one activity of daily life
- Experiences of discrimination due to disability were almost twice as likely than non-Indigenous people
- Around 2 in 5 people with disability lived in a major city
- Over half of people with disability reported Year 11 or higher as their highest level of education. This has increased significantly since 2012
- 41.7% of people with disability participated in the labour force
- 1 in 3 people with disability lived in a household in the lowest income quintile

LIFELONG IMMUNISATION

The immunisation rates for Aboriginal and Torres Strait Islander children, have been consistent for children aged 5 years, with some improvement in rates for children aged 1 year, over the four-year period of 2011-12 to 2015-16. However, there was a deterioration in the immunisation rates for children aged 2 years, over this four-year period. In terms of national ranking, the Darling Downs and West Moreton PHN had slipped from ranked positions of 16th (for children aged 1 year), 18th (for children aged 2 years) and 13th (for children aged 5 years) in 2011-12, to poorer ranked positions of 21st (for children aged 1 year), 22nd (for children aged 2 years) and 25th (for children aged 5 years) in 2015-16, falling below the national benchmark.

HARMFUL USE OF ALCOHOL AND OTHER DRUGS

For PHN funded services:

- Persons of Aboriginal and/or Torres Strait Islander descent accounted for 21.3% of all treatment episodes.
- Approximately 1/5 of treatment episodes in all substance categories involved an Indigenous person, except for heroin (38.1%; 24 episodes).
- Indigenous status was not reported for 6.0% of treatment episodes on average.

MENTAL HEALTH CARE

The following risk factors are interconnected, and a person with mental illness might show any number of them.

- Widespread grief and loss
- Stolen children
- Unresolved trauma

- Loss of identity and culture
- Discrimination and racism
- Poor physical health
- Incarceration
- Culturally inappropriate treatment
- Violence
- Substance abuse

Mental health conditions, as the underlying cause of death in Australia, rank higher in Aboriginal and Torres Strait Islander people than non-indigenous with the suicide rate being more than 2.5 times higher. The Queensland Indigenous Burden of Disease in 2011 estimated mental disorders as contributing 20% to the overall burden

According to the PHN mental health data set (MDS) client profile 2016-2017, 2,849 clients received mental health care captured by 128 practitioners in the region. The practitioners have various backgrounds and provide primary mental health related services inclusive of social worker, occupational therapist and nurses.

There has been a total of 2,849 clients recorded with *completed* treatment sessions only. The client profile demonstrated nearly 20% Aboriginal and/or Torres Strait Islander clients from the total with male Aboriginal and Torres Strait Islanders outnumbering females proportionally from 2016 to 2017 financial year.

Table MHHN5.1: Completed Treatment Sessions, PHN Service Provision, 2017-2018

Primary mental health care (2017-2018 FY)	Female clients	Male clients
Non-Indigenous	1,493	840
Indigenous	295	221
Aboriginal	89	68
Torres Strait Islander	2	0
Both Aboriginal and Torres Strait Islander	27	24
Not stated	177	129
Total clients (closed treatment sessions only)	1,788	1,061

SOCIAL AND EMOTIONAL WELLBEING

Following the National Apology Australia's Indigenous Peoples, and as part of the Council of Australian Governments' Closing the Gap strategy, funding is provided to the Aboriginal and Torres Strait Islander Healing Foundation to address the harmful legacy of colonisation, in particular the history of child removal that has affected Aboriginal and Torres Strait Islander people. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-23 published in October 2017 provides a dedicated focus on Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health. It sets out a comprehensive and culturally appropriate stepped care model that is equally applicable to both Indigenous specific and mainstream health services.

ACCESS

Across the region, the PHN provides funding for AMS chronic disease service delivery.

Table IHSN1.1: Rates of PHN Funded Indigenous Chronic Disease Service, 2017-18

Service Type	2016-17	2017-18
Care coordination services	40%	46%
Supplementary services	44%	36%
Clinical services accessed	15%	13%
Other	0	5%

WORKFORCE

Through consultation, the following factors have been highlighted as affecting the workforce:

- Reported difficulty recruiting qualified Aboriginal and Torres Strait Islander staff in rural areas; mental health and AOD support services
- Reported need for collaboration and partnerships with community organisations, GPs and Aboriginal and Torres Strait Islander Community Controlled Health Services
- Cultural awareness, cultural competence and the cultural appropriateness of services was identified as a problem
- Providers, particularly mainstream practices, do not know what services are available for chronic disease through Integrated Team Care
- Lack of Aboriginal Medical Services (AMS) in small rural areas; and youth suicide and mental health impacts, along with the need to consider impacts to Aboriginal and Torres Strait Islander people health across a broad spectrum of PHN programmes
- Recognised need for increased engagement with Elders and Community leaders to ensure increased understanding of needs

CULTURALLY APPROPRIATE SERVICES

Coordinated, culturally appropriate services across the health system— including primary health care, hospital care and aged care—will improve the patient journey and health outcomes for Aboriginal and Torres Strait Islander people and their families. While AMSs provide services to Aboriginal and Torres Strait Islander people within primary care, mainstream health services also have a role to play in the provision of accessible health care. Some GPs have developed expertise in Indigenous health, however, evidence states that these represent a low proportion of all GPs. The delivery of appropriate health services requires support of the breadth and variety of complex health needs of Aboriginal and Torres Strait Islander people. Acceptable health services operate from a position of cultural sensitivity and respect allowing cultural practices to be maintained. Ongoing capability improvement strategies are required to assist mainstream services in the provision of accessible and appropriate health care for Aboriginal and Torres Strait Islander people.

IMPROVING COMMUNITY CAPABILITY

One goal of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 is “the capabilities, potential and aspirations of Aboriginal and Torres Strait Islander people are realised and optimise their contribution as individuals to the health workforce and to strategies to achieve Aboriginal and Torres Strait Islander wellbeing.” The Plan encourages Aboriginal and Torres Strait

Islander employment, education and mentoring contributing to the improvement of human capability within communities.

Grow Your Own Workforce
An example of employment, education and mentoring has been developed through the Grow Your Own (GYO) program - a place-based workforce model that focuses on attracting, developing, supporting and retaining local residents, at any level and in any discipline, in an effort to create a sustainable pipeline of workers. It essentially involves two separate but complementary approaches, namely an outside-in and an inside-up approach.

- Developed with funding from Queensland Health and in consultation with industry, aims to strengthen the Queensland health sector's efforts to develop a capable and sustainable local health workforce
- Low educational attainment and few opportunities for Aboriginal and Torres Strait Islander peoples to participate in the health workforce in remote communities across Australia makes it a challenge to attract a culturally-competent health workforce in these areas
- Examples of Aboriginal and Torres Strait Islander specific projects include:
  - Connect 'n' Grow: offer a dual Certificate II in Health Support Services and Community Services, followed by specialisation in either a Certificate III in Health Services Assistance or Community Services. The program includes work experience opportunities and Discovery Days, where students can tour health facilities and meet local industry professionals. Aboriginal and/or Torres Strait Islander students are provided with mentoring, career guidance and support by the philanthropically-funded Seed Foundation Australia.

Thursday Island Renal Dialysis: The Aboriginal and Torres Strait Islander Health Worker role was identified as appropriate for role expansion to include specific dietetics, podiatry, physiotherapy and occupational therapy tasks and a trial has commenced. A program of work-place based training and competency assessment will be implemented for this employee. When the program is fully implemented the Health Worker will use these additional skills to deliver a broader range of services to clients.

COMMUNITY AND STAKEHOLDER CONSULTATION

- Disadvantage for Aboriginal and Torres Strait Islander people living in rural communities
- Transport issues - getting to health services of all types (primary, secondary & hospital care) described as a large and complex problem, incorporates broader aspects of access to care
- Community education: a strongly supported issue; focused on lack of understanding of services (what is available, what services do); improving health behaviours; and better health self-management
- Communication: a broad problem including communication from and between healthcare providers; the need for more work on coordinating care as transitioning between services is difficult; difficulty in navigating the health system generally; and the need for more collaboration with and between communities and healthcare providers
- Telehealth options always accessible (no internet or phone coverage, especially in rural areas); a need for more telehealth services in GP practices and residential aged care facilities; and the perception that there is resistance to providing telehealth services from specialists
- Concerns regarding inadequate or poorly directed healthcare funding
- Aged care and disability support

- Long wait times across all healthcare settings
- A desire to empower indigenous communities
- Improved access to quality dental services
- Services to address health issues associated with domestic violence

SOURCES

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- PHIDU Aboriginal and Torres Strait Islander Social Health Atlas of Australia: August 2017; NHPA report-hc33
- National Aboriginal and Torres Strait Islander Health Plan 2013-2023
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- PHIDU Health Atlas, October 2018

Workforce Capacity and Wellbeing

SERVICES

In seeking to create a health system which is more affordable, more equitable and more responsive to primary health care needs, health workforce programs are a key policy lever. An Australian health workforce review has focused on measures which might strengthen those programs which are built around the identification of local need and more investment in regionally-based education, training and incentive programs. Ensuring a capable and qualified health workforce.

Recommendations involve:

- Health education and training
- Health education scholarships
- Health education strategies for rural distribution
- Rural recruitment and retention strategies
- Reform of the ASGC-RA rural classification system
- Supporting the Aboriginal and Torres Strait Islander health workforce
- International recruitment, support and regulation
- District of Workforce Shortage classification system
- Achieving workforce distribution aims through return of service obligations
- Workforce distribution programs targeted at non-vocationally recognized medical practitioners
- Nursing workforce – education, retention and sustainability
- Dental and allied health workforce development
- Allied health workforce
- Grants management reform

As part of a new funding agreement in 2017/2018 with the Australian Government Department of Health, Health Workforce Queensland was asked to undertake an annual state-wide 'all of health' workforce needs assessment for **remote and rural Queensland**, leveraging off the comprehensive health and service needs assessments undertaken at regional levels through the Primary Health Networks (PHNs) and others.

PHN Priority SA2s identified through this assessment:

- Tara
- Kingaroy Region – North
- Millmerran
- Nanango
- Crows Nest – Rosalie
- Inglewood – Waggamba
- Jondaryan
- Lockyer Valley – East
- Southern Downs – West
- Warwick

Table GSN6.1 Top 3 Workforce Gaps (of 18) per Combined or Single SA2 in PHN Region

	1	2	3
Chinchilla, Miles Combined	Psychology (78.4)	Palliative Care (67.0)	Diabetes Education (64.0)
Goondiwindi, Inglewood Combined	General Practice (43.2)	Aboriginal and Torres Strait Islander Health Worker (42.3)	Palliative Care (41.8)
Kingaroy Combined	Psychology (75.4)	Palliative Care (74.8)	Social Work (71.4)
Lockyer Valley – East SA2	Palliative Care (66.0)	Radiology (58.7)	Speech Pathology (54.8)
Lowood, Esk Combined	Palliative Care (66.8)	Social Work (66.7)	Psychology (63.8)
Nanango SA2	Palliative Care (77.3)	Physiotherapy (77.3)	Dentistry (76.7)
Stanthorpe SA2	Optometry (80.7)	Nursing (80.0)	Occupational Therapy (60.0)
Toowoomba and Suburbs	Dentistry (34.0)	Occupational Therapy (31.6)	Audiology (29.8)
Wambo SA2	Dentistry (67.1)	Diabetes Education (54.8)	Psychology (53.9)
Warwick, Sth Downs Combined	Occupational Therapy (75.6)	Palliative Care (70.9)	Social Work (60.3)

- Of the 18 workforce gaps, Kingaroy Combined held the highest rankings in 7 areas
- The highest ratings were seen in Stanthorpe in the areas of Optometry and Nursing

Table GSN6.2 Top 3 (of 8) Service Gap Ratings for each Combined or Single SA2 in PHN Region

	1	2	3
Chinchilla, Miles Combined	Mental Health (81.8)	Alcohol, Tobacco and Other Drugs (71.5)	Child Health (68.2)
Goondiwindi, Inglewood Combined	Child Health (56.6)	Health Promotion (46.6)	Mental Health (41.7)
Kingaroy Combined	Alcohol, Tobacco and Other drugs (77.0)	Mental Health (60.7)	Refugee and Immigrant Health (59.0)
Lockyer Valley – East SA2	Refugee and Immigrant Health (83.0)	Mental Health (71.7)	Alcohol, Tobacco and Other Drugs (67.5)
Lowood, Esk Combined	Mental Health (73.2)	Child Health (68.9)	Alcohol, Tobacco and Other Drugs (67.4)
Nanango SA2	Aged Care (84.0)	Disability (66.5)	Alcohol, Tobacco and Other Drugs (66.0)
Stanthorpe SA2	Health Promotion (76.7)	Aged Care (75.0)	Disability (72.3)
Toowoomba and Suburbs	Mental Health (41.7)	Alcohol, Tobacco and Other Drugs (39.7)	Disability (33.8)
Wambo SA2	Mental Health (4.3)	Alcohol, Tobacco and Other Drugs	Child Health (54.7)

		(58.0)	
Warwick, Sth Downs Combined	Alcohol, Tobacco and Other Drugs (56.2)	Disability (54.4)	Refugee and Immigrant Health (52.9)

- The ratings for workforce and service gaps in General Practitioners and Aboriginal health workers in the Darling Downs and West Moreton PHN were more favourable than Central Queensland, Wide Bay and Sunshine Coast PHN, Northern Queensland PHN and Western Queensland PHN and Queensland as a whole.
- The nursing workforce ratings were less favourable than Central Queensland Wide Bay and Sunshine Coast PHN, however better than the Northern and Western PHNs and Queensland as a whole
- The proportion of workforce engaged in general practice across Queensland tends to decrease with increasing remoteness
- Almost 70% of Inner Regional and Outer Regional practitioners indicated that they intended to remain at their current practice for more than three years, this dropped to approximately 40% for Remote practitioners
- The self-reported average total hours worked per week by Queensland RA 5-2 practitioners was 43.9 hours. For Queensland practitioners this represents a 1.2-hour reduction in the self-reported total hours since 2012
- The average age of practitioners has increased 2.6 years since 2012
- The percentage of female practitioners has increased by 2.5% since 2012
- 4.3% of medical practitioners self-reported working as a solo doctor while another 0.7% described themselves as solo co-located
- The proportion of Queensland practitioners trained in Australia has increased from 50.6% in 2016 to 56.2% in 2017.
- The average age of remote, rural and regional medical practitioners in Queensland was 50.8 years

ISSUES WITH BUILDING AND SUSTAINING HEALTH WORKFORCE

- Ageing health workforce – impending loss of staff, work health and safety concerns
- Difficulties with recruitment – challenge of recruiting appropriately qualified staff, difficulty attracting to rural areas
- Difficulties with retention - lack of general learning and development opportunities available to staff that were more freely available in major cities, including limited career pathways, prospective candidates were potentially more attracted to the more complex and diverse caseloads associated with major cities; specific difficulties with recruiting dentists, mental health nurses, and, in the case of Chinchilla Hospital, midwives
- Ageing or limited accommodation – especially in rural towns causing a disincentive

Table GSN6.3 Health Workforce Comparison (Place of Work) per 100,000 population – PHN to Qld

Place of Work	Qld (Ratio per 100,000 population in Qld)	PHN (Ratio per 100,000 population in PHN)
General Practice Medical Services	409.53	**343.79**
Other Allied Health Services	272.20	**189.58**
Dental Services	216.36	**173.60**
Pathology and Diagnostic Imaging Services	195.34	**100.53**
Ambulance Services	88.09	**75.76**

Physiotherapy Services	82.16	**39.85**
Optometry and Optical Dispensing	65.30	**53.86**
Chiropractic and Osteopathic Services	31.28	33.57

PHN GENERAL PRACTICE TRAINING NEEDS ANALYSIS

- General Practitioner specific clinical education requested: Chronic pain, Alcohol and Other Drugs, mental health, vacuum dressings, dermatology, managing difficult patients at reception, trauma, paediatrics, orthopaedics, gender issues, CPC criteria and benefits, advanced surgical techniques, managing drug dependant patients
- Practice Manager specific clinical education requested: CVC, basic infection control, CPR, first aid, the PHN and future directions, Workcover and Centrelink requirements, legislation changes, receptionist staff training, RPHS training
- Practice Nurse specific clinical education requested: COPD, respiratory, Type 1 diabetes, GPMP training, care planning, mental health, CVC, sterilisation, chronic health, ear irrigation, cycle of care billing, immunisation for refugees, telephone triage
- Allied Health specific clinical education requested: trauma informed practice, mental health, using assistants, videoconferencing, linking private providers with Government services e.g. DDHHS, CPR, self-care for HPs, formulating plans, tender writing and Tenderlink, smoking management, high end business development, Functional Behavioural Analysis training (OTs and PYs).

COMMUNITY CONSULTATION

- Evidence of substantial workload for health professionals across region; concerns about healthcare staff becoming burnt out
- Outreach services requiring higher levels of travel for health professionals.
- Need for continued recruitment, retention, education and upskilling; health of workforce in particularly in rural areas and West Moreton

GP ATTENDANCES/ MBS SERVICES DELIVERED

- The majority of MBS services delivered across the PHN region (almost 74%) were GP consultations for care that required a standard consultation of approximately 20 minutes.
- In light of the prevalence of health risk factors, the utilisation of GP consultations for chronic disease and mental health issues appear notably low;
- Inglewood – 55%

DIGITAL HEALTH/ TELEHEALTH

Implementation of telehealth is one consideration for improving levels of access to care for persons living outside major centres of the PHN region.

- Medicare Benefits Schedule (MBS) data showed that Queensland is ranked third among states in per-capita telehealth activity for the 2017-18 financial year. Females in Queensland utilised

telehealth more than males overall (31,933 vs 26,432). The cohort between 45 and 74 years accounted for 47.8% of telehealth activity in Queensland.

- Telehealth-eligible areas are all areas outside the Remoteness Area 1 classification (Major Cities of Australia). The geographical area covered by PHN is entirely outside this classification with the exception of Ipswich city.
- It is noted that currently, MBS items for telehealth and Queensland Health's patient travel subsidy scheme (PTSS) are only available for specialist appointments and not general practice. It is recommended that the PHN examine opportunities to leverage technologies to reduce patient/practitioner travel.
- MBS online provides specific guidance on technical requirements for successful telehealth, however it can be generally considered that a reliable broadband internet connection is integral to telehealth capabilities. Census data for the PHN region show that rates of accessing the internet ranged from 53% - 92% across Statistical Area Level 2 (SA2) regions in 2016.
- Rates of access were poorest in Tara (53.3%), Millmerran (62.1%), Kingaroy North (62.7%), Inglewood-Waggamba (62.7%) and Miles-Wandoan (65.7%). Census 2011 data on the type of internet connection showed that the proportion of internet connections that were broadband ranged from 52% - 85% across SA2 regions. The lowest proportions were observed in Tara (52.3%), Kingaroy North (52.8%), Stanthorpe (54.5%), Inglewood-Waggamba (54.8%) and Gatton (55.0%).
- The rate of access and proportion of broadband connections were highly correlated across SA2 regions (r = .91). It was noted by the joint clinical council that telehealth availability faces barriers even in the major centres. In primary care, the availability may often be a matter of preference for the practitioner.
- It is likely that smaller practices will require support and resources to initially establish telehealth capabilities in terms of development of procedures, hardware and technical support.
- Mixed models of care that include face-to-face and telehealth modes of delivery where appropriate should be considered.
- Community consultation considered telehealth of critical importance while recognising infrastructure and usability as being inconsistent; telehealth is 'hit and miss' due to either lack of infrastructure/equipment or lack of skills to use equipment

VULNERABLE POPULATIONS CONSIDERATIONS

- Online communication can be highly effective with GPs explaining terms and choice implications and ensuring that there is two-way communication.
- Consumers reported specialists often not adhering to set appointment times with GPs and patients.
- Discussions surrounding telehealth being unsuitable for mental health counselling although research completed provides data indicating it can be a useful tool.

SOURCES

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Health for Older Australians

Australia's older generation (those aged 65 and over) continues to grow and is projected to more than double by 2057. The ageing of the population creates both pressures and opportunities for Australia's health and welfare sectors.

- In 2017, 1 in 7 Australians were aged 65 years and over
- In 2016, 1 in 8 older people were engaged in employment, education or training
- 105 days is the average time between approval and entry into residential care, compared with 67 days for home care
- Aboriginal and Torres Strait Islander people account for less than 1% of all permanent residential care and 4% of people in home care
- 47% of people in permanent residential aged care on 30 June 2017 had depression, the most commonly diagnosed mental health condition
- Nearly 1 in 10 Australians aged 65 and over had dementia in 2016
- 43% of people with dementia are aged 85 and over
- 52% people in permanent residential aged care have dementia
- 2% of residential aged care residents were assessed as required palliative care

DARLING DOWNS AND WEST MORETON PHN REGION

In June 2016*:*

- 3,885 residential aged care places
- 54,378 people aged 70 years and over
- 71.5 residential care places per 1,000 population aged 70 years and over; Queensland rate – 79.0; Australia rate – 82.6

The proportion of people aged 65 and over in the PHN region is 15%, 15th highest across all PHN regions for 2016. The Queensland proportion is at 14.7% and the National rate of 15.7%.

Table GHN4.1: Areas of Highest Proportion of People Aged 65 years and over for Darling Downs and West Moreton (2016)

West Moreton	Darling Downs
Boonah/ Rosewood – 17.8%	Stanthorpe/ Stanthorpe Region – 24.2%
Esk/ Lake Manchester - England Creek/ Lowood – 17.6%	Kingaroy Region - North/ Nanango – 24.1%
Kilcoy/ Woodford - D'Aguilar – 17.2%	Clifton - Greenmount/ Southern Downs – 21.9%
Ipswich - Central/ North Ipswich – Tivoli – 16.3%	Warwick – 20.6%
Lockyer Valley – East – 16.1%	Crows Nest - Rosalie/ Jondaryan – 20.1%

The proportion of Aboriginal and Torres Strait people aged 50 and over in the PHN region is 0.8%, 19th highest across all PHN regions for 2016.

Table GHN4.2: Areas of Highest Proportion of Aboriginal and Torres strait Islander People Aged 50 years and over for Darling Downs and West Moreton (2016)

West Moreton	Darling Downs
Churchill - Yamanto/ Raceview/ Ripley – 3.2%	Kingaroy/ Kingaroy Region – South – 4.5%
Bundamba/ Riverview – 2.5%	Cambooya - Wyreema/ Gowrie/ Toowoomba – West – 2.5%
Ipswich East – 2.5%	Darling Heights – 2.2%
Springfield - Redbank – North – 2.3%	Middle Ridge/ Rangeville/ Toowoomba – East2.1%
Springfield Lakes – 2.1%/ New Chum/ Redbank Plains – 2.1%	Newtown/ North Toowoomba - Harlaxton/ Wilsonton – 1.9%

DARLING DOWNS:

- 47.5% people using permanent residential aged care on 30 June 2017 had a diagnosis of dementia
- 63% people using permanent residential aged care is 63.3% comparative to Queensland at 66.5%
- The highest age proportion is 85-89 years
- Residential care average length of stay for specific discharge reason ranges from 5.5 months (other reason) to 31.7 months (death)
- Home care average length of stay for specific discharge reason ranges from 14.9 months (residential care) to 19.6 months (death)

WEST MORETON:

- 47.5% people using permanent residential aged care on 30 June 2017 had a diagnosis of dementia
- 65.2% people using permanent residential aged care is 63.3% comparative to Queensland at 66.5%
- The highest age proportion is 85-89 years
- Residential care average length of stay for specific discharge reason ranges from 3.8 months (other reason) to 30.7 months (death)
- Home care average length of stay for specific discharge reason ranges from 10.4 months (hospital) to 16.4 months (residential care)

DEMENTIA ACROSS THE REGION

- Increasing number of people living with dementia in the community, including those with early onset dementia
- There is concerns for a lack of appropriate and coordinated acute and community-based services across the Darling Downs for people and their carers living with dementia.
- People with dementia usually experience behavioural and psychological symptoms of dementia (BPSD) during their illness, which ranges from no symptoms to severe aggression and violence. There is a lack of appropriate acute hospital services to best manage dementia patients and associated behavioural challenges. Best practice promotes care of patients with dementia in safe and secure areas that are physically adapted to meet needs including access to outside garden area, and appropriate lighting.
- Concerns for a lack of understanding of BPSD and management strategies to improve quality of care and health outcomes across the health system.
- There is a need for an increase in staff training to understand dementia and its symptoms and how to communicate better and treat patients with dementia

HEALTHY AGEING

The World Health Organisation (WHO) defines Healthy Ageing "as the process of developing and maintaining the functional ability that enables wellbeing in older age". Functional ability is about having the capabilities that enable all people to be and do what they have reason to value. This includes a person's ability to:

- meet their basic needs;
- to learn, grow and make decisions;
- to be mobile;
- to build and maintain relationships; and
- to contribute to society

The health of the increasing number of older Australians is an important social and economic challenge facing Australia. It is also an opportunity, as extending a lifetime of good health enables older Australians to continue to contribute socially, culturally and economically to the wider community.

Facts about older Australians:

- 9 in 10 older people believe they have someone outside the household in whom they can confide
- Over 9 in 10 older people reported that they has support in a time of crisis from someone outside their household
- 1 in 8 older people were engaged in employment, education or training
- 2 in 5 older people reported being sufficiently active during the preceding week
- 7 in 10 older people are overweight or obese
- 94.8% older people live in households
- Over 1 in 3 need assistance with daily activities
- 96.9% older people had their assistance needs fully or partly met
- Over 1 in 5 older people are involved in voluntary activities
- 71.7% older people own their home outright

Healthy ageing involves more than just promoting good physical health. Social and mental wellbeing are also important determinants for a high-quality life into older age.

Table GHN4.3: Behavioural Risk Factors by Age Group, 2014-2015

	Aged 65 and over	Aged 18–64
Sufficiently **active**	35%	48%
Current daily **smoker**	7%	16%
Vaccinated against influenza	75%	23%
More than **2 standard drinks of alcohol** a day	16%	18%
At least **2 fruit + 5 vegetables** a day	8%	5%
Overweight or **obese**	72%	61%
Experienced **stress**	52%	63%

AGED CARE SERVICES

DARLING DOWNS

- 47 home support services
- 36 home care services
- 40 residential care services
- All types of residential care per 1,000 people aged 70+ is 69.6 (73.4 Queensland and 76.5 Australia)
- Government residential care per 1,000 people aged 70+ is 8.7 (2.5 Queensland and 3.4 Australia)
- Not for profit residential care per 1,000 people aged 70+ is 50.0 (42.8 Queensland and 42.8 Australia)
- Private residential care per 1,000 people aged 70+ is 10.9 (28.1 Queensland and 30.4 Australia)
- Distribution of aged care being used as of 30th June 2017- transition care 1.6%, home care 27.6%, residential care 70.8%

WEST MORETON

- 37 home support services
- 23 home care services
- 15 residential care services
- All types of residential care per 1,000 people aged 70+ is 52.5 (73.4 Queensland and 76.5 Australia)
- Government residential care per 1,000 people aged 70+ is 0 (2.5 Queensland and 3.4 Australia)
- Not for profit residential care per 1,000 people aged 70+ is 44.9 (42.8 Queensland and 42.8 Australia)
- Private residential care per 1,000 people aged 70+ is 7.5 (28.1 Queensland and 30.4 Australia)
- Distribution of aged care being used as of 30th June 2017- transition care 2.2%, home care 29.2%, residential care 68.6%

Table GSN9.1: Residential Aged Care Places, PHN

June 2016	
	PHN highest figures

Number of Residential aged care places	Middle Ridge/ Rangeville/ Toowoomba - East (209.1)
Population aged 70 years and over	Ipswich - Central/ North Ipswich - Tivoli (170.1)
Residential care places per 1,000 population aged 70 years and over	Bundamba/ Riverview (153.9)

Table GSN9.2: Population Forecast aged 70+ 2016-2026, PHN

Population aged 70 years and over	2016	2026	2036	Annual growth rate 2016-2026	Growth rate 2016-2026
PHN by SA2s	58,157	90,386	132,652	5.5%	55.4%
% based on total population	10.2%	12.5%	14.0%		
Queensland	473,751	722,231	1,014,017	5.2%	52.4%
% based on total population	9.8%	12.6%	15.0%		

AGE PENSION

- The highest rates of people over 65 receiving the age pension:
  - Springfield Lakes – 95.0%
  - New Chum/ Redbank Plains – 87.9%
  - Newtown/ North Toowoomba – Harlaxton/ Wilsonton – 79.2%
  - Warwick – 78.5%
  - Springfield – Redbank – North – 78.2%

Table GSN9.3: Aged Care Benefits, PHN

Indicator	PHN	Darling Downs	West Moreton	Qld	National
Age pensioners *(persons aged 65 and over)*	73.0% *(12th highest PHN Nationally)*	72.7%	73.4%	69.8 %	71.1%
Health care card holders *(persons 0 to 64 years)*	8.5% *(equal 11th highest PHN Nationally)*	**8.3%**	8.7%	7.7%	7.3%
Senior health card holder *(persons aged 65 and over)*	6.7% *(equal 23rd highest PHN Nationally)*	7.7%	5.3%	7.6%	8.0%

*(red: >10% higher than Qld rate; green: >10% below Qld rate; **bold**: >10% higher than National Rate)*

END OF LIFE DECISION MAKING

Consultation across the region identified the need for improved end of life planning and decision making to allow timely discussions with trusted health care providers. With more than 43% of the region's deaths occurring within the hospital setting, it is ideal that a reasonable discussion has occurred with the person's wishes recorded prior to admission to an acute care facility when they may no longer be able to be a participant in decisions.

The PHN Joint Clinical Councils acknowledged there is a requirement for anticipatory care and preparing patients for the expected unexpected elements of the ageing process especially in the case of chronic disease. There may be a slow onset of the effects of ageing resulting from multiple comorbidities, being frail or disabled with a lack of planning for a sudden insult on the ability to make decisions especially in regards care choices and decision making especially in regards end of life

planning. This is generally not a pleasant or easy conversation to initiate. There is also an observed lack of prominent resources to assist health care workers in providing support through the decision-making process. GPs expressed a concern for legalities of documentation and understanding their role. This planning can become more difficulty in population cohorts with people with low levels of health literacy such as Aboriginal and Torres Strait Islander people, some of our most vulnerable.

AGEING AND PALLIATIVE CARE

Palliative Care Australia's background report to the Palliative Care Service Development Guidelines emphasises discussion about dying and advanced care planning. Psychological, emotional and spiritual issues were comparatively important to physical health in palliative care. These values can be incorporated into a person's preferences for clinical care at the end of life through advanced care planning.

Illness trajectories may comprise either a short period of rapid and evident decline, long-term decline with intermittent serious episodes, or prolonged and progressive disability and reduced function. The traditional approach to palliative care has focused predominantly on the rapid decline aspects of death. It is acknowledged that Australia's ageing population will see an increased demand for care in long-term decline.

The PHN is working with the Department of Health in undertaking the Palliative Care Services Review consultation process. It is noted that the provision of palliative care may benefit up to 75% of all deaths. In Australia, 66% of deaths occur in persons aged 75 or over. To estimate the geographic distribution of probable demand for palliative care, net population growth and population growth simulations were employed.

Twelve key areas were identified. It is noted that demand for high-quality palliative care, especially care in the home or community, will be geographically dispersed and services must avoid a centralised approach that requires patients and their families to undertake unreasonable travel for palliative care. Nonetheless, the identified areas can be considered for pilot programs, further community consultation and research.

Method 1: Net population growth (empirical)

- Annual net population change by SA2 and 5-year age group calculated 2008-2017
- Median population change 2008-2017 ranked by SA2 for each age group
- SA2 included if 85+ ranked in top 10, or 75-79 and 80-84 ranked in top 10

Table GSN9.4: Net Population Growth (Empirical) Key Areas and Rank

	Rank		
SA2	**75-79**	**80-84**	**85+**
Pittsworth	42.5	4	5.5
Warwick	6	7.5	5.5
Boonah	4.5	4	11.5
Lockyer Valley - East	1	2	8
Ipswich - East	65	31	3
Darling Heights	42.5	11	1

Drayton - Harristown	60	16.5	4
Highfields	8	6	8
Toowoomba - West	13	4	2
Wilsonton	4.5	1	10

Method 2: Highest 'unexpected' growth (simulation)

- 2008 Estimated Resident Population aged year-on-year until 2017 in simulation and compared to actual annual population
- Median difference between simulation and observed population 2008-2017 ranked by SA2
- SA2 included if 85+ ranked in top 10, or 75-79 and 80-84 ranked in top 10

Table GSN9.5: Highest 'Unexpected' Growth (Simulation) Key Areas and Rank

	Rank		
	75-79	**80-84**	**85+**
Pittsworth	35.5	14	9
Lake Manchester - England Creek	17	10.5	5
Brassall	9	4	21
Raceview	5	5	32.5
Riverview	8	6.5	7
Bellbird Park - Brookwater	47	6.5	1
Carole Park	17	10.5	5
New Chum	17	10.5	5
Darling Heights	2	2.5	14.5
Drayton - Harristown	1	1	2
Middle Ridge	3	2.5	3
Toowoomba - West	25	16	8

While there is a recognised increased desire for people to die at home, there may also be an unappreciated knowledge deficit of supports for the carer and how these can be accessed. In the after-hours period, there is often no access to support in the community with available services often incurring expense for the family.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

- Generally lower health literacy in Indigenous communities combined with cost for advanced health planning and GP visit, and the difficult conversations, provides complexities in end of life planning
- Requirement for understanding of preferences, such as home care, and ability to support in a culturally appropriate manner that maintains dignity
- Noted complexities of chronic disease and lower life expectancy

SOURCES

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- Australian Institute of Health and Welfare analysis of the National Hospital Morbidity Database 2013–14 and Australian Bureau of Statistics, Estimated Resident Population 30 June 2013.
- Consultation Report for the Health Service Plan 2018-2028; Darling Downs Hospital and Health Service; August 2018
- https://www.gen-agedcaredata.gov.au/My-aged-care-region
- PHIDU Social Atlas of Australia, 2018
- https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/healthy-ageing/behavioural-risk-factors, 2018
- http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/2B056B8FE240D738CA2581A000206EAE/$File/a%20profile%20of%20older%20people%20in%20australia.pdf
- www.who.int/ageing/healthy-ageing/en/
- https://www.gen-agedcaredata.gov.au/My-aged-care-region
- HHS Consultation
- PHN Joint Clinical Council, Nov, 2018

Primary Mental Health Care

SUICIDE PREVENTION

At present there is no way to measure the number of people affected by each suicide death, nor the way in which these events impact on those affected. Similarly, there is limited understanding of how people are affected by a broader spectrum of suicidal behaviours such as attempts, plans and/or ideation.

Every year:
- Over 65,000 Australians make a suicide attempt
- More than 3,000 Australians died by suicide in 2017
- Suicide is the leading cause of death for Australians between 15 and 44 years of age
- Young Australians are more likely to take their own life than die in motor vehicle accidents
- In 2017, about 75% of people who died by suicide were males and 25% were females
- In 2017, the suicide rate among Aboriginal and Torres Strait Islander people was approximately twice that of non-Indigenous Australians

The causes of suicide are complex. Factors that may contribute to suicide include:
- stressful life events
- trauma
- mental illness
- physical illness
- drug or alcohol abuse
- poor living circumstances

Table MHHN1.1: Estimated Number of People aged 18 years+, with High or Very High Psychological Distress (based on the Kessler 10 Scale), PHN, 2014-2015

ASR per 100,000 (modelled estimates)			
PHN	QLD	Australia	SLAs with highest rate
13.9	12	11.7	Redbank Plains (19.1), Bundamba/ Riverview (18.1), Brassall/ Leichhardt - One Mile (17.8), Newtown/ North Toowoomba - Harlaxton/ Wilsonton (16.9)

By contrast, there are protective factors that make us more resilient and can reduce suicidal behaviour, such as:
- supportive social relationships
- a sense of control
- a sense of purpose
- family harmony
- effective help-seeking
- positive connections to good health services available

DARLING DOWNS AND WEST MORETON REGION
- Deaths from suicide and self-inflicted injuries – average annual ASR per 100,000 for the region from 2011-15 was 15.5 as compared to 14.1 (10% increase) for Queensland and 11.5 (35% increase) for Australia.
- The PHN region has the 5th highest deaths from suicide and self-inflicted injuries rate out of all PHNs.

Table MHHN1.2: Highest Rates of Avoidable Deaths from Suicide and Self-Inflicted Injuries, PHN, 2011-2015

West Moreton	Darling Downs
Esk/ Lake Manchester - England Creek/ Lowood – 29.2	Kingaroy Region - North/ Nanango – 26.9
Lockyer Valley – East – 25.4	Chinchilla/ Miles - Wandoan/ Roma/ Roma Region – 22.1
Brassall/ Leichhardt - One Mile – 25.1	Balonne/ Goondiwindi/ Inglewood - Waggamba/ Tara – 18.0
Ipswich – East – 19.9	Kingaroy/ Kingaroy Region – South – 17.7
New Chum/ Redbank Plains – 18.2	Stanthorpe/ Stanthorpe Region – 16.1

INTENTIONAL SELF-HARM HOSPITALISATIONS

- While the region has a rate of self-harm hospitalisations more than 30% above the National rate, the region is at the lowest end of all Queensland PHN regions.
- The highest rate is in the Ipswich Inner SA3

Table MHHN1.3: Comparison Rate of Intentional Self-Harm Hospitalisations (ASR per 10,000 people) PHN, 2015-2016

	2014-2015			2015-2016		
Primary Health Network area name	ASR	No. hosps. (a)	Bed day rate (b)	ASR	No. hosps. (a)	Bed day rate (b)
National	16	36696	83	17	39579	81
Brisbane North (Qld)	21	1995	133	21	2058	106
Brisbane South (Qld)	21	2257	103	22	2428	113
Gold Coast (Qld)	16	896	86	19	1043	76
Darling Downs & West Moreton (Qld)	**21**	**1098**	**108**	**22**	**1155**	**92**
Western Queensland	21	149	67	22	152	50
Central Qld, Wide Bay & Sunshine Coast	26	1925	101	27	2018	102
Northern Queensland	25	1711	97	26	1794	90
SA3 Local Area						
Darling Downs West-Maranoa (Qld)	**23**	**93**	**74**	**23**	**96**	**54**
Darling Downs-East (Qld)	**23**	**87**	**90**	**14**	**54**	**74**
Toowoomba (Qld)	**18**	**259**	**134**	**15**	**218**	**86**
Ipswich Hinterland (Qld)	**19**	**107**	**95**	**22**	**120**	**83**
Ipswich Inner (Qld)	**26**	**265**	**114**	**33**	**333**	**121**
Springfield-Redbank (Qld)	**22**	**178**	**86**	**23**	**193**	**69**

Footnotes
a Number of intentional self-harm hospitalisations
b Rate of intentional self-harm bed days per 10,000 people, age-standardised
ASR - age standardised rate

The PHN identifies that West Moreton ranks suicide in the top ten leading causes of death with elevated male mortality from suicide; high self-reporting rates of depression and anxiety and the PHN ranks in the top 8 of 31 Primary Health Networks for intentional self-harm hospitalisations and bed days. The Fifth National Mental Health and Suicide Prevention Plan identified suicide prevention as a clear priority area in mental health with suicide representing a significant health and social policy issue. The plan commits all governments to work together to achieve integration in planning and service delivery at a regional level and includes a Stepped Care guide on the range of service delivery options aimed at varying intensity. In support of this approach, The Queensland Mental

Health Commission clearly outlined four priority areas including stronger community awareness and capacity; improved service system responses and capacity; focused support for vulnerable groups and a stronger more accessible evidence base to drive continuous improvement (Queensland Suicide Prevention Action Plan 2015-17).

In 2016, Orygen, the National Centre of Excellence in Youth Mental Health, released findings from an Australian-wide study into youth suicide. The researchers found, *inter alia*, that:

- Suicide rates for youth aged 15-24 years are the highest in 10 years,
- Death by suicide accounted for the deaths of one third of all male youths,
- The prevalence of death by suicide has increased for children aged 14 years and younger, and
- One quarter of all young women aged 16-17 years have self-harmed

In 2018, the Australian Institute of Health and Welfare (AIHW) reported on certified deaths by suicide of veterans. The findings were limited to ex-ADF veterans who were serving at or after 2001 and who were discharged between 2001 and 2015. The AIHW found, compared with all Australian men of the same age, *male* veterans have elevated suicide rates;

- 32.5 deaths per 100,000 persons, approximately three times greater than in the general population,
- 14% higher rate than for men in the general population,
- Significantly higher if aged 18 – 29 years,
- Over twice the rate of those still serving and ex-serving women,
- Approximately twice the rate if medically-discharged c.f. those discharged voluntarily
- Over twice the rate in ranks other than commissioned officers, and
- Increased risk in those with less than 1 year service c.f. those who served 10 years or more.

In Queensland, the Institute for Suicide Research and Suicide Prevention (ISPR) at Griffith University reported that:

a. The prevalence of death by suicide was 1,914 deaths in three years (2011-2013, and
b. Gender differences existed in the incidence of death by suicide:
    - Deaths were three times higher for males than females (21.32 per 100,000 in males c.f. 6.94 per 100,000 in females),
    - Deaths in males were highest in those aged 33-44 years and those aged 75 years and over (32.59 per 100,000 and 32.33 per 100,000, respectively), and
    - Deaths in females were highest in those aged 33-44 years and those aged 45-55 years (11.70 per 100,000 and (9.15 per 100,000, respectively).

In the Darling Downs Region, the ISPR reported that the Darling Downs Hospital and Health Service (DDHHS) recorded:

a) A high male to female suicide ratio (7.2:1), the largest of all Queensland HHS, indicating a higher than usual ratio of males to females are dying from suicide in the region compared with other regions,
b) The highest percentage of suicides were observed in people aged 35 years and under (43.9%), representing the largest suicide rate of people aged 35 years and under in the state, except Greater Western Queensland Region,
c) Elevated rates of suicide in people aged 35–54 years (32.7%) and aged 55 years and over (23.5%),
d) Hanging (55.1%) was the most used method of suicide,

e) Firearms (15.3%) was a common method of suicide, above the all Queensland rate (6.7%), and the second-highest among all Queensland HHS, and
f) Poisoning (14.3%) was a common method of suicide.

In summary, government statistics have identified that there is *a disproportionately-high number of deaths by suicide in the Darling Downs Region*. Therefore, the current Plan addresses the urgent need to investigate death by suicide and apply multiple strategies and priorities including those that have been the focus of other suicide prevention plans over recent times. Continually developing such strategies to meet current community needs is essential to effectively apply the framework for suicide prevention planning adopted here.

CURRENT ACCESS OPTIONS

- Access public mental health services 24 hours a day by calling the State wide Toll-free “1300 MH Call”.
- Via local public hospital emergency department
- May also be referred directly to community mental health services by a general practitioner (GP) where clinical presentation is beyond that normally managed in primary care, or where specialist advice regarding treatment is sought
- Additional referral pathways are available to young people to access specialist Child and Youth Services via established linkages with Education Queensland as part of the Ed-Linq program

TREATMENT OPTIONS

- Referral back to a specialised GP for a Mental Health Care Plan including access to psychological services, acute care in the community, or where necessary acute treatment in a specialised inpatient mental health unit
- Brief support interventions, and referral on to one or more specialised therapy programs both within the service and external to where a GP Mental Health Care Plan exists
- Specialist treatment with medication, under the supervision of a psychiatrist is available in all areas of the public mental health services
- Individuals with enduring suicidality can access specialist Dialectical Behaviour Therapy (DBT) programs
- Individuals may also be referred to Alcohol and Other Drug Services, as well as a range of other community services and agencies that can support people to access social welfare services appropriate to their needs

HOSPITAL AND HEALTH SERVICES:

- 24-hour Acute Care Team
- Community Mental Health Teams
- Darling Downs Child and Youth Mental Health Service
- Older Persons Mental Health Services
- Specialist Inpatient Acute Mental Health services
- Specialist Adolescent Day Programs
- Specialist Ambulatory Alcohol and Other Drugs Service
- Referral Based Neuropsychiatric Clinic

PRIVATE SERVICE PROVIDERS

- Private providers offer additional services in Toowoomba and some outer regional centres.
- These services include acute specialist services, with some providing specific services in hospice care and rehabilitation services

GENERAL PRACTITIONERS

- Many GPs have completed mental health skills training courses which cover recognition, diagnosis, management (including basic Cognitive Behavioural Therapy, CBT) of common mental health conditions.
- Completion of this training allows access to a higher Medicare rebate for mental health care planning.
- Some GPs with a particular interest in mental health, also may apply focused psychological skills techniques during consultations

ABORIGINAL HEALTH SERVICES

- Three federally-funded Aboriginal Medical Services (AMS): Carbal Medical Services (Carbal), based in Toowoomba and Warwick; Goondir Health Services in Dalby and Oakey (Goondir); and Cherbourg Hospital.
- In Toowoomba there is also a bulk-billing general practice, Goolburri Aboriginal Health Advancement (Goolburri), aimed at the provision of health services to Aboriginal and Torres Strait Islander patients

OTHER MENTAL HEALTH SERVICES:

- Psychiatrists
- Psychologists
- Occupational therapists
- Social Workers
- Mental Health Nurses
- Guidance Officers through education providers
- headspace
- NGO providers
- Church based care groups

IDENTIFIED AREAS OF CONCERN*:*

- The Chinchilla community, which has suffered a downturn in economic fortune over the last few years, recently experienced 14 suicides within a 12-month period.
- The Aboriginal community of Cherbourg has had a long-standing problem with suicide, at a rate which is significantly above that of general rural and remote communities. Over the last year, up to five suicides have occurred in the community.
- The ex-ADF veteran community experienced an increase in suicides, veteran- and veteran family-related preventable deaths (including possible covert deaths due to for example, single occupant, single vehicle collisions, at excessive speed, on straight roads, in good conditions), domestic violence, and violence against children in the past year in the Darling Downs Police District (Toowoomba, Southern Downs and Goondiwindi regions).

RESOURCES AND COORDINATION

- Perceived information gap between clinical and community people
- A lack of coordination of these activities across the region, with many of them conducted by local champions and volunteer groups who often don't communicate with others outside their immediate context. Interagency communication is also an issue for many people working in the region

- Some at-risk people are lost in the transition between services
- Access barriers, including the cost of privately funded services, waiting times to see bulk billing psychologists or psychiatrists, and an insufficient or stretched workforce, are also of concern
- Clear referral pathways are needed. Health professionals need to better understand their referral options when someone is identified as at risk of suicide
- There are gaps in integrated delivery of services, particularly in the referral process for people at risk of suicide
- There is a strong feeling that for effective suicide prevention, efforts must be targeted to populations before mental health problems become obvious and cause concern. This highlights the need for a focus on young people and children, families and communities in general, particularly targeting at-risk groups.
- The negative stigma surrounding discussions about suicide needs to be addressed so that entire communities feel comfortable addressing any suicide issues they are confronted with

GAPS IDENTIFIED:

- Workforce
- Timely and affordable access to treatment
- Youth Services
- Culturally Appropriate Care
- Coordinated Advice
- Carer Support
- Shared patient information
- GP training costs time away from clinical service delivery
- Discharge into community without any community engagement, particularly regarding Aboriginal and Torres Strait Island people
- Continuity of care into community
- Existence of professionally supervised peer-support teams
- Community suicide prevention and awareness programs
- School based peer support and mental health literacy

MENTAL HEALTH CARE

EMERGENCY DEPARTMENT PRESENTATIONS

Mental health presentations were identified by ICD-10 code of primary diagnosis. Presentations that included any “F” code, or "X84","R45.81","R41.0" were flagged as mental health related. There were 243,048 presentations to emergency departments in the region for the 2017-18 financial year. Of these, 4.5% were related to mental health.

The nature of these presentations, including the hospital’s triage category indicate some scope for additional support for management of mental health in primary care. The distribution of arrival times was similar for both West Moreton and Darling Downs regions, with most presentations arriving between 10:00 and 20:00 (approximately 66% of presentations).

Darling Downs:

There were 158,980 emergency department presentations in the Darling Downs, of which 6,737 were related to mental health (4.4%). Suicidal ideation was the most common of these presentations (1,166 presentations; 17.3%), followed by anxiety (11.8%), depression (8.1%) and reaction to severe stress (7.1%). The mean age for these presentations was 30.3 years for suicidal ideation, 40.8 years for anxiety, 37.4 years for depression and 33.3 years for stress. All conditions had a high age range, approximately 9-90 years. The average age of all mental health presentations was 36.9 years.

Mental health presentations were predominantly classified as category 3 (55.6%). Those classified as category 4 or 5 constituted 36.2% of these presentations. Depression and anxiety were the most common of these presentations (17.6% and 10.1%, respectively).

West Moreton:
There were 84,068 emergency department presentations in West Moreton. Of these 4,125 were related to mental health (4.9%), with a mean presenting age of 37.1 years. The highest number of these presentations was also for suicidal ideation (924 presentations; 22.4%) with a mean age of 30.1 years. Unspecified mental disorders were second-most common (7.6%), followed by intentional self-harm (7.3%), anxiety (7.0%), and depression (6.4%). Mean ages were 34.2, 26.4, 42.8 and 35.8 years respectively. Age ranges were similar to those of Darling Downs, except for intentional self-harm for which the oldest presentation was 61 years.

A large proportion of these presentations were classified as category 3 (66.3%), with category 4 and 5 constituting 20.7% of mental health related presentations. Anxiety was the most common category 4/5 presentation (14.9%) followed by suicidal ideation (10.2%).

HOSPITALISATIONS

- Mental health hospitalisation rate shows small variation to the National rate
- The highest rates are in the Ipswich Inner and Toowoomba SA3 areas – these 2 areas are the base for acute mental health admissions for their respective regions

Table MHHN3.1: Comparison Rate of Mental Health Overnight Hospitalisations for Schizophrenia and Delusional Disorders (ASR per 10,000 people) PHN, 2015-2016

	2014-2015			2015-2016		
Primary Health Network area name	**ASR**	**No. hosps. (a)**	**Bed day rate (b)**	**ASR**	**No. hosps. (a)**	**Bed day rate (b)**
National	**16**	38004	359	**19**	43588	471
Brisbane North (Qld)	**18**	1665	341	**23**	2231	806
Brisbane South (Qld)	**17**	1872	300	**20**	2189	652
Gold Coast (Qld)	**14**	765	249	**17**	936	458
Darling Downs & West Moreton (Qld)	**15**	**749**	**403**	**17**	**852**	**698**
Western Queensland	**12**	82	109	**15**	107	179
Central Qld, Wide Bay & Sunshine Coast	**13**	972	241	**17**	1260	517
Northern Queensland	**17**	1156	334	**22**	1521	603
SA3						
Darling Downs West-Maranoa (Qld)	**11**	**46**	**133**	**11**	**45**	**154**
Darling Downs-East (Qld)	**8**	**31**	**184**	**12**	**49**	**216**
Toowoomba (Qld)	**18**	**253**	**762**	**22**	**309**	**1677**

Ipswich Hinterland (Qld)	10	59	170	8	47	275
Ipswich Inner (Qld)	19	187	458	23	232	553
Springfield-Redbank (Qld)	9	67	176	13	103	264

Footnotes
a Number of mental health overnight hospitalisations
b Rate of mental health overnight bed days per 10,000 people, age-standardised

ANXIETY AND DEPRESSION

Mental health disorders can vary in severity and be episodic or persistent in nature. A recent review estimated that 2–3% of Australians (about 730,000 people based on the estimated 2016 population) have a severe mental health disorder, as judged by diagnosis, intensity and duration of symptoms, and degree of disability caused. This group is not confined to those with psychotic disorders and it also includes people with severe and disabling forms of depression and anxiety. Another 4–6% of the population (about 1.5 million people) are estimated to have a moderate disorder and a further 9–12% (about 2.9 million people) a mild disorder. Mental and behavioural disorders, such as depression, anxiety and drug use, are important drivers of disability and morbidity.

DARLING DOWNS AND WEST MORETON REGION

- Highest percentage (nationally) of clients self-reporting current anxiety and 4th highest self-reporting current depression
- Highest percentage of clients reporting “recent suicidal thoughts and suicidal”
- Highest mean screening scores on all three assessments
- Smallest percentage improvement nationally in K10 scores after treatment
- High number of prescribed antidepressants and anxiolytics
  - 2.5% more women prescribed antidepressants in the PHN than national proportion (9.9%)
  - More than twice the proportion of anxiolytic use in Outer Regional areas (ASGC-RC 3) of the PHN (3.1%) than national rate (1.5%)

LONELINESS AND IMPACT ON MENTAL HEALTH

- Loneliness was associated strongly with poorer overall quality of life, lower happiness and pleasure, poorer psychological and mental health and a lesser ability to cope with problems.
- Loneliness was moderately associated with poorer overall physical health, poorer sleep and a worse experience with physical pain.
- Loneliness was only very weakly associated with not working or working less regularly.
- Lonely Australians were 15.2% more likely to be depressed and being depressed increased the likelihood of being lonely by 10.6%.
- Loneliness increased the likelihood of experiencing social interaction anxiety by 13.1% and being anxious about social interactions increased the likelihood of being lonely by 8.6%.
- Australians who are married/de facto are the least lonely compared to those who are single, separated or divorced. Australians over 65 are the least lonely, and other age groups report similar levels of loneliness.
- Loneliness can persist even in Australians who are well connected with their environment.
- There were no gender differences in loneliness.
- Feelings of lacking companionship were highest in young adults (62%) compared to seniors (46%).

- On average, 9.4% of respondents always felt isolated, alone and without meaningful relationships (and related survey items). Approximately 42.6% on average reported only sometimes feeling this way.
- Approximately 3.7% of respondents reported never feeling part of a group of friends or people they could turn to. For the same items, an average of 19% responded rarely feeling this way.

INDIGENOUS MENTAL HEALTH CARE

Indigenous Australians collectively face much higher levels of health risks and challenges than is found amongst the general Australian population. Research findings show that Indigenous Australians die at much younger ages than the general population. There is an increased burden of disease and injury among Indigenous Australians, due particularly to high rates of cardiovascular diseases, mental disorders, chronic respiratory disease, diabetes and cancer. Indigenous Australians are also more likely to experience disability and ill health, which in turn have further negative impacts on quality of life.

While mental health is one of the areas for which poorer outcomes are reported for the Indigenous population, there is only limited research into the extent and nature of the mental health difficulties faced by Indigenous Australians. hospitalisation rates for mental and behavioural disorders are twice as high for Indigenous as non-Indigenous Australians, and deaths due to mental and behavioural disorders are higher for Indigenous Australians across all age groups, including those under 2. Suicide death rates and hospitalisations due to non-fatal self-harm rates are also higher.

Community consultation raised the following concerns:
- Concerns centred on non-acute care; addressing physical health at the same time as mental health; and support for carers
- Noted impact to youth and children with a requirement for youth suicide and mental health programmes

Indigenous clients represent 9% of PHN funded primary mental health care service delivery (where status has been recorded)

RISK AND PROTECTIVE FACTORS FOR ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH

The following risk factors are interconnected, and a person with mental illness might show any number of them.
- Widespread grief and loss
- Stolen children
- Unresolved trauma
- Loss of identity & culture
- Discrimination and racism
- Poor physical health
- Incarceration
- Culturally inappropriate treatment
- Violence
- Substance abuse

Mental health conditions, as the underlying cause of death in Australia, rank higher in Aboriginal and Torres Strait Islander people than non-indigenous with the suicide rate being more than 2.5 times

higher. The Queensland Indigenous Burden of Disease in 2011 estimated mental disorders as contributing 20% to the overall burden

According to the PHN mental health data set (MDS) client profile 2016-2017, 2,849 clients received mental health care captured by 128 practitioners in the region. The practitioners have various backgrounds and provide primary mental health related services inclusive of social worker, occupational therapist and nurses.

There has been a total of 2,849 clients recorded with *completed* treatment sessions only. The client profile demonstrated nearly 20% Aboriginal and/or Torres Strait Islander clients from the total with male Aboriginal and Torres Strait Islanders outnumbering females proportionally from 2016 to 2017 financial year.

Table MHHN5.1: Completed Treatment Sessions, PHN Service Provision, 2017-2018

Primary mental health care (2017-2018 FY)	Female clients	Male clients
Non-Indigenous	1,493	840
Indigenous	295	221
Aboriginal	89	68
Torres Strait Islander	2	0
Both Aboriginal and Torres Strait Islander	27	24
Not stated	177	129
Total clients (closed treatment sessions only)	1,788	1,061

SOCIAL AND EMOTIONAL WELLBEING

Following the National Apology Australia's Indigenous Peoples, and as part of the Council of Australian Governments' Closing the Gap strategy, funding is provided to the Aboriginal and Torres Strait Islander Healing Foundation to address the harmful legacy of colonisation, in particular the history of child removal that has affected Aboriginal and Torres Strait Islander people. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-23 published in October 2017 provides a dedicated focus on Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health. It sets out a comprehensive and culturally appropriate stepped care model that is equally applicable to both Indigenous specific and mainstream health services.

CHILD AND YOUTH

A national household survey, the Australian Child and Adolescent Survey of Mental Health and Wellbeing, was conducted for the second time in 2013–14 (also referred to as the '*Young Minds Matter' survey*). Common mental disorders covered in the survey included major depressive disorder, anxiety disorders, attention deficit hyperactivity disorder (ADHD) and conduct disorder. The prevalence of mental health disorders for 4–17-year olds decreased with increasing severity, with 8.3% having 'mild' disorders, 3.5% 'moderate' and 2.1% 'severe' disorders. Importantly, the higher prevalence conditions, such as ADHD and Anxiety disorders, were more likely to be rated as having 'mild' and 'moderate' than 'severe' impact. Major depressive disorder was the only condition in which 'mild' impact was less common than 'moderate' and 'severe' impact.

Almost 1 in 7 (13.9%) children and adolescents aged 4–17 years were assessed as having mental health disorders in the previous 12 months, which is equivalent to about 586,000 (based on the

estimated 2016 population) children and adolescents. *Attention Deficit Hyperactivity Disorder* (ADHD) was the most common mental disorder (7.4% of all children and adolescents, or about 312,000 based on the estimated 2016 population), followed by *Anxiety disorders* (6.9% or about 291,000), major *Depressive disorder* (2.8% or about 118,000) and *Conduct disorder* (2.1% or about 89,000). Almost one third of children and adolescents (30.0% or 4.2% of all 4–17-year olds) with a disorder had 2 or more mental health disorders at some time in the previous 12 months.

Consultation across the region has identified child and youth mental health as an area of concern, particularly as a result of trauma and intergenerational effects (e.g. parental mental health, domestic violence)

SELF-HARM, SUICIDAL IDEATION AND ATTEMPTED SUICIDE

The relationship between suicide and previous self-harm behaviours is strong, with around half of young people who die by suicide having previously engaged in self-harm behaviours. While suicide is uncommon among young people aged 0–14, it is the leading cause of death for young Australians aged 15–24.

11% of young people aged 12–17 have ever self-harmed, which equates to around 186,000 adolescents. However, these figures are likely to be an underestimate, with around 7.5% of survey (Young Minds Matter) respondents preferring not to answer questions about self-harm. Females aged 16–17 had the highest prevalence of ever having harmed themselves (23%), over 3 times the rate of males of the same age. Self-harm was shown to be most commonly associated with Major Depressive Disorder, with nearly half of all females with the disorder having ever self-harmed.

One in 20 young people (5.6%) aged 12–15 had thoughts of suicide in the 12 months prior to the survey. The suicidal ideation rate for 16–17-year olds was greater than the 12–15 age group: 1 in 10 (11%) had suicidal thoughts, and 7.8% had made a suicide plan in the 12 months prior to the survey. Rates were higher in females (15%) than males (6.8%) and, similar to self-harm, the strongest association between thoughts of suicide and mental health disorders occurred for those with a Major Depressive Disorder.

Mental health disorders that emerge during the formative years of childhood can have a lasting impact on the health and wellbeing of the individual and on the lives of those around them. The 2013–14 Young Minds Matter Survey results provide information on the use of services by all children and adolescents, as well as those with mental health disorders.

SERVICE USE BY 4–17-YEAR OLDS WITH A MENTAL HEALTH DISORDER

- Over half (56%) of 4–17-year olds with a mental health disorder had used services for emotional or behavioural issues in 2013–14.
- Service use comparisons with 1998 estimates can only be made for those aged 6–17 years with either Major depressive disorder, ADHD or Conduct disorder. Service use in this group was 68% in the 12 months prior to the 2013–14 survey compared with 31% in the six months prior to the 1998 survey.
- Service use for all disorders in 2013–14 was greater for the 12–17 years age group than for the corresponding 4–11 years age group.
- The service-use profiles for each of the mental health disorders largely reflect the severity profile of each disorder: that is, disorders with a greater proportion of severe impact were associated with greater service usage rates.

- When severity is considered, regardless of disorder, 88% of young people with a mental disorder that severely affected their daily lives accessed services, compared with 73% of those with moderate disorders and 41% with mild disorders.

REGIONAL CONSULTATION

- High impact and requirement for service provision in youth mental health
- A shortage of relevant mental health services for children and adolescents across the region as indicated by long waitlists, particularly in some areas such as Cherbourg and Tara which lack Child Youth Mental Health Service (CYMHS) and are reliant on visiting specialists
- perceived overemphasis on triaging and prioritisation in CYMHS, with a need for balance between triaging and case management
- A strong correlation between poor child and adolescent mental health, high rates of juvenile crime and substance abuse in areas of socioeconomic disadvantage
- An important need to provide mental health services as early as possible to paediatric patients to avoid later developmental and behavioural issues
- Health services reported increasing incidence and complexity of child mental health presentations to Emergency Departments requiring intensive staff resources to manage, usually after-hours. It was noted that most children were discharged home or to their usual residence. The vast majority of these presentations were for suicidal ideation

HEADSPACE

headspace operates 3 centres in the PHN region – Ipswich, Toowoomba and Warwick – which together service approximately 400-600 young people each month (approximately .43% of persons aged 10-24 in the region). Headspace clients were more likely to be female (60.5% in Ipswich, 57.8% in Toowoomba) except in Warwick where males constituted 57.6% of clients.

Approximately 63% were between 12 and 17 years of age. The PHN region has a higher proportion of 12-14 year old clients (30.9%) compared to the national Headspace figure of 22.1%. The region also has a slightly higher proportion of Aboriginal and Torres Strait Islander clients (12.7% vs 8.2% nationally).

The nature of these services is predominantly classed as 'mental health' (67.0% for Ipswich, 79.5% for Toowoomba, 57.0% for Warwick), with the broad reason for a client's visit being 'Problems with how I feel' (63.5-74.0%). Between 15% and 30% of services are for engagement and assessment. The overall distribution of these services in the PHN is comparable to the national Headspace data, with mental health services comprising 65.0% and engagement and assessment at 23.5%.

Regionally, Warwick had a much higher component of general assistance/care coordination with 21%, compared to less than 2% in the other centres nationally. Darling Downs and West Moreton Headspace centres also saw a smaller proportion of physical (1.8% vs 3.1%) and sexual health problems (.2% vs 1.1%).

The Toowoomba centre was more likely to see cases of higher severity with 47.4% of clients presenting at Stage 2 (threshold diagnosis) compared to less than 30% in the other centres and 20.1% nationally, and Stage 4 (ongoing severe symptoms) at 22.8% compared to 3.7% nationally. Only 2.2% of Toowoomba clients required no diagnosis compared to approximately 30% in the other centres, and there is a higher proportion of depressive and anxiety disorders (30.9% and 25.7%

respectively) compared to the national figure of 20.1% and 14.9%, respectively. Further, the Toowoomba centre was more likely to refer clients to specialist care (38.9% vs 20.4% nationally).

Wait times were typically 1-2 weeks nationally. The distribution of wait times in the PHN region was longer, with 25.1% being seen in 1-2 weeks (compared to 33.6% nationally) and 25.6% seen in 3-4 weeks (compared to 16.5% nationally) and 22.6% waiting longer than 4 weeks (compared to 10.4% nationally).

Headspace Ipswich typically had wait times of around 3-4 weeks (34.9%) and 1-2 weeks (26.4%) while Toowoomba predominantly saw clients after 4 weeks (41.1%). Headspace Warwick largely saw clients within 1-2 weeks (39.5%). These wait times were reflected in clients' perceptions of whether they waited too long. In Ipswich 19.6% reported waiting too long for service, compared to 31.2% in Toowoomba and 8.6% in Warwick.

There were only slight reductions in distress (K10 scores) between the beginning and end of episodes of care in both the PHN regional centres and the national figures, however client satisfaction was universally high (over 4 on a 5-point scale) for the domains – general, centres and staff. Satisfaction with outcomes achieved was slightly lower, averaging 3.7 to 3.9, comparable with the score of 3.8 nationally.

OUTCOMES

Psychological therapies delivered by PHN funded mental health professionals to underserviced groups demonstrated a 0.2% completion of episodes of care with recorded outcome measures at Episode Start and Episode End.

Due to the small proportion of outcome measures at both Episode Start and Episode End, a reliable repeated-measures analysis of client outcomes was not possible. However, an independent groups comparison of the K10 for the cohort of patients at intake compared to those at review or discharge was possible.

There were 141 recorded K10 measures in the Minimum Data Set. Where a client had more than one K10 recorded (e.g. for both Episode Start and Episode End), the most recent report (Review or Episode End) was kept in order to establish independent groups. There were 64 clients in the Episode Start group, 20 in Review and 31 in the Episode End group.

A one-way analysis of variance was used to examine differences in level of distress (K10 score) between the different cohorts. Levene's test confirmed homogeneity of variance ($p=.904$).

Patients at either discharge or review had lower levels of distress than those at intake ($F(2,112)=16.91$, $p < .001$). Pairwise comparisons (applying the Bonferroni correction for Type I error) showed that patients at review were on average 10.47 points lower in distress than those at intake (95% Confidence Interval [5.41, 15.52]), and patients at discharge were on average 7.93 points lower in distress than those at intake (95% Confidence Interval [3.61, 12.25]).

These results demonstrate meaningful reduction in levels of distress for patients accessing mental health services, for instances with available K10 outcome measures. Improving the assessment and reporting of outcome measures by service providers is a key priority toward validating this finding.

UTILISATION OF MBS AND BETTER ACCESS

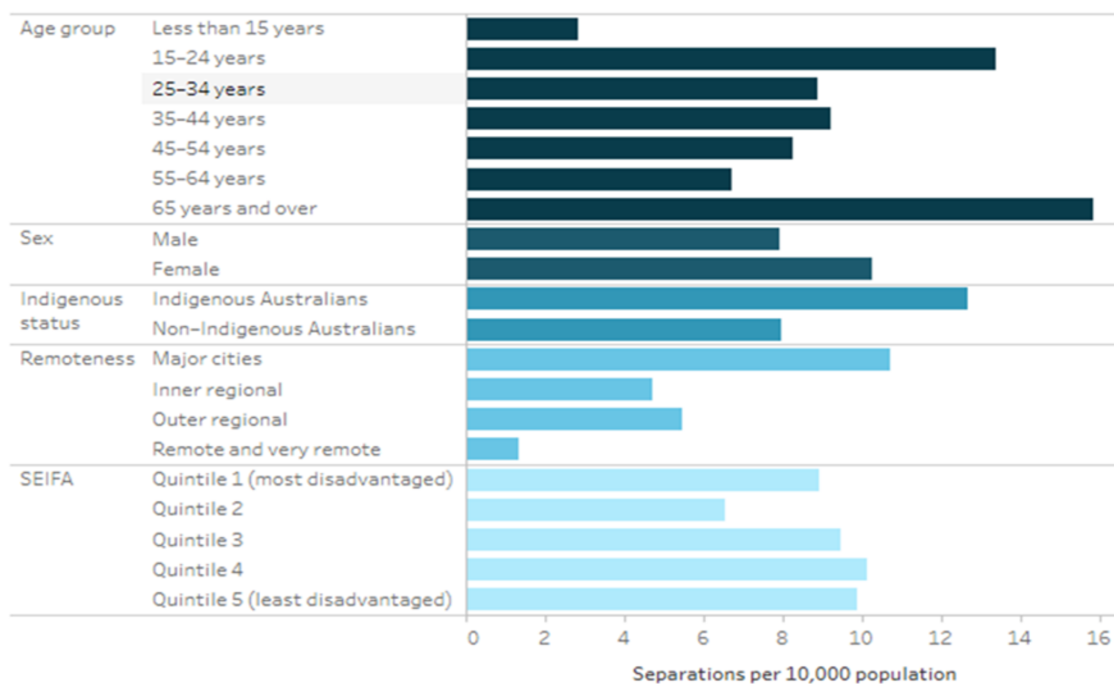
- Utilisation of MBS mental health services from GPs decreases relative to national rate as rurality increases - remote areas of the PHN (ASGC-RA 4) GP service rate is half the national rate (which is 2.8%)
- Inconsistent utilisation of Better Access mental health services across the region - Ipswich Inner has above national rate for patients using Better Access services and Toowoomba has above national rate for Better Access services provided but both rate of patient access and services provided in Darling Downs (West) - Maranoa is less than half the national rate

HOSPITALISATION VS COMMUNITY CARE

Depending on a person's needs, the severity of symptoms, their level of distress and risk of harm to either themselves or others, mental illness treatment may be provided in their own environment in the community, or in hospital within a specialist mental health inpatient unit.

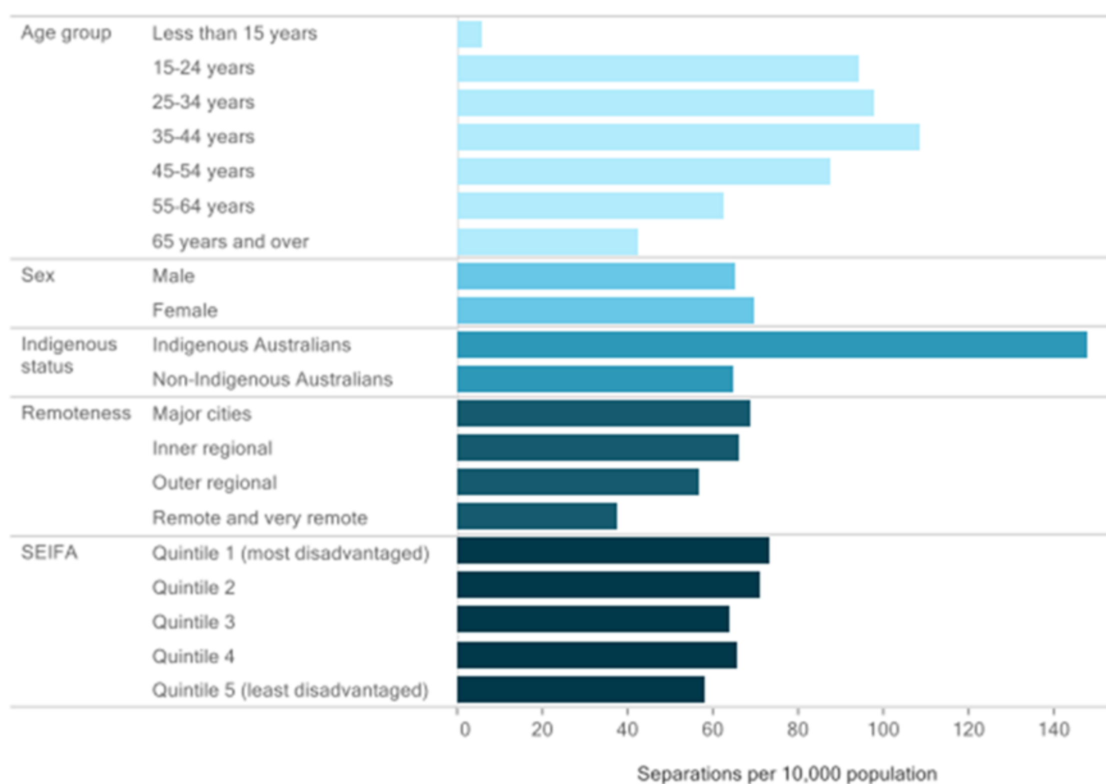
- Demonstrated longer length of stay for mental health hospitalisations with a disparity between bed day and hospitalisation rates
- The PHN ranks in the top 8 PHNs (of 31) for Intentional self-harm hospitalisations and bed days
  - Hospitalisation rates high compared to national rates for residents from Granite Belt, Ipswich Inner, Caboolture Hinterland and Burnett SA3 areas
  - Bed days high for Ipswich Hinterland, Ipswich Inner, Caboolture Hinterland and Burnett SA3 areas
  - Bed day rate low in Darling Downs (West) – Maranoa
- Limited availability of affordable or accessible care in the community
- Difficulties with stepping down patients, especially rural patients, due to a lack of appropriate psychosocial supports in the community to facilitate post-discharge care
- Lack of low-intensity, early intervention services for mild-to-moderate patients in the community, resulting in unnecessary hospitalisations of patients to hospitals - the rising complexity of patient needs has been cited as raising the threshold for care in the community, making it difficult for patients to access low-intensity counselling appropriate for their acuity
- Lack of dedicated wards for patients over the age of 65 with mental health disorders in rural hospitals

Table MHSN2.1: Same Day Public Admitted Mental Health-Related Separations with Specialised Psychiatric Care, by Demographic Category, Australia, 2016-17



Data form the same day admissions and overnight (on following page) show a significantly larger number of admissions of Aboriginal and Torres Strait Islander people. While people aged 65 years and over have a larger number of same day admissions, people aged 35-44 have more overnight admissions. The most frequent admission diagnosis for same day hospitalisations was depressive episode (23.0%), followed by other anxiety disorders (9.3%) and schizophrenia (8.6%).

Table MHSN2.2: Overnight Mental Health-Related Separations with Specialised Psychiatric Care, by Demographic Variable, Australia, 2016-17



The most frequent principle diagnosis of overnight admitted patients was schizophrenia (14.7%) followed by depressive episode (14.4%) and reaction to severe stress and adjustment disorders (10.0%).

PSYCHOSOCIAL

The National Psychosocial Support (NPS) measure aims to support people with a severe mental illness and psychosocial functional impairment who are not more appropriately supported through the National Disability Insurance Scheme (NDIS), for non-clinical mental health services, improved coordination and care for individuals with psychosocial disability. Further, it is designed to provide support services targeted to assist those who are not receiving psychological services through other programs such as Partners in Recovery, Day to Day Living or Personal Helpers and Mentors.

Estimates were derived using the age distribution for severe mental illness prevalence in the National Mental Health Service Planning Framework (NMHSPF; 3.1% for persons 65 years and over, and 3.0% for persons under 65).

Persons 65 years and over are not eligible for the NDIS. Other characteristics of eligibility for the NDIS requires complicated case-by-case consideration. A recent report from the Partners in Recovery program stated that 43/246 (17.5%) NDIS applications had not met the eligibility criteria and were undergoing further work. This proportion was used to anchor an arbitrary estimate of 25% of persons under 65 with severe mental illness who would require services under the NPS.

That is, potential demand for services is estimated as all persons 65 years and older with severe mental illness, plus 1 out of 4 persons under 65 with severe mental illness.

Table MHSN4.1: Estimated NPS annual demand (NMHSPF-based estimates)

Region	Under 65	65+	Total

Darling Downs	1751	1610	3361
West Moreton	1914	1091	3005
Total	3665	2701	6366

Using the NMHSPF It is estimated that the workforce of individual peer workers for this cohort is at least 33 FTE for the Darling Downs region and 35 FTE for the West Moreton region, for a forecast 32,000 hours of client demand on average. Group peer work is estimated at 1 FTE for each region for an approximate 5,600 hours of client demand on average.

SURVEY OF DISABILITY, AGEING AND CARERS

Estimates for the prevalence of psychosocial disabilities were taken from the 2015 Survey of Disability, Ageing and Carers (SDAC) and applied to the 2017 estimated resident population for the PHN. The distribution of age-specific prevalence for Queensland reflected that of all Australia (less than 1% difference for each age group, except for 25-34 years which had a 1.2% difference between Queensland and Australian prevalence).

The SDAC defines psychosocial disability as any:

- nervous or emotional condition that restricts everyday activities,
- mental illness or condition requiring help or supervision,
- memory problems or periods of confusion that restrict everyday activities, or
- social or behavioural difficulties that restrict everyday activities.

The SDAC estimated that in 2015 there were 208,500 Queenslanders with a psychosocial disability, representing 4.4% of the 2015 estimated resident population. Approximately 70.1% of this estimated cohort is under 65 years of age.

Applying the same estimation rubric (1 in 4 persons under 65 and all persons over 65) to this cohort arrived at the following estimates of NPS service demand:

Table MHSN4.2: Estimated NPS annual demand (SDAC-based estimates)

Region	Under 65	65+	Total
Darling Downs	1717	673	2389
West Moreton	1877	456	2332
Total	3593	1128	4722

The SDAC definition of psychosocial disability does not precisely define the characteristics of those expected to require services provided for psychosocial support as outlined in the PHN Psychosocial Support Guidance. However, the SDAC reports that 94.9% of persons with a psychosocial disability need assistance with at least one activity. Most notably, 84.9% needed assistance with cognitive or emotional tasks.

Further, the reliance on government pensions in those with psychosocial disabilities is much higher than that of other disabilities (66.8% vs. 32.1%) and have a much lower capacity to support themselves through wages or salary compared to other disabilities (15.6% vs. 44.8%). Over half (56.9%) required equipment and aids for at least one activity, including medical aids for managing health conditions (23.9%).

Overall, large proportions of this cohort experienced difficulties that may be eligible for non-clinical services under the NPS, however only 2.1% reported that needs for assistance were not met, and 47.5% reported that needs were partly met:

Table MHSN4.3: Area of Assistance Required, NPS

Area in which assistance is required or difficulty experienced	Proportion (%)
Self-care (core)	42.0
Mobility (core) (excludes walking 200m, stairs and picking up objects)	54.8
Oral communication (core)	21.7
Core activity subtotal(a)	*63.6*
Cognitive or emotional tasks	84.9
Health care	50.7
Reading or writing tasks	29.7
Private transport	41.4
Household chores	38.6
Property maintenance	40.1
Meal preparation	22.3
All persons needing assistance or experiencing difficulty with at least one activity	*94.9*
Assistance not needed and difficulty not experienced with any broad area of activity	4.9
Total	**100.0**

IMPLICATIONS FOR THE DARLING DOWNS AND WEST MORETON PHN REGION

Currently, only broad estimates from the abovementioned resources have been applied to the Darling Downs and West Moreton region. The prevalence figures modelled in the NMHSPF are national estimates, useful for anchoring an estimate of local prevalence but it is well-known that these models do not currently account for rural variations or Aboriginal and Torres Strait Islander populations.

Similarly, estimates from the SDAC are at the Queensland level and have been applied proportionally to the PHN region. In the last financial year, regional activity recorded in the Primary Mental Health Care Minimum Data Set (PMHC MDS) reported 7.4% of episodes were for persons 65 years and older. Clinical care coordination and complex care packages accounted for only 7.5% of the total number of episodes and approximately 10% of this activity was for persons 65 and over. A fraction of these may also require NPS services, however there are currently no robust local estimates of this demand.

The development of adequate promotion and referral lines to NPS services within other providers of primary care will also provide a platform for monitoring prevalence and demand.

COMMUNITY CONSULTATION

People sharing stories provides rich understanding of their journey as they navigate an ongoing journey to wellness. The PHN Darling Downs Mental Health Consumers and Carers Consultation Workshop provided valuable insight into what is working well and into individual experiences. Stories were able to provide a real perspective:

- Connecting with General Practitioners

  - Time taken to obtain an appointment – can take days
  - Having to self-manage while waiting for appointment and then GP unable to provide correct reports or not being willing to truly help
  - When unwell, can't leave the house
  - If well enough to access the support, may cause other access issues
- Rural Support
  - Benefits of peer support to escort to hospital however no further follow up
  - Restrictions caused by living in rural areas
  - Understanding that this is a 'rest of my life' health issue and the need for self-management not just medication
  - Questioning if video and tele-chat can actually work
  - Understanding what is required for rural support
- Peer Support
  - Own experience – in and out of A&E for 20 years, being tested for everything to finally find answers
  - Experience leading to a story of growth
  - Belief that peer support saves lives
  - Ongoing understanding that health is interconnected – the physical can affect the mental
  - Provides a diversity of service
  - Reshaping long held ideas
  - Benefits of being able to recover quickly at home with peer support

Further discussions with stakeholders and community focused on specific areas of support with the following feedback recorded.

Table MHSN4.4: Consumer and Carers Workshop 2018 - Housing

Working Well	Barriers
Community housing hub	Public housing through real estate is hard
Having peer support in completing forms	Cost
Taught living skills	Lack of suitable accommodation
Transitional respite	Pets not being allowed
2-week rental grants	Shared housing is extremely difficult (sensory issues)
Having pensioner discounts	Emergency lack of support
Cleaning packages	Lack of family support
Having a pet	Maintenance
Security	Rent assistance is low
Managing meals	Can't live independently
Having more choices	Bonds are difficult to get
Peer support	Getting blacklisted
Services to maintain	Processing times are long
Things are starting to work	Rising living costs
	Boarding houses are difficult
	Rental inspections anxiety
	Public housing tenancy act is restrictive

Table MHSN4.5: Consumer and Carers Workshop 2018 – Coordinated Support

Working Well	Barriers
Police referrals are effective to NGOs	Privacy paper work is bulky
GPs to psychologists	Staff turnover
Good PIR or peer support worker	Not enough training

Needing good caring people	No communication
	More staff
	No choice
	Anything happening after treatment is i=unlikely
	Rural issues
	NDIS doesn't provide enough direction
	Access criteria

Table MHSN4.6: Consumer and Carers Workshop 2018 – Non-Government Services

Working Well	Barriers
When it works, it works well	NGOs are understaffed
Less staff turnover – good not to repeat story	People can fall between the cracks
Taking pressure off hospitals	Changing to NDIS policies is difficult
NDIS plans	Inter-agencies are gone
Home support plus	Lack of crisis options
Recovery focused	Communication could be better
Lifeline access	No support in NDIS packages
Transport has improved	We're getting less support and there's no consistency
Neighbouring funding	A lack of availability of support workers
Lived experience for all	Funding is essential
More peer workers	Transport access in rural areas
More programs	Complex needs are being rejected
More government funding	NDIS funding to NGOs is falling
Growth in group funding	People taking advantage of the system – need to support people in the right way
PIR has come a long way	Lack of services in rural sector
	Lack of recovery programs – how can we help ourselves
	Knowing who is calling and having access without anxiety

Table MHSN4.7: Consumer and Carers Workshop 2018 – General Practitioners

Working Well	Barriers
Bulk billing services	Treatment authority
Tele-health	Not enough time spent with GPs
Having the choice of doctor	Rural area disadvantage
Having a good rapport	Not enough mental health training
Having peer support	Family care and medication – creating treatment plans
Psychologists	Costs have risen
Ensuring they're good communicators	No-shows
Utilising GPs for more services	Hospital waiting times are too long
Having peer workers to come along to appointments	Under-staffed
Access to hospitals	Lack of listening
Some free access to GPs	Trouble in communication
Being able to shop around	Not enough visits in the mental health plan
	Not enough diverse skills
	Making assumptions
	Gap payments required
	Lack of continuity
	Over medicated
	'Uber' peer support

Table MHSN4.8: Consumer and Carers Workshop 2018 – Hospital Services

Working Well	Barriers
Employing peer support	Too many clients
Outsourcing of services – a community of peers is formed	Clinicians not trained to work with peer workers
Consumer advocates	Rural is non-existent
Choosing a support team	No peer support in rural or A&E
Medication and education	No support or safety in the wards
Staff are better trained	Repeating the story each visit
Daily access is good	Issues with early discharge
Efficient	Previous bad experiences
Polite bedside manner	
Buildings are being improved/ New wind St Andrew's	

CARERS AND FAMILIES

While there is general recognition of the impact on families and carers of those with mental illness, consultation highlighted the need for greater ongoing support for those caring for people with mental illness

WORKFORCE

A range of health care and community welfare professionals, including psychiatrists, psychologists, nurses, general practitioners and social workers, provide the various mental health-related support services available in Australia. Throughout the region, there is a need for enhanced mental health, drug and alcohol services, especially in smaller rural and regional towns with stronger links and referral pathways to Toowoomba Hospital, to manage the rising prevalence of mental health and AOD conditions in the region.

Table MHSN7.1: Current PHN Primary Mental Health Funded Service Provision

Organisation_Type	Number
Private Psychiatry Practice	4
Private Allied Health Professional Practice	60
Community-managed Community Support Organisation	5
Aboriginal Health/Medical Service	1
General Medical Practice	4
Division of General Medical Practice	1
Other	6
Missing	2
Total	83

COMMUNITY CARE

Further longer-term measures to improve the resilience of rural communities to handle drought conditions are being developed across Government in response to the issues raised with the Prime

Minister, Deputy Prime Minister and Agriculture Minister during our listening tour of NSW and Queensland in early June.

Funding takes into account the mental toll drought takes on farmers, families and rural communities and embeds an Empowering Communities program that allows local communities to tailor local mental health responses to their needs.

Map of the drought affected communities in our PHN below:
The PHN has conducted 2 round tables consultations to date (1 other is planned):

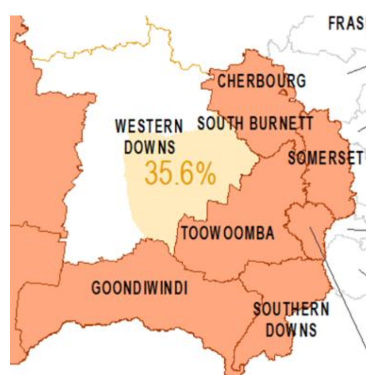
- 29/10/2018 – Inglewood for the Southern Downs and Goondiwindi
- 30/10/2018 – Toowoomba, Western Downs, South Burnett and Cherbourg

Issues identified include:

- Cost of services, assistance with psychologist travel and travel to psychologist assistance.
- Lack of knowledge about available services.
- People seeking help at last minute and wanting help then and there.
- Trust/respect required for rural people to seek help and to create a moment of reaching out.
- One bad experience makes people wary of seeking assistance.
- Reduction in community events with reduction in population level.
- Pride and stigma prevent help seeking.

Funded service ideas identified:

- Key community members could be trained to provide light touch counselling, referrals to PHN services, financial assistance. Builds a sustainable network of support staff that can continue after funded support network is not available. Clinical supervision to be wrapped around key community members to prevent/mitigate vicarious trauma.
- Localised events with a draw card. Not metal health branded but with an aim to get harder to reach community members to talk and engage.
- Shed sessions wrapped around agribusiness activities to bring attention and acceptance of mental health.
- Increased knowledge of services available required to refer people to. Increased availability of services by advertising – pocketbooks, magnets.



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Drug and Alcohol Misuse

HARMFUL USE

Alcohol and illicit drug use are serious and complex issues that contribute to substantial illness, disease, injury, and deaths in Australia. Alcohol consumption is associated with an increased risk of chronic disease, injury and premature death. Illicit drug use can have severe health effects, including poisoning, mental illness, self-harm, suicide and death by accidental poisoning (overdose).

- The burden due to amphetamine use is projected to rise by 14% between 2011 and 2020
- 4.6% of all disease burden in Australia was from alcohol use alone, of which one-third was due to alcohol dependence
- The burden from alcohol use fell slightly between 2003 and 2011 and further reductions are expected by 2020
- 41% illicit drug use burden was from opioids, followed by amphetamines (18%), cocaine (8%) and cannabis (7%)

The Darling Downs and West Moreton PHN region was the second lowest *drug and alcohol use* related overnight hospitalisations in 2015-2016. This was followed by Central, Wide Bay and Sunshine Coast PHN.

Table ADSN1.1: Rate of Overnight Bed Days (per 10,000people, ASR), 2015 - 2016

Indicator	DDWM PHN	National	DDWM PHN	National
Drug and alcohol use	16	20	85	145

ALCOHOL CONSUMPTION (2014-15)

The estimated number of people aged 15 years and over who consumed more than two standard alcoholic drinks per day on average (modelled estimates) for the PHN region is 16.1 (ASR per 100). This places the region as the 22nd highest (out of 31 regions). The rate for all of Australia is 16.7 and Queensland is 17.2. The top 5 SA2 areas are:

- Clifton-Greenmount/ Southern Downs – 22.6
- Chinchilla/ Miles – Wandoan/ Roma/ Roma region – part a – 21.1
- Banana/ Biloela – part a – 20.8
- Millmerran/ Pittsworth/ Wambo – 20.0
- Middle Ridge/ Rangeville/ Toowoomba – East – 19.7

CURRENT SMOKERS (2014-15)

The Estimated number of people aged 18 years and over who were current smokers (modelled estimates) for the PHN region is 18.7 (ASR per 100). This places the region as the 15th highest (out of 31 regions). The rate for all of Australia is 16.1 and Queensland is 17.0. The top 5 SLA areas are:

- Kingaroy Region – North/ Nanango – 28.3
- Bundamba/ Riverview – 23.3
- Ipswich – Central/ North Ipswich – Tivoli – 22.1
- Springfield – Redbank – North – 21.8
- Warwick – 21.7

NATIONAL DRUG STRATEGY HOUSEHOLD SURVEY (NDSHS), 2016 – MAIN POINTS

Tobacco Smoking

- While smoking rates have been on a long-term downward trend, for the first time in over two decades, the daily smoking rate did not significantly decline over the most recent 3-year period (2013 to 2016).
- There were fewer teenagers smoking—the proportion who had never smoked more than 100 cigarettes significantly increased between 2013 and 2016, from 95% to 98%.
- Smokers smoked fewer cigarettes in 2016 than in 2001—the average number of cigarettes smoked per week declined from 110 to 94 cigarettes.

Alcohol Use

- Compared to 2013, fewer people in Australia drank alcohol in quantities that exceeded the lifetime risk guidelines in 2016
- Young adults were drinking less
- Fewer 12–17-year olds were drinking alcohol and the proportion abstaining from alcohol significantly increased from 2013 to 2016
- More people in their 50s were consuming 11 or more standard drinks in one drinking occasion in 2016 than in 2013
- Fewer people reported being a victim of an alcohol-related incident

Illicit Use of Drugs

- Declines were seen in recent use of some illegal drugs in 2016 including meth/amphetamines (from 2.1% to 1.4%), hallucinogens (1.3% to 1.0%), and synthetic cannabinoids (1.2% to 0.3%)
- About 1 in 20 Australians had misused pharmaceuticals in 2016
- Crystal/ice methamphetamines continued to be the main form of methamphetamines used in 2016. here was a significant decline in recent meth/amphetamine users who used powder as their main form
- Australians now consider meth/amphetamines to be more of concern than any other drug
- More people reported being a victim of an illicit drug-related incident in 2016

Table ADSN2.1: Recent Illicit Use of Any Drug, People 14 years +, 2001 – 2016

Table 7.14: Recent illicit use of any drug[a], people aged 14 years and older, by state/territory, 2001 to 2016 (per cent)

State/territory	2001	2004	2007	2010	2013	2016
NSW	15.6	14.6	12.1	13.8	14.2	14.7
VIC	15.9	14.3	12.8	13.7	14.3	15.0
Qld	**16.3**	**15.9**	**13.7**	**15.1**	**15.5**	**16.8**
WA	21.7	17.3	16.2	18.6	17.0	16.8
SA	17.6	15.4	14.7	14.9	15.7	15.7
Tas	14.4	15.4	14.8	12.0	15.1	17.4
ACT	17.8	17.6	13.8	13.9	15.3	12.9
NT	28.7	26.0	20.4	21.3	22.0	21.6
Australia	16.7	15.3	13.4	14.7	15.0	15.6

(a) Used at least 1 of 16 illicit drugs in 2016 - the number and type of illicit drug used varied between 1998 and 2016.

Table ADSN2.2: Summary of recent(a)drug use, people aged 14 years or older, by state/territory, 2010 to 2016 (per cent)

Summary of recent[a]drug use, people aged 14 years or older, by state/territory, 2010 to 2016 (per cent)		
	Qld	**Australia**

Risk status	2010	2013	2016	2010	2013	2016
Current smoker	19.7	17.4	**17.2**	18.1	15.8	**14.9**
Recent drinker	83.2	80.4	**79.8**	80.5	78.2	**77.5**
Illicit (excluding pharmaceuticals)						
Cannabis	11.0	11.1	**11.9**	10.3	10.2	**10.4**
Ecstasy[b]	2.7	2.4	**2.1**	3.0	2.5	**2.2**
Meth/amphetamine[c]	1.9	2.3	**1.5**	2.1	2.1	**1.4#**
Cocaine	1.3	2.0	**2.1**	2.1	2.1	**2.5**
Hallucinogens	1.4	1.2	**0.9**	1.4	1.3	**1.0#**
Inhalants	0.6	0.8	**1.0**	0.6	0.8	**1.0**
Heroin	*0.1	**<0.1	****0.1**	0.2	0.1	**0.2**
Ketamine	**<0.1	**0.2	***0.2**	0.2	0.3	**0.4**
GHB	*0.1	n.p.	**n.p.**	0.1	*<0.1	***0.1**
Synthetic Cannabinoids	n.a	1.5	****0.4#**	n.a	1.2	**0.3#**
New and Emerging Psychoactive Substances	n.a	*0.5	****0.4**	n.a	0.4	**0.3**
Injected drugs	0.5	*0.3	***0.3**	0.4	0.3	**0.3**
Any illicit[d]excluding pharmaceuticals	12.3	12.6	**13.7**	12.0	12.0	**12.6**
Pharmaceuticals						
Pain-killers/analgesics and opioids[c](includes OTC[e])	3.4	3.7	**n.a**	3.3	3.5	**n.a**
Pain-killers/analgesics and opioids[c](excludes OTC[e])	n.a	2.5	**4.1**	n.a	2.3	**3.6**
Tranquillisers/sleeping pills[c]	1.4	1.7	**1.3**	1.5	1.6	**1.6**
Steroids[c]	*0.2	**0.1	**n.p.**	0.1	*0.1	***0.1**
Methadone or Buprenorphine[c]	*0.2	*0.3	****0.1**	0.2	0.2	**0.1**
Misuse of pharmaceuticals[f](includes OTC[e])	4.2	4.8	**n.a**	4.2	4.7	**n.a**
Misuse of pharmaceuticals[f](excludes OTC[e])	n.a	3.8	**5.0**	n.a	3.6	**4.8**
Any illicit[f]	15.1	15.5	**16.8**	14.7	15.0	**15.6**
None of the above	14.3	16.9	**17.0**	16.6	18.5	**19.5**

NATIONAL WASTEWATER DRUG MONITORING PROGRAM*:*
Wastewater analysis is widely applied internationally as a tool to measure and interpret drug use within national populations, with the current national program in Australia representing world best practice. Wastewater analysis provides a measure of one important aspect of national health—the demand for a range of licit and illicit drugs. This report includes wastewater data from all states and territories and covers both capital city and regional sites, however regional sites are not identified within the report. The survey did not test for cannabis though will in the future.

- Alcohol and nicotine remain the highest consumed substances and methylamphetamine continues to be the most consumed illicit drug
- Increased fentanyl use is of concern, with April 2018 capital city and regional average consumption at the highest levels recorded however the study is unable to distinguish from prescribed use of fentanyl. Four regional Queensland sites are above the National regional average for consumption, whereas all Queensland regional areas, apart from one, are above the all site national average.
- Capital city cocaine and heroin average consumption exceeded regional consumption
- Regional nicotine, alcohol, methylamphetamine, MDMA, MDA, oxycodone and fentanyl average consumption exceeded capital city consumption
- Of the 23 countries with comparable reported data for the four common stimulants considered (MDMA, cocaine, amphetamine and methylamphetamine), Australia has the second highest total estimated consumption overall after the United States of America
- Oxycodone and fentanyl are legally prescribed pharmaceuticals with abuse potential. Although wastewater analysis cannot be used to differentiate between prescribed and illicit use, the

relative scale of use of these substances remain of interest. 3 Queensland regional sites are above the national average for oxycodone consumption.
- Methylamphetamine is the highest consumed drug in Queensland, highest ranking Australian consumed drug when compared to other countries and consumption 2nd only to USA when compared with various countries. Three Queensland regional sites are above the National regional average for consumption of methyl amphetamine.

PHN SERVICE PROVIDER DATA

PHN service provider data from the AIHW were examined for the 2015-16 financial year period:

PURPOSE/NATURE OF TREATMENT

- The majority of treatment episodes involved counselling (40.8%) and education (34.8%).
- Withdrawal management and rehabilitation together accounted for less than 3% of treatment episodes.
- Assessment-only episodes constituted 15.6% of episodes on average but were much more likely for episodes in relation to alcohol (19.1%), amphetamines (19.7%), heroin (49.2%) and pharmaceuticals (41.0%).

AGE AND SUBSTANCE

- Treatment episodes were more prominent in the 20-29 years age group (1356 episodes; 33.9%), followed by 30-39 (1026 episodes; 25.6%).
- Treatment related to cannabis use was most common for the Darling Downs & West Moreton, constituting 49.5% of all treatment episodes for the period. These episodes were largely for people in the 20-29 years age group (38.6%) followed by the 10-19 years group (26.4%), and the 30-39 age group (19.4%).
- Alcohol was the second-most common drug of concern in treatment, constituting 19.1% of all episodes in the period. The average age for these episodes was higher than that of cannabis treatment, with 28.2% of episodes for persons 30-39 and 27.1% for persons 40-49 years.
- Amphetamine use accounted for 17.3% of episodes, which were mostly utilised by persons 20-29 (40.3%) and 30-39 (36.7%).

GENDER AND SUBSTANCE

- Treatment was more likely to be directed to males than females (68.6% vs. 31.3%) with males receiving higher rates of treatment for heroin (74.6% vs. 25.4%) and cannabis (70.6% vs. 29.4%).

INDIGENOUS STATUS

- Persons of Aboriginal and/or Torres Strait Islander descent accounted for 21.3% of all treatment episodes.
- Approximately 1/5 of treatment episodes in all substance categories involved an Indigenous person, except for heroin (38.1%; 24 episodes).
- Indigenous status was not reported for 6.0% of treatment episodes on average.

EMERGENCY DEPARTMENT PRESENTATIONS

- Emergency departments data for the 17-18 financial year were examined. Presentations directly related to alcohol and other drugs accounted for 1460 presentations during the period (approximately 1%) of all emergency presentations. Emergency Department coding does not account for secondary or related causes for presentation, e.g. head injury related to intoxication.

CLINICAL COUNCIL CONSULTATION

- Concern that alcohol use/ misuse in the region is more problematic than can be depicted by current data
- Concern about prescription drug use, particularly opiates – over and inappropriate prescribing
- Increasing prevalence of substance abuse in communities
- Inability to qualify the extent of drug and alcohol use impact to enable better planning and response from health care workers.

HOSPITALISATIONS

The PHN region is the second lowest drug and alcohol use overnight hospitalisations followed by Central, Wide Bay and Sunshine Coast PHN in 2015-2016.

Table ADHN1.1: Drug and Alcohol Use Overnight Hospitalisations, PHN, 2015-2016 (ASR per 10,000)

2015-2016	Rate of overnight bed days			
Indicator	PHN	National	DDWM PHN	National
Drug and alcohol use	16	20	85	145

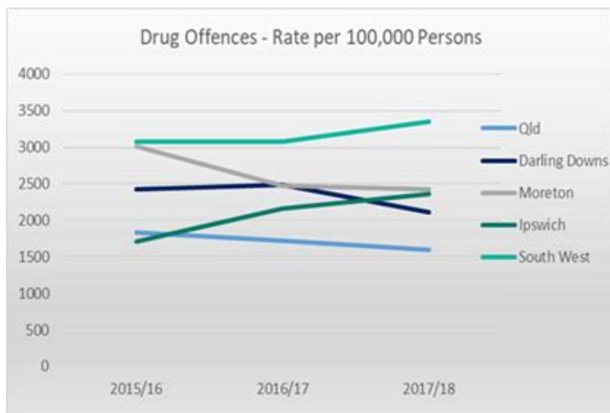
Rates of hospitalisation are equal or lower than the national rates.

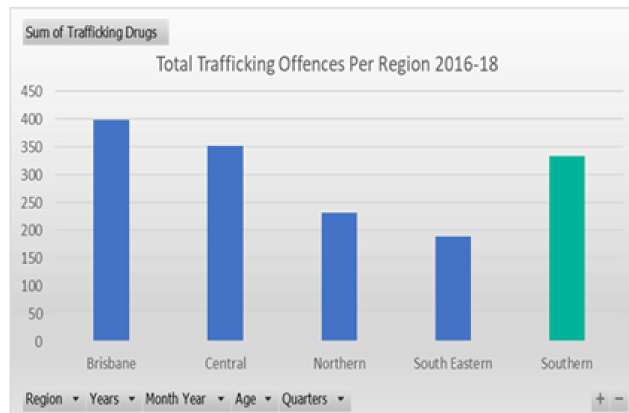
Table ADHN1.2: Rate of Mental Health Overnight Hospitalisations for Drug and Alcohol Use, PHN, 2015-2016 (ASR per 10,000)

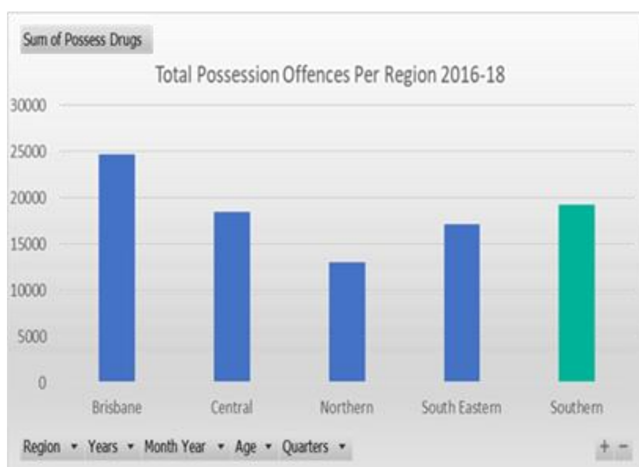
	2014-2015			2015-2016		
Primary Health Network area name	**ASR**	No. hosps.	Bed day rate	**ASR**	No. hosps.	Bed day rate
National	**18**	41685	136	**20**	46604	145
Brisbane North (Qld)	**19**	1779	131	**20**	1937	139
Brisbane South (Qld)	**16**	1714	91	**17**	1878	99
Gold Coast (Qld)	**16**	913	143	**19**	1094	156
Darling Downs & West Moreton (Qld)	**14**	717	84	**16**	816	85
Western Queensland	**31**	220	94	**32**	220	109
Central Qld, Wide Bay & Sunshine Coast	**15**	1139	91	**14**	1089	82
Northern Queensland	**18**	1224	90	**19**	1324	115
SA3 Local Area						
Darling Downs West-Maranoa (Qld)	**18**	76	60	**13**	56	61
Darling Downs-East (Qld)	**12**	49	66	**11**	44	58
Toowoomba (Qld)	**12**	180	107	**12**	172	74
Ipswich Hinterland (Qld)	**14**	81	59	**15**	86	76
Ipswich Inner (Qld)	**13**	129	76	**20**	200	109
Springfield-Redbank (Qld)	**10**	75	61	**14**	112	82

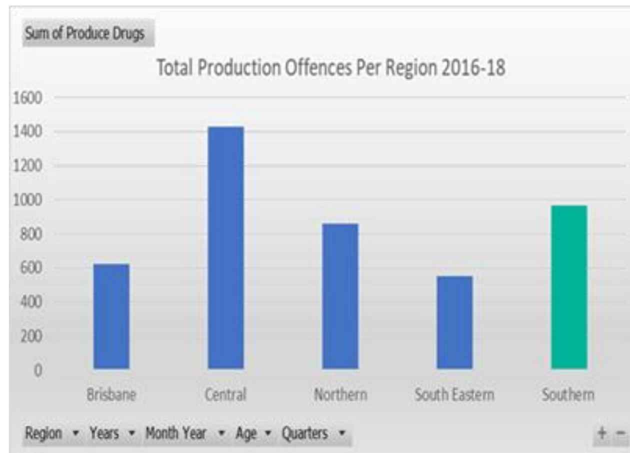
DRUG OFFENCE RATES

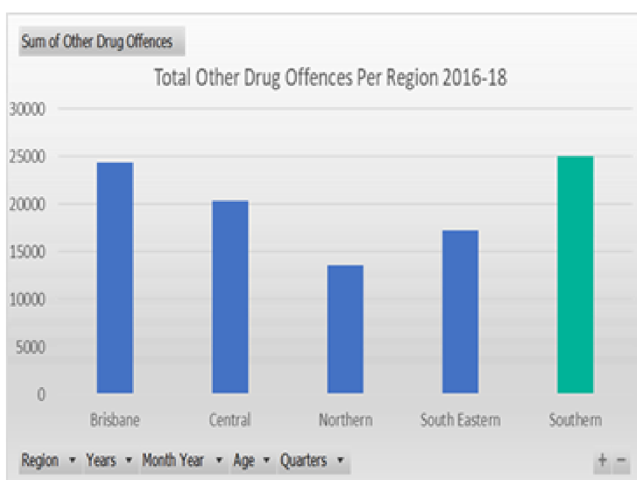
Rates of drug offences may be an indication of the extent of usage across the region. In the following graphs, the Darling Downs and West Moreton region is represented through the Queensland Police Service southern region. As compared to other regions, selling and supplying and possession offences rank the highest for the region.

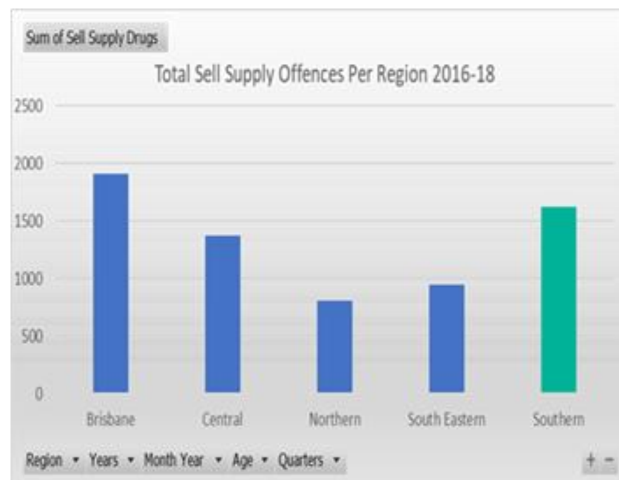

Drug Offences - Rate per 100,000 Persons
4000
3500
3000
2500
2000
1500
1000
500
0
2015/16
2016/17
2017/18
Qld
Darling Downs
Moreton
Ipswich
South West


Sum of Trafficking Drugs
Total Trafficking Offences Per Region 2016-18
450
400
350
300
250
200
150
100
50
0
Brisbane
Central
Northern
South Eastern
Southern
Region Years Month Year Age Quarters


Sum of Possess Drugs
Total Possession Offences Per Region 2016-18
30000
25000
20000
15000
10000
5000
0
Brisbane
Central
Northern
South Eastern
Southern
Region Years Month Year Age Quarters


Sum of Produce Drugs
Total Production Offences Per Region 2016-18
1600
1400
1200
1000
800
600
400
200
0
Brisbane
Central
Northern
South Eastern
Southern
Region Years Month Year Age Quarters


Sum of Other Drug Offences
Total Other Drug Offences Per Region 2016-18
30000
25000
20000
15000
10000
5000
0
Brisbane
Central
Northern
South Eastern
Southern
Region Years Month Year Age Quarters


Sum of Sell Supply Drugs
Total Sell Supply Offences Per Region 2016-18
2500
2000
1500
1000
500
0
Brisbane
Central
Northern
South Eastern
Southern
Region Years Month Year Age Quarters

Region	Drink Driving Offences 2016-18
Brisbane	**15318**
Adult	15164
Juvenile	154
Central	**19020**
Adult	18751
Juvenile	269
Northern	**13580**
Adult	13414
Juvenile	166
South Eastern	**14778**
Adult	14628
Juvenile	150
Southern	**18003**
Adult	17813
Juvenile	190
Grand Total	**80699**

ACCESS

Queensland Network of Alcohol and other Drug Agencies (QNADA) NGO AOD Services Report for the Darling Downs and West Moreton PHN illustrates that there are limited service and treatment options (such as brief intervention and counselling) in the Darling Downs and West Moreton PHN region.

There is also no Queensland Health funded withdrawal management facility in the Darling Downs and West Moreton region with clients needing to travel to the Hospital Alcohol and Drug Service (HADS), Royal Brisbane and Women's Hospital, for the nearest service. Providing an admitted withdrawal management program is important for clients withdrawing from benzodiazepines or alcohol due to the risk of complications. Return transport from HADS is also difficult for clients form the region as the service's bus only returns clients to Queensland Health facilities and not PHN funded facilities.

Accessing opiate withdrawal across the region can be difficult due to low numbers of replacement therapy prescribers (registration provided by Queensland Health) and a low willingness of pharmacies to administer the medication.

Most PHN funded services are at a continued maximum capacity which can make access difficult in communities.

Consultation across the region has highlighted:

- Lack of appropriate AOD services in the community, such as opioid treatment – patients often required to travel to Brisbane for appropriate services
- Lack of affordable options for rehabilitation with rural patients in particular required to shoulder significant costs in order to travel to access facilities
- Lack of after-hours services for AOD patients, resulting in patients resorting to inappropriate ED presentations
- Limited awareness from HHS of community services and lack of linkages between health services and in-community supports

Community consultation provided feedback:

- Lack of clarity regarding access to drug and alcohol primary health services in the Darling Downs and West Moreton PHN region.
- Ongoing requirement for improved and stronger community engagement and further education related to Drug and Alcohol Treatment Services

WORKFORCE

The AOD workforce includes workers whose primary role involves reducing AOD-related harm as well as those whose primary work focus is on other issues but, nevertheless, play an important role in reducing AOD harm. Workforce development (WFD) in the AOD field aims to build the capacity of organisations and individuals to prevent and respond to AOD related problems and to promote evidence-based practice. It goes beyond the provision of education and training to include issues such as recruitment and retention, workforce planning, professional and career development and worker wellbeing.

QNADA have highlighted some areas for consideration within the region:

- Capacity and capability limitations with resourcing a major factor affecting services
- Lack of available training a barrier to improving service capability
- Broad existing skill set across Drug and Alcohol Treatment specialist services in region, ranging from certificate level to bachelor qualifications
- Perception that expanding access to withdrawal services would meet a service gap in the region

Further regional consultation has identified the following points:

- Available services are inaccessible because of cost
- Service gap in pain management and addiction services in West Moreton and Darling Downs
- Long wait list for some service providers
- Difficulties in recruiting service providers
- Service providers overworked and understaffed with high turnover
- Lack of appropriate services in rural areas
- Travel issues for providers
- Lack of understanding of the range of available PHN funded and other services

- A need for enhanced mental health, drug and alcohol services, especially in smaller rural and regional towns with stronger links and referral pathways to Toowoomba Hospital, to manage the rising prevalence of mental health and AOD conditions in the region

TIMELINESS OF RESPONSE

PHN CLINICAL COUNCIL CONSULTATION

- Through clients seen, methylamphetamine is regarded as a drug causing high impact with a high prevalence of usage within the community
- Actual breadth and depth of problem is unquantified
- GPs require more confidence and knowledge to be able to address all drug addictions that present however this is of heightened concern with methylamphetamine due to the immediate safety issues and often desperation – knowledge of the first step, cycle of change, change behaviours and motivational interviewing
- Believe there are innovative ideas in the community though GPs are unsure of access points
- Need to educate community on access to ensure intervention is timed to when person is seeking help
- Require a community response and therefore improved education for all health workers, police, youth workers, teachers
- Benefits of psychoeducation

DRUG AND ALCOHOL TREATMENT SERVICES JOINT PLANNING SESSION, MAY 2018

Attendees provided feedback on the current service system structure including treatment types available, areas of the system working well, service gaps, and barriers to accessing services.

Table ADSN5.1: DATS Joint Planning Consultation – 2018 - Prevention

<table>
<tr><th>What's working well</th><th>What's not working well</th><th>What's needed</th></tr>
<tr><td rowspan="2">Court diversion programs can commence a conversation around the support available for individuals</td><td rowspan="2">Clients experience stigma in the community and the health system</td><td>Proactive prevention programs</td></tr>
<tr><td>Education and prevention activities focused on youth population</td></tr>
<tr><td rowspan="2">Local Drug Action Teams: there are currently 3 LDATs in the PHN region (Granite Belt, Ipswich and Toowoomba)</td><td rowspan="2">Limited education opportunities in schools</td><td>Community education and awareness</td></tr>
<tr><td>Health Promotion Officers through QLD Health</td></tr>
</table>

Table ADSN5.2: DATS Joint Planning Consultation – 2018 – Primary Health Care Support

What's working well	What's not working well	What's needed

Some organisations, especially ACCHOs, provide a wrap-around service for individuals	Limited access to ORT dosing in rural areas	Greater collaboration between organisations
	Insufficient general practices prepared to engage with AOD clients	
The majority of services are keeping up with demand	Limited communication between health professionals	Better integration between mental health, alcohol and other drug services, and other providers in the primary health care system
	Some NGO AOD services are very busy while others have no clients	

Table ADSN5.3: DATS Joint Planning Consultation – 2018 – Harm Reduction

What's working well	What's not working well	What's needed
Local Drug Action Teams	Stigma at community and individual levels	Increase in services
	Location of some services are inappropriate and may make individuals less likely to attend the service	Stigma reduction
		Community awareness and understanding of harm reduction
	Lack of safe injecting education	Safe injecting education

Table ADSN5.4: DATS Joint Planning Consultation – 2018 – Opioid Replacement Therapy

What's working well	What's not working well	What's needed
Opioid replacement therapy (ORT) provides treatment options for individuals	Limited access to ORT dosing in rural areas	Increase in ORT prescribers
	Cost can be prohibitive for individuals	
	Limited prescribers of ORT in primary health in PHN region	Increase in ORT dispensing pharmacies
	Limited places available in QLD Health ORT program	

Table ADSN5.5: DATS Joint Planning Consultation – 2018 – Family Services

What's working well	What's not working well	What's needed
Family Drug Support	Access to family services	Increased funding for emergency relief
Families are increasingly being recognised as part of an individual's treatment	Limited funding for emergency relief	Increased awareness of available family support services
Counselling and emergency relief, but limited funding available	Confidentiality requirements prevents contact details being passed on to support services	Promotion of importance of families in individuals' recovery
Services that provide wraparound in-house services, e.g., ACCHOs	Limited recognition of importance of families	

Table ADSN5.6: DATS Joint Planning Consultation – 2018 – Peer Support

What's working well	What's not working well	What's needed
SMART Recovery groups	Lack of peer worker education	Peer workforce education
Peer workforce in becoming more valued and recognised		Increased peer workforce

Community based peer support programs	Limited peer workforce	Better integration with clinical teams
Good geographic coverage of groups and programs		Recognition of peer workforce importance in the system
Peer support programs that link in to other alcohol and other drug services	Peer workforce not integrated with clinical teams	

Table ADSN5.7: DATS Joint Planning Consultation – 2018 – Counselling

What's working well	What's not working well	What's needed
Brief interventions	Inflexible funding contracts	Inclusion of consumer feedback to evaluate and improve services
There are a range of NGO AOD services available	Limited after hours' support services	Increase in Indigenous AOD workers in rural and remote regions
Flexible options for support, i.e., inreach and outreach	Family support	Longer funding contracts to reduce staff turnover
NGO AOD counselling	Limited culturally appropriate settings and counselling	Increase in after hours' support services
Organisations that provide in-house services such as primary health, financial counsellors, family support	Funding and contract uncertainty compromises quality due to staff turnover	Increase in family support services
QLD Health services that provide groups, psychologists and social workers	Engagement of at-risk clients who don't readily seek support through traditional service models	More flexible funding contracts
Counselling that provides flexibility with appointments, home visits, and flexible procedures	Mental health outreach support	
What's working well	What's not working well	What's needed

Table ADSN5.8: DATS Joint Planning Consultation – 2018 – Non-Residential Rehabilitation

What's working well	What's not working well	What's needed
Day programs offered in the region	Limited services across the PHN region	Commissioned services are evidence-based
	Minimal interaction between state and federal funding bodies	
	Non-evidence based commissioned services in PHN region	Increase in available services

Table ADSN5.9: DATS Joint Planning Consultation – 2018 – Withdrawal Management

What's working well	What's not working well
There are some GPs who will assist in withdrawal management	No inpatient withdrawal management facility
	Limited ambulatory withdrawal management
	Extensive waiting times for existing services
Consideration of Toowoomba for a withdrawal management service	Access issues for existing services
	Limited withdrawal management options, especially in rural areas

Table ADSN5.10: DATS Joint Planning Consultation – 2018 – Residential Rehabilitation

What's working well	What's not working well
Two residential rehabilitation services in Toowoomba, Teen Challenge & Sunrise Way	West Moreton does not have a facility like Sunrise Way or Teen Challenge. IARC is a small unit, not staffed 24 hours/day.
Option of accessing services in Brisbane	Lack of pre- and post-treatment support
	No facility for mothers with children since Fresh Hope closed
Some services permit clients to keep their mobile phones	Clients with co-morbidity mental health diagnosis are frequently excluded
	Delay from point of acceptance in to service and admission
Several group options offered during residence	Facilities are too strict, i.e., client lapse will result in being discharged from the service

Table ADSN5.11: DATS Joint Planning Consultation – 2018 – Aftercare/ Relapse Prevention

What's working well	What's not working well	What's needed
Group support	Limited access to post-residential programs	Increase in aftercare and relapse prevention services
Counselling	Limited access to supported accommodation	
Linkages for clients to ongoing support	Organisations with a silo mentality	

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Access and Integrated Service Delivery

DISABILITY

Disability is an umbrella term for any, or all, of the following components, all of which may also be influenced by environmental and personal factors:

- impairment—problems in body function or structure
- activity limitation—difficulties in executing activities
- participation restriction—problems an individual may experience in involvement in life situations.

IN AUSTRALIA:

- 1 in 150 Australians has autism
- At birth, Australians can expect to live, on average, over one-fifth of their lives with some level of disability
- At age 65, Australians can expect to live, on average, over half of their remaining years with some level of disability
- Aboriginal and Torres Strait Islander people experience disability at approximately twice the rate of other Australians.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE FACTS IN AUSTRALIA

- 1 in 4 reported living with disability in Australia in 2015
- Higher rates of disability were experienced across all age groups when compared to non-indigenous people
- Around 1 in 3 people with disability have profound or severe disability
- Around 3 in 5 people with disability needed assistance with at least one activity of daily life
- Experiences of discrimination due to disability were almost twice as likely than non-Indigenous people
- Around 2 in 5 people with disability lived in a major city
- Over half of people with disability reported Year 11 or higher as their highest level of education. This has increased significantly since 2012
- 41.7% of people with disability participated in the labour force
- 1 in 3 people with disability lived in a household in the lowest income quintile

The below table (*GHN5.1)* highlights areas of specific disability cohorts. All indicators for the region are higher than the Queensland rate with most being **more than 10%** higher demonstrating higher proportions of people with, or caring for someone with, disability

Table GHN5.1: Disability Indicators for Darling Downs and West Moreton, 2016

Indicators in 2016	PHN (%)	QLD (%)	Australia (%)	SLAs with highest rates (%)
Resident				
Providing assistance to persons with a disability (15 years and over)	**11.9**	10.7	11.3	Esk/Lowood (14.1), Kingaroy Region - North/ Nanango (13.9), Stanthorpe/ Stanthorpe Region (13.6)
Persons with a profound or severe disability (all ages)	**6.4**	5.4	5.4	Kingaroy Region - North/ Nanango (10.6), Ipswich - East (8.6), Esk/Lowood (8.3)
Persons aged 0 to 64 with a profound or severe disability	**4.2**	3.2	3.0	Kingaroy Region - North/ Nanango (7.5), Ipswich - East (6.3), Brassall/ Leichhardt - One Mile (6.3)
Persons aged 65 years and over with a profound or severe disability	**18.5**	17.4	18.4	Ipswich - Central/ North Ipswich - Tivoli (26.4), Bundamba/ Riverview (26.0), Brassall/ Leichhardt - One Mile (22.0)
Disability support pensioners (aged 16-64)	**7.4**	5.1	5.1	Kingaroy Region - North/ Nanango (16.1), Esk/Lowood (11.5), Ipswich - Central/ North Ipswich - Tivoli (11.4)
Community				
Persons with a profound or severe disability and living in the community (all ages)	**5.7**	4.8	4.7	Kingaroy Region - North/ Nanango (9.7), Brassall/ Leichhardt - One Mile (7.9), Esk/Lowood (7.5)
Persons aged 0 to 64 years with a profound or severe disability and living in the community	**4.1**	3.2	2.9	Kingaroy Region - North/ Nanango (7.4), Brassall/ Leichhardt - One Mile (6.3), Esk/Lowood (5.7)
Persons aged 65 years and over with a profound or severe disability and living in the community	**14.6**	13.9	14.3	Springfield Lakes (19.7), Brassall/ Leichhardt - One Mile (19.2), Springfield - Redbank - North (19.0)

Consultation throughout the region has revealed some concerns with service access and supports for carers of people with disability:

- Persons with disabilities, and those who care for them, require additional supports and equality of access to primary health services
- There is an indication that those with disabilities in the Darling Downs and West Moreton PHN region, require service access and integration assistance to support those living with a disability, their families and carers to navigate the various systems and optimise health access. Those with a disability often have an increased need of health care services, and reduced access due to their disability
- Multiple stakeholders expressed their concerns regarding access to disability assessment, support and funding under the NDIS reforms for persons aged less than 65 years and “My Aged Care” services for persons aged 65 years and older (Aboriginal and Torres Strait Islander people aged 50 years and older).

Table GSN2.1: Disability Support Pensions for Darling Downs and West Moreton (2014-2015)

Indicator	PHN	Darling Downs	West Moreton	Qld	National
Disability support pensioners *(persons aged 16 to 64 years)*	7.4% *(7th highest PHN Nationally)*	7.9%	7.1%	5.1%	5.1%

*(red: >10% higher than Qld rate; green: >10% below Qld rate; **bold**: >10% higher than National Rate)*

Table GSN2.2 Areas with Highest Rates of Disability Support Pensions for Darling Downs and West Moreton (2016)

West Moreton	Darling Downs
Ipswich - Central/ North Ipswich – Tivoli – 11.4%	Kingaroy Region - North/ Nanango – 16.1%
Bundamba/ Riverview - 11.4%	Warwick – 9.9%
Ipswich – East – 11.1%	Stanthorpe/ Stanthorpe Region – 9.8%
Brassall/ Leichhardt - One Mile – 11.1%	Kingaroy/ Kingaroy Region – South – 9.6%
Lockyer Valley – East – 9.4%	Drayton - Harristown/ Toowoomba – Central – 9.5%

SERVICE ACCESS

A number of differing consultation events across the region has allowed consumers and stakeholders to express their concerns with service access. These have been related to rurality, the services themselves, coordination of services, transport, vulnerability of populations and social isolation/ connection.

RURALITY

- Some services are not available locally in rural areas
- Gaps identified in accessing cancer care

SERVICES

- Evidence of waiting lists and wait times across a range of primary and secondary health services that are not meeting the needs of consumers
- Concerns that telehealth is not optimised to improve access opportunities
- Difficulties in accessing services in the after-hours time frame
- Difficulties in accessing specialist clinics
- Concerns that services are framed around funding arrangements, tender processes, project scope and timeframes.
- An expressed need to allow services to have greater flexibility in meeting the specific requirements of people in particular circumstances and to coordinate their access to other services and resources. This was important to the confidence and capability of people in vulnerable situations.

Table GSN3.1 Difficulty Accessing Healthcare for Darling Downs and West Moreton (2016)

Access (2014) – Rates ASR per 100	PHN	Darling Downs	West Moreton	Qld	National
Estimated number of people aged 18 years and over who often have a difficulty or cannot get to places needed with transport, including housebound	3.9 *(equal 15th highest PHN Nationally)*	3.6	4.1	3.8	4.0

Estimated number of people aged 18 years and over who experienced a barrier to accessing healthcare when needed it in the last 12 months, with main reason being cost of service	**3.2** *(Equal 2nd highest PHN Nationally)*	**2.8**	**3.4**	2.7	2.0

*(red: >10% higher than Qld rate; **bold**: >10% higher than National Rate)*

Table GSN3.2 Areas with Highest Experience of Cost Barrier to Accessing Healthcare for Darling Downs and West Moreton (2016)

West Moreton	Darling Downs
New Chum/ Redbank Plains – 4.5	Newtown/ North Toowoomba - Harlaxton/ Wilsonton – 5.4
Ipswich – East – 4.1	Drayton - Harristown/ Toowoomba – Central – 5.3
Lockyer Valley – East – 4.1	Darling Heights – 5.0
Bundamba/ Riverview – 3.9	Middle Ridge/ Rangeville/ Toowoomba – East – 3.1
Ipswich - Central/ North Ipswich – Tivoli – 3.9	Kingaroy Region - North/ Nanango – 2.7

SERVICE COORDINATION

- 39% of Toowoomba residents, 41% of Ipswich residents and 46% of rural residents indicated often needing to see more than one health care provider for a health concern (of those surveyed)
- 65% of community respondents, 79% of GPs, 79% of allied health professionals and 80% of hospital doctors and specialist agreed or strongly agreed that health care pathways are too convoluted (of those surveyed)
- 50% of community, 36% of GPs, 59% of allied health professionals and 50% of hospital doctors and specialists agreed or strongly agreed that health care providers are too busy to effectively coordinate care (of those surveyed)

TRANSPORT

- Transport and rurality is a barrier to accessing health care for many regional and rural residents of the Darling Downs and West Moreton PHN; distance from remote areas and need for frequent healthcare service visits can make access to services difficult
- For residents with complex health needs, there are challenges in coordinating timely access to health care.
- Expressed desire for more public transport and more tailored transport services as well as more localised service delivery
- Services in neighbouring towns cannot be accessed when independent transport is unavailable
- Lack of available and affordable transportation options for rural patients who needed to travel to receive care was a consistent topic of discussion amongst stakeholders, who noted the significant time and financial costs associated with such travel
- Limited access to transport consistently raised as a barrier to *vulnerable persons* in regional and rural communities in accessing primary care including diagnostics, support services, treatments and procedures. Many people in the cohorts often did not have a driver's licence, a reliable registered vehicle, an available driver nor the funds for fuel.
- *Vulnerable persons* often rely on public transport where it was available, and it was often impractical or inaccessible for those who are unwell.

- *Vulnerable persons* in many communities wanted to coordinate the provision of a community car and some communities have established a service that often involve collaborative arrangements with the local government, businesses, Queensland Health and community service providers. Others need funding support and coordination

PROJECT ECHO

Project ECHO increases access to specialty treatment in rural and under-served areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions. It is a collaborative model of medical education and care management that empowers clinicians everywhere to provide better care to more people, right where they live. As a project of the University of New Mexico, it is claimed that ECHO addresses inadequate or disparities in access to care, rising costs, systemic inefficiencies, and unequal distribution of best practice. Clinicians are involved in a continuous learning system and are partnered with specialist mentors at an academic medical center or hub enabling primary care clinicians to treat patients with complex conditions in their own communities. Project ECHO has been utilised to address hepatitis C, HIV, substance use disorders, diabetes and endocrinology, chronic pain, tuberculosis, autism, palliative care, crisis intervention training and assistive technologies in training.

SERVICE AWARENESS

Various regional consultation identified difficulties in awareness of services available and their linkage points across the region.

- Lack of clarity surrounding referral pathways seen by stakeholders as a key obstacle to developing an integrated model of care that could allow patients to access care at the right time and place and with the right provider, resulting in patient deterioration and eventual ED presentations. Acknowledgement that HealthPathways will assist however ongoing concerns regarding responsibilities for referrals not deemed appropriate by the health service
- Poor or inappropriate discharge planning with difficulties obtaining timely discharge summaries causing flow-on effects for organising patient care. There were also reports of minimal follow-up from hospitals with GPs regarding referred patients. This was a particular area of concern for Aboriginal and Torres Strait Islander patients, with stakeholders from Aboriginal Medical Services (AMSs) across the DDHHS noting limited engagement and follow-up between the AMSs and Hospital Liaison Officers in hospitals
- Role definition between primary and secondary care especially where there is a lack of access to GPs, specifically bulk-billing GPs and primary care services after-hours, resulting in presentations to acute hospital EDs which may not be the appropriate care setting. Wound care was a recurring issue between hospitals and GPs. While wound care is funded in general practice to ensure that GPs and practice nurses are able to provide in-community care for patients requiring wound management, GPs reported that the cost of consumables was not adequately funded under current funding models
- While “greater integration” was raised as an issue demonstrating a general interest in a more collaborative approach, the lack of tangible initiatives underpinning this interest suggested a need to better articulate the steps to achieving integration
- Lack of in-community supports, especially in mental health or allied health, which resulted in inconsistent transitional care and expressed a need for a more efficient and effective means of returning patients to their home towns
- Transfers to Toowoomba Hospital was particularly disruptive for certain patient groups, such as Aboriginal and Torres Strait Islander patients and mental health patients, as it separated them

from important social supports and networks with transfer often due to logistical rather than clinical need
- Need for community education around local topics including healthy family activities, diet, disease, mental health, aged care and AOD
- Need for education around chronic diseases and falls prevention

SERVICE AVAILABILITY

Lack of or unclear service availability was highlighted as providing gaps in primary health care across the region:
- Identified key gaps in maternity services and paediatric services across the region, despite Darling Downs' paediatric population representing 20.7% of the current population
- Service gaps were also identified in dental services, cancer services, renal dialysis, interventional cardiology and services for bariatric patients
- Stakeholders highlighted limited routine access to appropriate speciality and subspecialty services for rural and remote communities, which was driven by high staff turnover, significant travel time, and a lack of available consulting and treatment rooms
- Stakeholders noted limited access to appropriate clinical support services including radiology, pathology and pharmacy for rural communities due to minimal, non-existent, or business hours-only service provision
- Lack of understanding and appropriate services for people with dementia and associated behavioural challenges was identified as a significant gap across the DDHHS

VULNERABLE POPULATIONS

- Approved NDIS service providers are often only available to rural clients in specific larger centres requiring travel and additional costs;
- While primary health services are available in centres across the region, many people do not have appropriate services available locally and others cannot afford to access non-bulk billed services;
- Hospitals in the region cannot admit people needing acute mental health care due to concern for other patients' wellbeing and security;
- Services for crisis support, such as emergency accommodation, acute mental health care, and domestic violence support, are very limited;
- There are limited bulk billing general practices in the region and often general practices have full patient lists and are not accepting new patients;
- Some service providers that are listed as available in the region are not necessarily delivering effective services locally on the ground

ALLIED HEALTH

- General lack of allied health professionals to provide multidisciplinary, non-acute interventions in rural areas with patients forced to contend with long waiting lists
- Allied health staff an underutilised resource with significant potential to address clinical service gaps more widely across the region
- Deficit in the number of occupational therapists, physiotherapists and exercise physiologists in the Darling Downs region, which posed complications for appropriate post-discharge and step-down care for patients, rehabilitation (especially to address the biomechanical stresses of obesity), chronic disease management, and even eligibility for certain surgeries, which required prolonged physiotherapy prior to surgery
- Increase in administrative and bureaucratic complexity for allied health workers meant that more support was required, either in the form of administrative support or allied health assistants

AFTER-HOURS

- Need for after-hours access to GPs as well other services such as pathology, pharmacy, allied health, dentistry and medical imaging
- Changing expectations from clinicians about sociable hours and work-life balance, with a growing preference for moving away from traditionally long, on-call hours
- Higher likelihood of certain patient groups requiring after-hours services, such as patients with mental health and AOD conditions
- Funding implications of expanding after-hours services – stakeholders noted that new funding arrangements for after-hours service provision have been implemented by the commonwealth government, namely the Practice Incentives Programme (PIP) and need to be considered when identifying the most appropriate and effective service delivery model for local communities

FUNDING

- Recent changes to the health funding environment as a result of the introduction of the NDIS and My Aged Care a recurring source of concern for stakeholders, with many noting a need for greater clarity regarding implications for service provision

- Significant administrative and bureaucratic burdens associated with applying for care under the NDIS and My Aged Care with uncertainty surrounding guidelines and eligibility
- Reports of inadequate packages for patients under the NDIS
- Reported delays in waiting for assessments by the Aged Care Assessment Team (ACAT), resulting in prolonged and unnecessary hospitalisations of elderly patients with dementia

HIGH POPULATION GROWTH AREAS

- High growth rates over the past 5 years (5-10% per annum) in Bellbird Park-Brookwater, Ripley, Springfield Lakes & Redbank Plains
- Rates over 3% in Cambooya-Wyreema, Brassall, Goodna, Highfields and Lowood
- Future growth rates over 6% per annum for the next 20 years are projected for Ripley, Rosewood, Bellbird Park-Brookwater & Springfield Lakes
- Population growth may have attracted more specialty medical services to West Moreton high growth areas, potentially highlighting opportunity for health improvement

WORKFORCE/ SERVICES

- The ratings for workforce and service gaps in General Practitioners and Aboriginal health workers in the Darling Downs and West Moreton PHN were more favourable than Central Queensland, Wide Bay and Sunshine Coast PHN, Northern Queensland PHN and Western Queensland PHN and Queensland as a whole.
- The nursing workforce ratings were less favourable than Central Queensland Wide Bay and Sunshine Coast PHN, however better than the Northern and Western PHNs and Queensland as a whole
- The proportion of workforce engaged in general practice across Queensland tends to decrease with increasing remoteness
- Almost 70% of Inner Regional and Outer Regional practitioners indicated that they intended to remain at their current practice for more than three years, this dropped to approximately 40% for Remote practitioners
- The self-reported average total hours worked per week by Queensland RA 5-2 practitioners was 43.9 hours. For Queensland practitioners this represents a 1.2-hour reduction in the self-reported total hours since 2012
- The average age of practitioners has increased 2.6 years since 2012
- The percentage of female practitioners has increased by 2.5% since 2012
- 4.3% of medical practitioners self-reported working as a solo doctor while another 0.7% described themselves as solo co-located
- The proportion of Queensland practitioners trained in Australia has increased from 50.6% in 2016 to 56.2% in 2017.
- The average age of remote, rural and regional medical practitioners in Queensland was 50.8 years

Table GSN6.2 Top 3 (of 8) Service Gap Ratings for each Combined or Single SA2 in PHN Region

	1	2	3
Chinchilla, Miles Combined	Mental Health (81.8)	Alcohol, Tobacco and Other Drugs (71.5)	Child Health (68.2)
Goondiwindi, Inglewood Combined	Child Health (56.6)	Health Promotion (46.6)	Mental Health (41.7)
Kingaroy Combined	Alcohol, Tobacco and Other drugs (77.0)	Mental Health (60.7)	Refugee and Immigrant Health (59.0)
Lockyer Valley – East SA2	Refugee and Immigrant Health (83.0)	Mental Health (71.7)	Alcohol, Tobacco and Other Drugs (67.5)
Lowood, Esk Combined	Mental Health (73.2)	Child Health (68.9)	Alcohol, Tobacco and Other Drugs (67.4)
Nanango SA2	Aged Care (84.0)	Disability (66.5)	Alcohol, Tobacco and Other Drugs (66.0)
Stanthorpe SA2	Health Promotion (76.7)	Aged Care (75.0)	Disability (72.3)
Toowoomba and Suburbs	Mental Health (41.7)	Alcohol, Tobacco and Other Drugs (39.7)	Disability (33.8)
Wambo SA2	Mental Health (4.3)	Alcohol, Tobacco and Other Drugs (58.0)	Child Health (54.7)
Warwick, Sth Downs Combined	Alcohol, Tobacco and Other Drugs (56.2)	Disability (54.4)	Refugee and Immigrant Health (52.9)

EMERGENCY DEPARTMENT PRESENTATIONS

Many health problems can be prevented, managed or treated by a general practitioner while more serious injuries and complex conditions are often more appropriately treated in a hospital ED. However, EDs in Australia are under increasing demand with management of these pressures aimed at care being delivered in the most local and least complex care setting that is appropriate for the patient. Within the PHN region, there are very high rates of after-hours GP attendance types for residents of Ipswich Inner and Springfield-Redbank (more than double estimated national rate) with higher after-hours emergency department (ED) attendances than in-hours ED attendances for these two areas.

2016-17 after hours presentations to EDs at major public hospitals in the PHN:

- Ipswich – 53%
- Toowoomba – 51%
- Warwick – 38%
- Kingaroy – 37%
- Dalby – 43%
- Goondiwindi – 34%
- Chinchilla – 38%
- Cherbourg – 45%
- Inglewood – 55%

Table GSN6.4 Percentage of Patients Seen on Time According to ED Triage Category 2016-2017

Category – Presentation Type	Ipswich Hospital	Toowoomba Hospital
1 – Resuscitation (immediate treatment)	100%	97%
2 – Emergency (treatment < 10 mins)	77%	82%
3 – Urgent (treatment < 30 mins)	37%	57%
4 – Semi-urgent (treatment < 60 mins)	56%	64%
5 – Non-urgent (treatment <120 mins)	86%	85%
Total patients	**61,898**	**50,975**

POTENTIALLY PREVENTABLE HOSPITALISATIONS

These are hospitalisations thought to have been avoidable if timely and adequate non-hospital care had been provided, either to prevent the condition occurring, or to prevent the hospitalisation for the condition. They are categorised as *Vaccine preventable* conditions (for example measles); *Acute* conditions (for example ear, nose and throat infections); and *Chronic* conditions (for example diabetes complications).

The PHN has high rates of potentially preventable hospitalisations, relative to other PHN regions, with chronic and vaccine preventable conditions being the most common. The PHN ranks 3rd in the nation in total PPH:

- 4th in Total Chronic
- 2nd in Total Vaccine Preventable
- 2nd in Asthma
- 2nd in 'Other' Vaccine preventable
- 4th in Pelvic inflammatory disease
- 5th in COPD and Hypertension and Pneumonia (not vaccine preventable)
- PPH rates particularly high in Darling Downs (West) - Maranoa, Ipswich Inner, Springfield-Redbank, and Burnett SA3 areas

Table GSN6.5: Top 5 Chronic PPH for the Region

Condition	PPH per 100,000 people (age standardised)	Percentage of PPH that are same day (%)	Average length of stay (days)
Chronic obstructive pulmonary disease (COPD)	354	11.4	5.3
Congestive heart failure	233	8.2	6.9
Iron deficiency anaemia	208	78.3	1.6
Asthma	189	33.1	2.3
Angina	173	39.5	1.8

Table GSN6.6: Top 5 Acute PPH for the Region

Condition	PPH per 100,000 people (age standardised)	Percentage of PPH that are same day (%)	Average length of stay (days)
Kidney and urinary tract infections	368	24.0	3.5
Dental conditions	333	84.4	1.2
Cellulitis	299	16.0	4.0
Ear, nose and throat infections	225	38.7	1.6

Table GSN6.7: Vaccine Preventable PPH for the Region

Condition	PPH per 100,000 people (age standardised)	Percentage of PPH that are same day (%)	Average length of stay (days)
Pneumonia and influenza (vaccine preventable)	130	6.7	6.6
Other vaccine-preventable conditions	275	80.6	6.3

INTEGRATION WITH HOSPITALS AND HEALTH SERVICES

The following themes were identified as particularly important areas of focus throughout the DDHHS regional consultation:

- Toowoomba - Stakeholders identified a range of key issues including the need for hospital redevelopment, the lack of step-down services, pressure on inpatient admissions, the high prevalence of patients admitted with obesity, and specific health needs such as demand for interventional cardiology.
- Southern Downs - Key areas of focus included better integration for elderly patients, improved rural service models of care, pressure on service utilisation due to cross border patients, and specific health needs including ophthalmology, renal dialysis, and mental health
- South Burnett - There was key interest in greater prioritisation of infrastructure renewal, Aboriginal and Torres Strait Islander health, and the improved recruitment and retention of staff in health service planning. Stakeholders also cited specific health needs such as primary care, ophthalmology, renal dialysis, chemotherapy and obstetrics.
- Western Downs - There was strong support for health service planning to better address the social determinants of health, high demand for mental health and alcohol and other drug services, and specific health needs such as paediatrics and aged care
- Stakeholders recognised the benefits of strong relationships between the HHS and broader health system, including primary and community services and GPs to deliver services in partnership or outside the acute healthcare system. This should also include greater clarity about the key roles and responsibilities of all providers
- There was widespread agreement that more innovative recruitment and retention strategies and approaches were required to address current and expected shortfalls in the DDHHS' health workforce in the future.
- There was an identified need to promote and enhance the number of junior medical officers across DDHHS who choose to participate in the rural generalist program

Stakeholders supported developing a formal rotation training program for all disciplines across the district that involves working at Toowoomba Hospital for a specific time period to enhance skills, training and relationships between Toowoomba Hospital and the rural facilities

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Health for Priority Populations

SERVICE ACCESS

- Research indicates people living with disadvantage are impacted by access and equity barriers
- Access impacted due to financial hardship, disadvantage (disability, sole parents, vulnerable groups)
- Many people are aware that a health service is likely to be available, but often don't know how to initiate access to services. For example, people not understanding what was offered by different services and how services related to their situation
- Refugees often did not know how to access interpreters and health services sometimes found it difficult to use of telephone interpreters
- People were often not familiar with telehealth or visiting services
- People often required assistance in accessing services such as with online registration, overcoming social isolation, or some people had a disability that limited their cognition or communication
- People were often uncomfortable with interactions with health services such as feeling unfamiliar, intimidated, awkward, and in some cases, treated with inadequate respect, understanding or trust
- NDIS packages for people with a disability do not cover "health" costs and people are ineligible to access local allied health/nursing services as a result
- Some people do not have transport or transport options to access services in their community or in other centres
- Some people have difficulty in keeping appointments (such as lack of transport, overnight accommodation, English literacy, finances, addictions and illness, and mental health issues)
- Social stigma such as fear of judgement prevents some people from actively seeking assistance until there is a crisis, or an escalated level of need which may act as a further impediment to seeking relevant services
- Some people are overwhelmed by their social and emotional circumstances with reduced capacity to self-manage, access services or manage the maintenance of their health.

SOCIAL ISOLATION/ CONNECTION

Social isolation is a major factor that limited the capacity and confidence of people in all vulnerable cohorts. It diminished people's autonomy, resilience and self-help which affected their ability to access healthcare. In rural communities, service providers repeatedly mentioned the need for a service that would function as a helper, facilitator, or "bridge-builder" between services and vulnerable groups. This was variously described as:

- A "one-stop shop" where people can go and know they will find help;
- A local community mentor;
- A social worker;
- A navigator/facilitator; and,
- A community services coordinator.

All communities had a network of formal and informal community and health support services that were able to assist people with needs. Most services had a working knowledge of what health services were accessible based on existing relationships. In order for people to act on their own

needs and seek appropriate services, there is a need for accessible, holistic, referral pathways and community networking that included counselling, and tailored support. This networking along with local pathways can help people better address their situation and improve their circumstances.

SERVICE AWARENESS

- Many people are not familiar with health system processes, programs or assistance available;
- Many people are socially isolated with barriers to social engagement such as disability, “otherness”, social judgement, homelessness, mental illness or limited English language skills
- People from a refugee background often do not expect services to be available because they have come from cultures with few services and a high degree of self-reliance. They are also often unfamiliar with cultural norms such as gender roles in relation to accepted behaviour with regard to domestic and family violence
- Many people become compromised by the situation they are in, such as homelessness, experiencing domestic violence or suffering from mental illness. This narrows their view of options, reduces self-efficacy and confidence, and can limit them being able to organise access to primary healthcare

REFUGEES AND CULTURALLY AND LINGUISTICALLY DIVERSE

- Though parts of the Darling Downs and West Moreton PHN region are culturally and linguistically diverse, overall the region is less diverse than Queensland as a whole.
- Within the Darling Downs and West Moreton PHN region, 78,156 persons (14.0%) were born overseas. By comparison, the proportion of Queensland residents who were born overseas is 21.6%.
- The largest proportion of overseas born English speaking residents originated from New Zealand.
- The largest proportion of people from a non- English-speaking background are from the Philippines
- The areas with the highest number of residents of non- English-speaking backgrounds are Redbank Plains in Ipswich (3,192 people) and Darling Heights in Toowoomba (3,023 people).
- The Darling Downs & West Moreton region is home to more than 10,000 people from migrant and refugee backgrounds from diverse cultural such as Afghanistan, Iraq, Syria, Pakistan, Congo, South Sudan, Rwanda, Liberia, Eritrea, Cuba, Burundi and more.
- The Department of Social Services have set indicative arrival numbers at 760 (individuals) to arrive in Toowoomba during the 2017/2018 financial year. There has been a delay in arrivals due to Erbil airport closure and other offshore hold-ups, however MDA are still on track to receive the remaining 400 individuals between March – June 2018.
- Overall, the proportion of people who speak another language at home, and who report speaking English ‘not well’ or ‘not at all’ is 1.1%. This proportion is less than Queensland’s reported proficiency of speaking English ‘not well’ or ‘not at all’ of 1.8%. However, in some communities of Darling Downs and West Moreton PHN, this proportion is greater:
    - Gatton: 6.8% report speaking English ‘not well’ or ‘not at all’
    - Goodna: 5.6% report speaking English ‘not well’ or ‘not at all’
    - Darling Heights: 3.9% report speaking English ‘not well’ or ‘not at all’
    - Redbank Plains: 3.5% report speaking English ‘not well’ or ‘not at all’
    - Collingwood Park – Redbank: 3.2% report speaking English ‘not well’ or ‘not at all’

Studies into detention health demonstrate that detainees have more social, digestive, psychological, neurological, eye problems, injuries and risk factors (especially self-harm) and, reflecting their younger age, less cardiovascular, endocrine and respiratory problems than a typical primary care population. The more time in detention, the more health problems for a detainee's development, especially mental health and social problems, but also neurological (headache), musculoskeletal (back pain and injuries), ear (otitis) and skin (lacerations). Both the time in, and reasons for, detention were found to be significantly related to the rate of new mental health problems detainees develop. Also of importance is the treatment and prophylaxis of infectious and parasitic diseases.

While much of the literature focuses on initial screening, the health needs of refugees are much broader. There is increasing recognition in the mainstream health literature on the need for effective diagnosis and treatment of chronic diseases such as diabetes and heart disease. It logically follows from the goals of connecting refugees to primary care as well as to specialist refugee and mainstream services, that the burden of navigating a complex health system will be greater for refugee groups who have complex health problems.

Literature describes a number of principles and frameworks for health services for refugees with themes around screening and settlement with primary care provision of the same quality as the local population, and specialist services for full integration of health care. Along with advocacy services to ensure refugees gain the maximum benefits from existing health and social care services, is the provision of ancillary services such as language and information services, specialist mental health and services for survivors of torture, and targeted health promotion and training of health workers.

SOCIAL DETERMINANTS OF HEALTH

Determinants of health are factors that influence how likely people stay healthy or become ill or injured. Many of the key drivers of health reside in everyday living and working conditions—the circumstances in which people grow, live, work and age. These social determinants include factors such as income, education, employment and social support. Evidence on the close relationship between living and working conditions and health outcomes has led to a renewed appreciation of how human health is sensitive to the social environment.

Table GSN8.1: SEIFA Index of Relative Socio-economic Disadvantage

	PHN	Darling Downs (average)	West Moreton (average)	Qld	National
Based on Australian score of 1000	963 *(3rd highest PHN Nationally)*	967	960	997	1000

*(red: >10% lower than Qld rate; **bold**: >10% lower than National Rate)*

The 6 areas of the PHN with the lowest SEIFA:

1. Kingaroy Region – North/ Nanango – 848
2. Bundamba/ Riverview – 884
3. Brassall/ Leichardt – One Mile – 901
4. Ipswich East – 917
5. New Chum/ Redbank Plains – 918
6. Newtown/ North Toowoomba – Harlaxton/ Wilsonton – 919

The 5 highest areas are:

1. Highfields – 1083
2. Ipswich Inner – North – 1076
3. Middle Ridge/ Rangeville/ Toowoomba – East – 1056
4. Springfield Lakes - 1056
5. Cambooya – Wyreema/ Gowrie/ Toowoomba – West - 1045

REGION'S POPULATION

- There are 144,506 families in the region with a large proportion (41.8%) of couple families with children.
- Family composition proportions for the region are very similar to Queensland proportions. Bellbird Park - Brookwater is the SA2 area with the largest proportion of couple families with children (57.2%); Riverview has the largest proportion of One-parent families (35.5%); and Esk has the largest proportion of couple families with no children (55.7%).
- The vast majority of households in the region are one family households (71.2%).
- The proportion of group households in the Darling Downs and the West Moreton PHN region (3.4%) is lower than the Queensland proportion.
- Goodna and Karalee – Barellan Point are the only two areas in the region with more than 3.5% of households comprised of multiple family households.
- The areas with more than 30% lone person households, are Drayton/Harristown, Ipswich Central, Ipswich East, Newtown, North Ipswich/ Tivoli, North Toowoomba/ Harlaxton, Stanthorpe, Tara, Toowoomba Central, Toowoomba East, and Wilsonton

INCOME AND EMPLOYMENT

- The median household income in the Darling Downs and West Moreton PHN region is $76,577 per year (almost $10,000 lower per year than the Queensland median).
- In terms of total family income, the region has a larger proportion of households in the $33,800 to $77,999 bracket and fewer in the $156,000 or more per year bracket than the total Queensland proportion.
- There are pockets of the region that have considerably lower incomes than State levels. 9.4% of Queensland households have annual incomes in the lowest bracket, there are eight SA2 areas in the Darling Downs and West Moreton PHN region with over 15% of households in this bracket. (Crows Nest – Rosalie (15.1%), Esk (15.1%), Goodna (15.6%), Nanango (16.5%), Kingaroy region – North (17.3%), Leichhardt – One Mile (17.3%), Tara (18.7%), and Riverview (19.6%). At the LGA level, 41.0% of Cherbourg LGA households have annual incomes in the lowest bracket. No other LGA exceeds 15%.

Table GSN8.2: Pensions and Income Benefits, PHN

Indicator	PHN	Darling Downs	West Moreton	Qld	National
Age pensioners *(persons aged 65 and over)*	73.0% *(12th highest PHN Nationally)*	72.7%	73.4%	69.8%	71.1%
Disability support pensioners *(persons aged 16 to 64 years)*	7.4% *(7th highest PHN Nationally)*	**7.9%**	**7.1%**	5.1%	5.1%
People receiving an unemployment benefit *(persons aged 16 to 64 years)*	7.0% *(10th highest PHN Nationally)*	**7.0%**	**7.1%**	6.2%	5.4%
People receiving an unemployment benefit long-term *(persons aged 16 to 24 years)*	5.7% *(equal 10th highest PHN Nationally)*	**5.6%**	**5.7%**	4.9%	4.4%
Young people 16-24 receiving an unemployment benefit	6.4% ***(3rd highest PHN Nationally)***	**6.6%**	**6.2%**	4.7%	3.5%
Health care card holders *(persons 0 to 64 years)*	8.5% *(equal 11th highest PHN Nationally)*	**8.3%**	**8.7%**	7.7%	7.3%
Pension concession care holders *(persons aged 15 and over)*	26.4% *(12th highest PHN Nationally)*	**28.4%**	**24.5%**	21.7%	21.3%
Senior health card holder *(persons aged 65 and over)*	6.7% *(equal 23rd highest PHN Nationally)*	7.7%	**5.3%**	7.6%	8.0%

(red: >10% higher than Qld rate; green: >10% below Qld rate; ***bold****: >10% higher than National Rate)*

- The highest rates of people over 65 receiving the age pension:
  - Springfield Lakes – 95.0%
  - New Chum/ Redbank Plains – 87.9%
  - Newtown/ North Toowoomba – Harlaxton/ Wilsonton – 79.2%
  - Warwick – 78.5%
  - Springfield – Redbank – North – 78.2%

- The highest rates of people aged 16 to 64 receiving disability support pensions in the PHN region:
  - Kingaroy region – North/ Nanango – 16.1%
  - Esk/ Lake Manchester – England Creek/ Lowood – 11.5%
  - Bundamba/ Riverview – 11.4%
  - Ipswich – Central/ North Ipswich – Tivoli – 11.4%
  - Brassall/ Leichardt – One Mile – 11.1%Ipswich – East – 11.1%

- The highest rates of people aged 16 to 64 receiving an unemployment benefit:
  - Kingaroy Region – North/ Nanango – 12.3%
  - Bundamba/ Riverview – 10.5%

   - Ipswich – Central/ North Ipswich – Tivoli – 10.0%
   - Brassall/ Leichardt – One Mile – 9.7%
   - Newtown/ North Toowoomba – Harlaxton/ Wilsonton – 9.4%

- The highest rates of people aged 65 and over holding a senior health card:
   - Middle Ridge/ Rangeville/ Toowoomba East – 12.8%
   - Banana/ Biloela – part a – 12.4%
   - Chinchilla/ Miles – Wandoan/ Roma/ Roma Region – part a – 12.4%
   - Highfields – 11.0%
   - Millmerran/ Pittsworth/ Wambo – 10.2%

- There are an estimated 36,907 children in the Darling Downs and West Moreton PHN region living in low income, welfare dependent families.
   - This equates to 28.7% of children under 16 years which is higher than the Queensland proportion of 23.9%.
   - The Darling Downs and West Moreton PHN has the 6th highest proportion of children in low income, welfare dependent families of all 31 PHNs in Australia.

Table GSN8.3: Indicator of Low Income Families, PHN

Indicator of Low Income Families	PHN	Darling Downs	West Moreton	Qld	National
Low income, welfare-dependent families (with children) *(out of total families)*	**14.1%** *(3rd highest PHN Nationally)*	**12.7%**	**15.5%**	11.0%	10.1%
Children in low income, welfare-dependent families *(out of total children <16years)*	**28.7%** *(6th highest PHN Nationally)*	**27.2%**	**30.1%**	23.9%	22.5%

*(red: >10% higher than Qld rate; **bold**: >10% higher than National Rate)*

- The 5 areas with highest proportions are:
   1. Kingaroy Region – North Nanango – 46.8%
   2. Bundamba/ Riverview – 47.0
   3. Brassall/ Leichardt – One Mile – 42.3%
   4. New Chum/ Redbank Plains – 38.7%
   5. Newtown/ North Toowoomba – Harlaxton/ Wilsonton – 38.1%

Given the above, areas of high financial vulnerability within the PHN region include Kingaroy Region – North/ Nanango, Bundamba/ Riverview, Brassal/ Leichardt – One Mile and Newtown/ North Toowoomba – Harlaxton/ Wilsonton.

PRIVATE HEALTH INSURANCE

- The rate for people holding private health insurance in the region is 39.3 people per 100 Age Standardised Rate1 (ASR), which is lower than the Queensland rate of 47.9 (2014-2015 data).
- The LGAs with rates above 40 per 100 ASR, are Banana LGA (49.9) and Toowoomba LGA (48.2). The ASR rate per 100 population is lowest in Cherbourg LGA (30.7) and Somerset LGA (32.6).

HOUSING

- In the Darling Downs and West Moreton PHN region, 25.9% of households receive rent assistance (June 2016) compared to a Queensland rate of 22.2%.
- Proportions are particularly high for Cherbourg LGA (58.5%) and Ipswich LGA (31.9%).
- 2.7% of dwellings in the region are rented from the government housing authority (Qld 3.5%), (2011 data).
- Only Ipswich LGA (4.1%) and Banana LGA (4.8%) have proportions of households receiving rent assistance, which are higher than the Queensland proportion.
- The Darling Downs and West Moreton PHN region also has a lower rate of homelessness (36.8 per 100,000) than the Queensland rate (44.5 per 100,000).
- The highest rates of homelessness for the Darling Downs and West Moreton PHN region are those, which are approaching or exceeding 100 per 100,000.
- The top 5 SA2 areas for homelessness are: Darling Heights, Goodna, Ipswich – Central, Kingaroy region – North, and Riverview.

OWN TRANSPORT

- The proportion of dwellings in the Darling Downs and West Moreton PHN region without a motor vehicle is 5.1%, which is lower than the Queensland proportion of 6.0%.
- Of the LGAs in the Darling Downs and West Moreton PHN region, only Cherbourg LGA (45.6%) has a higher proportion than Queensland.
- The only other LGAs with proportions over 5% are Southern Downs (5.9%), Toowoomba (5.6%), and Ipswich (5.4%).
- Conversely, all Darling Downs and West Moreton PHN LGAs other than Cherbourg (7.1%) have a higher proportion of dwellings with three or more motor vehicles than Queensland (19.0%).

INTERNET ACCESS

- Overall, the proportion of dwellings in the Darling Downs and West Moreton PHN region, where the internet is not accessed is 17.5%.
- The proportion is greater than 20% in 26 of the total 65 statistical areas (SA2 level) in the region.
- This occurrence is highest in Kingaroy region – North and Tara SA2s, where the proportion of dwellings, which do not access the internet, is over 30%.

EDUCATION

- The proportion of adults in the Darling Downs and West Moreton PHN region, whose highest year of school completed is Year 11 or 12 education, is 50.5%. This proportion is 8.9 percentage points lower than the State Year 11 and 12 completion rates.
- Within the Darling Downs and West Moreton PHN, some SA2 areas have notably less education levels than the region overall.
- The SA2 with the lowest completion rate is Tara, where only one-third of adult residents have completed Year 11 or 12.
- Other areas where the completion rate is below 40% are Nanango, Kingaroy region – North, Millmerran, Inglewood – Waggamba, and Esk.
- The number of adult residents of the Darling Downs and West Moreton PHN who did not attend school or who completed education up to Year 8 is 32,331 (7.7%). The comparative proportion for Queensland is 5.4%.
- Within the Darling Downs and West Moreton PHN region, notable SA2 areas with similar levels of education are Kingaroy region – North (12.8%), Gatton (12.5%), Riverview (12.2%) and Stanthorpe (12%).
- Stakeholder feedback also noted limited education and work skills as a contributor to low self-esteem, alcohol and other drug use and intergenerational welfare dependency

AREAS OF SOCIOECONOMIC DISADVANTAGE (SEIFA)

CONSULTATION

- Need for more holistic collaboration between the HHS and other social services and departments to address patients' multifaceted needs e.g. health and education services
- Lack of community crisis support or supported accommodation in the Darling Downs region, creating difficulty in ensuring patients with mental health conditions receive appropriate post-discharge care and support

Difficulties resulting when children and families with complex problems or disruptive behaviours presented to EDs and subsequently admitted to hospital for lengthy periods of time while CYMHS worked with the Department of Child Safety, Youth and Women to find appropriate supports. Stakeholders cited a need for more efficient arrangements to avoid prolonged and inappropriate hospitalisations of such cases, which sometime resulted in development of patient dependency on staff and security of hospital setting, patient assaults, and disruptive behaviours.

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Health Promotion and Prevention Strategies

Primary prevention refers to actions aimed at avoiding the manifestation of a disease. This may include:

- actions to improve health through changing the impact of social and economic determinants on health;
- the provision of information on behavioral and medical health risks, alongside consultation and measures to decrease them at the personal and community level;
- nutritional and food supplementation;
- oral and dental hygiene education; and
- clinical preventive services such as immunisation and vaccination of children, adults and the elderly, as well as vaccination or post-exposure prophylaxis for people exposed to a communicable disease.

Examples of services and activities include:

- Vaccination and post-exposure prophylaxis of children, adults and the elderly;
- Provision of information on behavioural and medical health risks, and measures to reduce risks at the individual and population levels;
- Inclusion of disease prevention programmes at primary and specialised health care levels, such as access to preventive services (ex. counselling); and
- Nutritional and food supplementation; and
- Dental hygiene education and oral health services.

The importance of prevention strategies has been well-voiced across the region through consultation:

- A call for prevention and intervention strategies to minimise the incidence of obesity
- A concern for the local governments planning approach to assist with placement of fast food, alcohol and tobacco outlets
- The need to prioritise health promotion, prevention and increased early intervention, particularly in the primary care setting, to reduce rates of obesity, diabetes and chronic disease, as well as hospitalisations
- Recognition that high rates of non-compliance and failures to attend (FTAs) in certain regions of the Darling Downs, attributed partially to a lack of health literacy and understanding.

CLINICAL COUNCIL CONSULTATION:

- Obesity is a significant problem and a region wide issue.
- Renal disease is not serviced in Ipswich at all and is poorly recognised in the West Moreton area.
- Sugar consumption contributes significantly to Chronic Disease development but addressing the issue of sugar addiction is difficult when public forums can be shut down due to political pressure by groups with a vested interest in the industry.
- Smoking rates are reducing because the Quit Line and other smoking initiatives are working. Large scale, consumer led health promotion works (successful examples include past campaigns regarding HIV Aids, and bicycle helmets) and it would be beneficial to have similar sorts of large scale initiatives to help reduce sugar consumption
- Transport and potential costs (e.g. tests) are barriers to accessing Chronic Disease services in West Moreton.
- A potential barrier to effective care is the tendency to separate mental health and physical health – a person is a whole person – and it can be a challenge for GPs and other health professionals to consider the whole person. Individuals can also find it difficult to see themselves holistically.

- Social exclusion, typically as a result of poverty, or belonging to a minority social group, is a barrier to people learning about, and accessing, services.

LIFE EXPECTANCY

Life expectancy is the most commonly used measure to describe population health and reflects the overall mortality level of a population. Life expectancy measures how long, on average, a person is expected to live based on current age and sex-specific death rates. Life expectancy in Australia has improved dramatically for both sexes in the last century, particularly life expectancy at birth. Compared with their counterparts in 1881–1890, boys and girls born in 2014–2016 can expect to live around 33 and 34 years longer, respectively.

For the Aboriginal and Torres Strait Islander population born in 2010–2012, life expectancy was estimated to be 10.6 years lower than that of the non-Indigenous population for males (69.1 years compared with 79.7) and 9.5 years for females (73.7 compared with 83.1). Between 2005–2007 and 2010–2012, Indigenous life expectancy at birth for boys increased by 1.6 years and by 0.6 years for girls. Over the same period, the gap between Indigenous and non-Indigenous life expectancy narrowed by 0.8 years for males and 0.1 years for females.

DARLING DOWNS AND WEST MORETON REGION

- Life expectancy for residents of the Darling Downs and West Moreton PHN region as 80.7 years, which ranks 5th lowest of all PHNs.
- The average life expectancy for men in the region is 78.4 years and for women, 83.2 years
- The number of potentially avoidable deaths (per 100,000 people, age-standardised, 2011-13): males – 179; females – 102; persons – 140.
- Nine of the top ten causes of death in the Darling Downs and West Moreton PHN are in common with the national top ten. However, suicide ranks within the top 10 (placed 10th) within the Darling Downs and West Moreton PHN, whereas heart failure and complications ranks in the top 10 for Australia (in 9th place) for leading causes of death. While there is commonality between the majority of leading causes of death, the percentage of deaths attributable to each cause varies between Australia and the Darling Downs and West Moreton PHN, thereby varying the ranked score for specific causes.
- The top 10 causes of death across the PHN region are:
  - Coronary heart disease,
  - cerebrovascular disease,
  - lung cancer,
  - chronic obstructive pulmonary disease,
  - dementia and Alzheimer disease,
  - diabetes,
  - colorectal cancer,
  - cancer (unknown, ill defined),
  - prostate cancer, and
  - suicide.

CANCER SCREENING

There is a recognised benefit of early detection and intervention of cancer through screening programs. Despite this, the PHN ranks 30th of 31 in National Cancer Screening Program participation; all SA3 areas of the PHN region are below the national participation rate (56.4%); rates

are particularly low (below 50%) for Granite Belt, Ipswich Hinterland, Ipswich Inner, and Springfield-Redbank

Early detection of cancer greatly increases the chances for successful treatment. There are two major components of early detection of cancer: education to promote early diagnosis and screening. Screening refers to the use of simple tests across a healthy population in order to identify individuals who have disease, but do not yet have symptoms.

Table GHN6.1: Screening Participation Rates PHN, 2015-2016

Screening	PHN 2014-15	Australia 2014-15	PHN 2015-16	Australia 2015-16
Breast	56.8%	53.7%	56.2%	55.1%
Bowel	37.9%	38.9%	40.1%	40.9%
Cervical	49.2%	56.4%	48.0%	55.4%

Improvements need to be made in cervical screening throughout the region.

Table GHN6.2: Incidence of Cancer PHN per 100,000, 2009-2013

Type of Cancer	PHN	National
Breast	123	120
Cervical	7.5	7.0
Colorectal	66	60
Lung	43	44
Melanoma	76	49
Prostate	168	173

CAUSES OF DEATH

Causes of death are often a flag for the major health issues affecting our population. Of the premature causes of death in the Darling Downs and West Moreton PHN region, there is concern regarding the number of circulatory system diseases, which research suggests are mostly preventable. To reduce death rates our region must adopt healthier lifestyles

LIFELONG IMMUNISATION

While immunisation rates across SA3 areas in the Darling Downs and West Moreton PHN region, are in line or higher than national rates for children aged 1, 2 and 5 years, these fall short of the target of 95% (see also *GHN3: Children and Youth).*

Data relative to hospital admissions for potentially preventable hospitalisations (PPH) indicate that presentations to Darling Downs and West Moreton Hospital and Health Services (HHSs) continues to occur for vaccine preventable illnesses, indicating opportunities for improvement in immunisation rates across the region.

The immunisation rates for Aboriginal and Torres Strait Islander children, have been consistent for children aged 5 years, with some improvement in rates for children aged 1 year, over the four-year period of 2011-12 to 2015-16. However, there was a deterioration in the immunisation rates for children aged 2 years, over this four-year period. In terms of national ranking, the Darling Downs and West Moreton PHN had slipped from ranked positions of 16th (for children aged 1 year), 18th (for children aged 2 years) and 13th (for children aged 5 years) in 2011-12, to poorer ranked

positions of 21st (for children aged 1 year), 22nd (for children aged 2 years) and 25th (for children aged 5 years) in 2015-16, falling below the national benchmark.

2016-17 Rates of Child Immunisation demonstrates ongoing improvement for the immunisation of Aboriginal and Torres Strait Islander children at 5 years of age with the rates exceeding the national benchmark.

Table GHN7.1: Immunisation Rates of Children of the PHN, 2016-2017

1 year olds	2 year olds	5 year olds
National Rate		
93.8%	90.9%	93.5%
All PHN Children		
94.7%	92.6%	94.8%
National Aboriginal and Torres Strait Islander Children		
93.2%	88.6%	95.7%
Aboriginal and Torres Strait Islander Children - PHN		
93.0%	89.9%	96.3%

While there is currently no national benchmark for Human Papilloma Virus (HPV) and despite school immunisation programs, immunisation rates for HPV are below the national rates.

Table GHN7.2: HPV Immunisation Rates of Children of the PHN, 2015-2016

Gender	2013-14	2014-15	2015-16
National Rate	74.3%	78.6%	80.1%
Girls	71.1%	72.6%	75.2%
National Rate		67.3%	74.1%
Boys		66.9%	69.9%

VACCINE PREVENTABLE DISEASES

The Darling Downs region ranked 3rd among HHS for incidence of other vaccine preventable diseases, with a rate of 943.2 per 100,000 compared to 772.0 per 100,000 for Queensland. Higher rates of Influenza and Pertussis were the key diseases with rates in the Darling Downs approximately 34% and 25% higher, respectively than those of the state.

Table GHN7.3: Incidence of Other Vaccine Preventable Diseases PHN HHSs, 2013-2017

	Queensland		Darling Downs (rank=3)			West Moreton (rank=10)		
Disease	N	Rate	N	Rate	RR (QLD)	N	Rate	RR (QLD)
Diphtheria	18	0.08	0	0.00	0.00	2	0.15	**1.96**
Influenza (lab confirmed)	131335	549.89	10383	737.09	**1.34**	7242	533.89	0.97
Measles	166	0.70	7	0.50	0.71	12	0.88	**1.27**
Mumps	593	2.48	10	0.71	0.29	11	0.81	0.33
Pertussis	10566	44.24	781	55.44	**1.25**	555	40.92	0.92
Poliomyelitis	0	0.00	0	0.00		0	0.00	-
Rotavirus	7089	29.68	372	26.41	0.89	480	35.39	1.19
Rubella	18	0.08	0	0.00	0.00	0	0.00	0.00

Tetanus	6	0.03	0	0.00	0.00	0	0.00	0.00
Varicella	34588	144.82	1733	123.03	0.85	1614	118.99	0.82

Table GHN7.4: Incidence of Zoonotic Diseases PHN HHSs, 2013-2017

	Queensland		Darling Downs (rank=6)			West Moreton (rank=9)		
Disease	N	Rate	N	Rate	RR (QLD)	N	Rate	RR (QLD)
Anthrax	0	-	0	-	-	0	-	-
Avian influenza	0	-	0	-	-	0	-	-
Brucellosis	44	0.18	17	1.21	**6.55**	1	0.07	0.40
Hantavirus	0	-	0	-	-	0	-	-
Hendra virus	0	-	0	-	-	0	-	-
Leptospirosis	399	1.67	21	1.49	0.89	14	1.03	0.62
Lyssavirus/ rabies	1	0.00	0	-	0.00	0	-	0.00
Potential ABLV exposure	1667	6.98	83	5.89	0.84	111	8.18	1.17
Potential rabies exposure	1480	6.20	25	1.77	0.29	53	3.91	0.63
Ornithosis (Psittacosis)	7	0.03	0	-	0.00	0	-	0.00
Plague	0	-	0	-	-	0	-	-
Q fever	1188	4.97	264	18.74	**3.77**	89	6.56	**1.32**
Tularaemia B	0	-	0	-	-	0	-	-

SEXUAL/ REPRODUCTIVE HEALTH

Sexual health refers to a state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity.

Reproductive health refers to a state of physical, mental and social wellbeing – and not merely the absence of disease or infirmity – in all matters relating to the reproductive system and to its functions and processes, and across all stages of life

The Queensland Sexual Health Strategy 2016-2021 aims to support healthy and safe sexual experiences and optimal reproductive health and provide a service system that is responsive to the needs of all Queenslanders. One of the signs of a deficit of health, is the presence of disease.

AUSTRALIAN SEXUALLY TRANSMITTED INFECTIONS (STI) FACTS:

HIV

- The number of new HIV diagnoses in Australia has remained stable over the past five years
- Male to male sex continues to be the major HIV risk exposure in Australia
- The trend in HIV notifications among Aboriginal and Torres Strait Islander people is very different from that in non-Indigenous people, with a steady increase in the annual HIV notification rate in

Aboriginal and Torres Strait Islander people over the past five years, as compared to a declining rate in the Australian born non-Indigenous population

Hepatitis C

- In 2016 there were 11 949 new hepatitis C diagnoses. About two thirds (67%, 7972) of new hepatitis C diagnoses in 2016 were in males. This represents a 12% rise from the previous stable rates from 2012-2015
- The increase in the rate of notification of hepatitis C diagnoses between 2015 and 2016, following stable rates between 2012 and 2015, is likely to relate to increased testing in the context of new hepatitis C treatments
- The age standardised rate of hepatitis C notification in the Aboriginal and Torres Strait Islander population in the Northern Territory, Queensland, South Australia, Tasmania and Western Australia increased by 25% over the five past years
- The hepatitis C notification rate in the Aboriginal and Torres Strait Islander population was 3.8 times as high as in the non-Indigenous population in 2016
- In Aboriginal and Torres Strait Islander people aged under 25, the rate of hepatitis C notification was 6.3 times as high as in non-Indigenous people in 2016
- The prevalence of hepatitis C among people who inject drugs attending needle and syringe programs was 51% in 2016

Hepatitis B

- The notification rate of hepatitis B in 2016 was highest in the 30–39 year age group (61 per 100 000) and 25–29 year age group (48 per 100 000)
- Over the five years 2012 to 2016, the annual notification rate of hepatitis B has remained stable in Australia
- The hepatitis B notification rate has declined in younger age groups over the past five years (16% decline in people aged 15–19 years, 31% decline in those aged 20–24 and 25% decline in those aged 25–29), in contrast to increases in older age groups (5% increase in those aged 30–39, and a 9% increase in people aged 40 and over), reflecting the impact of the infant and adolescent vaccination programs
- In 2016 coverage of infant hepatitis B vaccination at 12 months of age was 94% in the non-Indigenous population and 92% in the Aboriginal and Torres Strait Islander population, reaching 96% and 97% respectively by 24 months

Chlamydia

- Chlamydia was the most frequently notified sexually transmissible infection (STI) in Australia, with a total of 71 751 notifications in 2016. Three-quarters (75%) of these notifications were among people aged 15–29 years
- In 2016, chlamydia notification rates were highest in the age groups 20–24 years (1970 per 100 000), 15–19 (1285 per 100 000) and 25–29 (1116 per 100 000). Over the past five years, there was a decline in the annual chlamydia notification rate among people aged 15–19 year (15% decline)
- The annual rate of notification of chlamydia in the Aboriginal and Torres Strait Islander population in the Northern Territory, Queensland, South Australia and Western Australia was 2.8 times that in the non-Indigenous population in 2016 (1194 per 100 000 compared to 419 per 100 000)
- Between 2012 and 2016, there was a 16% increase in the proportion of people aged 15–29 attending general practices who had a Medicare-rebated chlamydia test, but the overall proportion tested remained low in 2016 (15%). The proportion tested in 2016 was higher in women (20%) than in men (9%)

Gonorrhoea

- Between 2012 and 2016, gonorrhoea notification rates increased by 63% (62 to 101 per 100 000), with an increase in both males (72%) and females (43%)
- In males, the highest gonorrhoea notification rates were in the age groups 25–29 (438 per 100 000) and 20–24 years (383 per 100 000), and in females in the age groups 20–24 (199 per 100 000) and 15–19 years (177 per 100 000).
- The rate of notification of gonorrhoea in the Aboriginal and Torres Strait Islander population was 6.9 times that in the non-Indigenous population in 2016 (582 per 100 000 compared to 84 per 100 000)

Syphilis

- Over the past five years (2012–2016), the notification rate of infectious syphilis increased 107% from 6.9 per 100 000 in 2012 to 14.3 per 100 000 in 2016, with an increase in both males (103%) and females (157%).
- In 2016, infectious syphilis notification rates were highest in people aged 25–29 years (34 per 100 000), 30–39 (29 per 100 000) and 20–24 (25 per 100 000)
- The rate of notification of infectious syphilis in the Aboriginal and Torres Strait Islander population (67 per 100 000) in 2016 was 5.4 times as high as in the non-Indigenous population (12 per 100 000)
- One in five (21%) infectious syphilis notifications in the Aboriginal and Torres Strait Islander population were in people aged 15–19 years, compared with only 2% in the non-Indigenous population
- Over the last 10 years (2007–2016), more than half (24, 55%) of the 43 congenital syphilis notifications were in the Aboriginal and Torres Strait Islander population

DARLING DOWNS AND WEST MORETON REGION

Annual reporting data showed both Darling Downs and West Moreton Hospital Health Service (DDHHS) Regions had lower rates of sexually transmissible infection than those of all Queensland. The Darling Downs area had an STI incidence of 337.5 per 100,000 for the period 2013-2017 inclusive, compared to the Queensland rate of 543.6 per 100,000. Among the 15 HHS areas, the Darling Downs ranked 14th for STI incidence.

Rates in DDHHS were lower than those for Queensland for all individual STI. The highest rates were observed for Chlamydia (304.3 per 100,000; compared to 452.5 per 100,000) and Gonorrhoea (24.4 per 100,000; compared to 71.9 per 100,000). Human papillomavirus (HPV) is the most common sexually transmitted infection (STI) (see *Table GHN7.2: HPV Immunisation Rates of Children of the PHN, 2015-2016*).

Table GHN8.1: Sexually Transmitted Infection Incidence Darling Downs HHS, 2013-2017

	Darling Downs		Queensland		
STI	N	Rate	N	Rate	Rate Ratio
Chancroid	0	0.00	1	0.00	0.00
Chlamydia (STI)^	4286	304.26	108066	452.46	0.67
Donovanosis	0	0.00	0	0.00	
Gonorrhoea (STI)^	344	24.42	17182	71.94	0.34
Lymphogranuloma venereum	1	0.07	44	0.18	0.39

Syphilis (infectious)	78	5.54	3065	12.83	0.43
Syphilis (late)	45	3.19	1479	6.19	0.52

West Moreton had a higher STI incidence than the Darling Downs, with a rate of 423.5 per 100,000, lower than the Queensland rate, and ranked 9th among Queensland HHS areas. All individual STIs had lower rates than those of Queensland, with the highest incidence observed in Chlamydia (377.8 per 100,000) and Gonorrhoea (35.3 per 100,000).

Table GHN8.2: Sexually Transmitted Infection Incidence West Moreton HHS, 2013-2017

	West Moreton		Queensland		
STI	N	Rate	N	Rate	Rate Ratio
Chancroid	0	0.00	1	0.00	0.00
Chlamydia (STI)^	5125	377.82	108066	452.46	0.84
Donovanosis	0	0.00	0	0.00	
Gonorrhoea (STI)^	479	35.31	17182	71.94	0.49
Lymphogranuloma venereum	0	0.00	44	0.18	0.00
Syphilis (infectious)	73	5.38	3065	12.83	0.42
Syphilis (late)	68	5.01	1479	6.19	0.81

HIV:

Rates of HIV were 2.3 per 100,000 for the Darling Downs and 3.2 per 100,000 for West Moreton for the 2013-2017 period. These were lower than the Queensland rate of 4.2 per 100,000. Among HHSs, the Darling Downs and West Moreton were ranked 10th and 8th, respectively.

Blood Borne Viruses

The West Moreton region ranked 6th among HHSs for blood borne viruses with a rate of 78.5 per 100,000 compared to 77.6 per 100,000 for Queensland. This was primarily driven by rates of Hepatitis C and D, which were approximately 22% and 40% higher, respectively, than the rates of Queensland

Table GHN8.3: Incidence of Blood Borne Viruses HHS, 2013-2017

	Queensland		Darling Downs (rank=13)			West Moreton (rank=6)		
Disease	**N**	**Rate**	**N**	**Rate**	**RR (QLD)**	**N**	**Rate**	**RR (QLD)**
Hepatitis B (newly acquired)	234	0.98	6	0.43	0.43	14	1.03	1.05
Hepatitis B (unspecified)	4627	19.37	107	7.60	0.39	248	18.28	0.94
Hepatitis C (newly acquired)	1596	6.68	69	4.90	0.73	111	8.18	**1.22**
Hepatitis C (unspecified)	11015	46.12	582	41.32	0.90	644	47.48	1.03
Hepatitis D	63	0.26	3	0.21	0.81	5	0.37	**1.40**
HIV	1007	4.22	33	2.34	0.56	43	3.17	0.75

MEDICATION MANAGEMENT

PAIN MEDICATION

Consultation with the PHN clinical councils has highlighted a need for good pain management practices especially since the 2018 up-scheduling of codeine. Concerns have been based on pain management being viewed as a drug management routine with the first point of discussion answered with a prescription. Some people are determined to stay away from medication which has been difficult for those general practitioners with little understanding of other techniques. Developing a Pain Management Plan requires involvement of the patient and carers and includes the management of expectations and natural therapies. Various medication management strategies should be explored along with on-medication related techniques for pain management. There is a recognition of long waiting lists for pain management services with a concern for people who are not interested in rehabilitation.

ANTIBIOTIC MANAGEMENT

The Clinical Council highlighted the differences caused by the generational gap with the older generation seeking GP advice while the younger generation seek the internet and social media in the first instance. This may influence the ability of a General Practitioner (GP) to provide advice. There are people who do not want to take antibiotics however many people rely on experience of what has worked in the past or be pressured from employers who don't tolerate sick leave.

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