



Capital Health Network

ACT PHN Baseline Needs Assessment

2016

About Capital Health Network

Capital Health Network (CHN) is ACT's Primary Health Network. We play a pivotal role in supporting general practice, primary, aged care and community care services to better meet the health needs of the community.

Acknowledgements

CHN wishes to acknowledge and thank everyone who provided valuable input to this assessment and made this report possible. CHN also acknowledges that Canberra has been built on the land of the Ngunnawal people. We pay our respects to the Elders of the land both past and present and to their continual relation to their ancestral lands. We celebrate Aboriginal and Torres Strait Islander cultures and their ongoing contributions to the ACT community.

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List of abbreviations

ABS – Australian Bureau of Statistics
ACP – Advance Care Planning
ACTML – ACT Medicare Local
AECD – Australian Early Development Census
AIHW – Australian Institute of Health and Welfare
AOD – Alcohol and Other Drugs
AODTS-NMDS – Alcohol and Other Drug Treatment Services National Minimum Data Set
ATAPS – Access to Allied Psychological Services
ATODA – Alcohol Tobacco and Other Drug Association ACT
BNA – Baseline Needs Assessment
CALD – Culturally and Linguistically Diverse
CALMS – Canberra After Hours Locum Medical Service
CDM – Chronic Disease Management
CHF – Chronic Heart Failure
CHN – Capital Health Network
CKD – Chronic kidney disease
CNA – Comprehensive Needs Assessment
COPD – Chronic Obstructive Pulmonary Disease
COTA – Council on the Ageing
CVD – Cardiovascular disease
DoH – Department of Health (Commonwealth)
DFV – Domestic and Family Violence
DVCS – Domestic Violence Crisis Service
DVPC – Domestic Violence Prevention Council
ECCM – Expanded Chronic Care Model
ED – Emergency Department
EMC – Early Morning Centre
GPLU – GP Liaison Units
GPMP – GP Management Plan
GRACE – Geriatric Rapid Acute Care Evaluation
HCCA – Health Care Consumers’ Association
LGBTI – Lesbian, Gay, Bisexual, Transgender, Intersex
MBS – Medicare Benefits Scheme
NDIS – National Disability Insurance Scheme
NHDS – National Home Doctor Service
NHMRC – National Health and Medical Research Council
PHN – Primary Health Network
PPH – Potentially Preventable Hospitalisation
RACF – Residential Aged Care Facility
RACGP – Royal Australian College of General Practitioners
SA3 – Statistical Area Level 3
SUSOS – Service Users’ Satisfaction and Outcomes Survey (AOD)
TCA – Team Care Arrangement

Preamble

As a Primary Health Network (PHN), we are required to conduct a needs assessment of the ACT region. The needs assessment is based on population health data and stakeholder views on service gaps, major health concerns and system capacity issues. The needs assessment is part of our planning cycle and will be formally updated annually. Needs Assessment is a crucial step in the commissioning process. A good understanding of the current and likely future needs of the local population is critical if a suitable strategy to meet those needs is to be produced and put into practice efficiently and effectively.

The process for the 2016 Baseline Needs Assessment (BNA) built on the work undertaken for the ACT Medicare Local (ACTML) 2014 Comprehensive Needs Assessment (CNA), which provided a good foundation. Engagement was focussed on issues identified in the CNA and the 6 key priority areas that the Department of Health set PHNs for targeted work: mental health; Aboriginal and Torres Strait Islander health; population health; health workforce; eHealth and aged care.

Data and information presented in the BNA has been collected from a range of sources, including, published reports, journal articles, government datasets, survey data, and consultation with government, peak bodies, non-government organisations, providers, consumers and community in the ACT.

We also considered it important to collect information relating to health inequalities in the ACT population and to have a focus on those groups who are disadvantaged or vulnerable. We were interested in exploring those groups who have unmet needs in the community and who may not have access to mainstream primary health care services.

ACT Government priorities were also kept in mind so that local priorities reflected these priorities as well as issues/needs identified by local stakeholders. We are working closely with ACT Government (both Health and Community Services Directorates) to ensure that we have maximum alignment of priorities where possible.

Through this work, we have gained a better understanding of the needs and resources of the ACT community. The BNA lays the foundation for our Activity Work Plans (2016-2018), which guide the activities to correspond with the PHN Objectives, Key Priorities and/or the National Headline Performance Indicators. The Activity Work Plans address gaps in service provision and aim to improve service integration within the PHN region. These Activity Work Plans are available on our website: <https://www.chnact.org.au/>

We would like to thank everyone who took part in this assessment and made this report possible.

Executive Summary

Many key findings and priority issues are highlighted throughout the BNA. Being a single PHN jurisdiction has meant that we have had a particular emphasis on whole-of-system issues, as there are often common barriers that need to be addressed, particularly across the acute-primary care interface. Transition of care issues that were identified include lack of knowledge and awareness of community based support services; need for better access to outpatient services; lack of consistency in discharge planning processes and poor communication between different parts of health system.

Chronic disease prevalence and the expected years of life with a chronic disease has increased in the ACT. This has emphasised the need to develop higher levels of health literacy and competence in patients for managing their own health as well as the need to increase the capacity and capability of general practice to undertake early identification, assessment and intervention for patients at risk. There is also a need for improved information and infrastructure to support shared care planning and transition of care and the need to increase the capacity and capability of the health care system to deliver coordinated care to patients with complex chronic conditions that would most benefit.

CHN recognises that a workforce that is sufficient, capable and sustainable is a critical success factor towards an integrated health care system. There is a need to support a sustainable workforce supply of primary health care clinicians in order to deliver the health care needs for the population, which will be impacted by the ageing population, an increase in the prevalence of chronic diseases and more informed consumers. Advanced or high performing primary health care is a prerequisite for best practice chronic disease prevention and management and, the foundations of an efficient and effective health care system.

While the ACT has made progress in closing the gap in key areas, there remain many health inequalities between Aboriginal and Torres Strait Islander people and non-Indigenous Australians in the ACT. Priority issues identified include difficulty accessing non-Indigenous-specific primary care services; access barriers for support of social; emotional and cultural wellbeing and need for a child-centric integration of early childhood services across health, community services and education sectors.

There are other vulnerable populations in the ACT that are at greater risk of poor physical, psychological and/or social health status and health care access. For these vulnerable populations, there is a need to understand the link between social determinants of health and how these affect

health outcomes. These vulnerable population groups include people from a CALD background; people from refugee backgrounds; those who are homeless or at risk of being homeless; people experiencing domestic and family violence and those who are LGBTI. Priority issues identified include the need for access to primary health care services and ongoing need for outreach services for vulnerable people; the lack of interpreters and need for their appropriate use; the need for a more proactive role of GPs in screening, risk assessment and referral of people experiencing domestic and family violence and a need for information and training; and the lack of LGBTI inclusive referral options and access to a health service sector which can often be very heteronormative.

Early childhood (0-8 years) is a time of rapid brain growth and development and a critical time for laying foundations of future health, wellbeing, learning and development. The need for access to early intervention services, particularly for those families who have been identified as vulnerable, is extremely important.

As people age, they are more likely to access health care, with older people (aged 65 years and over) more likely to be admitted to hospital (and stay for longer periods of time), have more visits to GPs and allied health, and be prescribed more medication. Identified priorities in the ACT include the need to improve admission and discharge planning and communication processes; the need to prevent avoidable ED attendances and the need to improve integrity and uptake of end of life care planning.

Mental health and behavioural disorders affect approximately 15.5% of the ACT population. Key priority issues identified in the BNA include the need for early intervention in life, illness and/or in episode; the need for services for moderate to severe presentations; the need to improve management of physical comorbidities; the need for a systems approach to suicide prevention; a lack of peer participation in service development, implementation, delivery and evaluation; a lack of awareness and uncertainty surrounding the NDIS transition for those with psychosocial disability as well as barriers to accessing services for vulnerable populations.

CHN commissioned the Alcohol Tobacco and Other Drug Association ACT (ATODA), the peak body for the alcohol, tobacco and other drug sector in the ACT, to provide expert independent advice on AOD needs in the ACT. The key priorities identified were the need for improved community based specialist alcohol and other drug treatment support and the need for improved specialist treatment for Aboriginal and Torres Strait Islander people.

Although there has been significant financial investment in the support of after hours primary health care, as well as the introduction of a new market entrant in the National Home Doctor Service, the

number of potentially avoidable presentations to ED during the after hours period in the ACT remains consistent and is still a concern. Priority needs identified in the after hours period include more cost-effective deployment of after hours primary care resources for urgent care; access to GPs in after hours period for RACFs; access to diagnostic services, and awareness of after hours services.

1. Whole of System Issues

Overview

A number of whole of system issues have been identified that have significant adverse impacts on the efficiency and effectiveness of the health system, outcomes for patients and the effective operation of the primary care team. These in particular relate to:

- transitions of care between the acute/sub-acute/primary health care
- preventable hospitalisations

These broad issues have a significant relationship to one another.

Transition of care

The transition of care¹ between sectors is a key point in the delivery of health care, where adverse events and disruptions in the continuity of care often occur. It impacts on patient quality of care and the overall performance of the ACT's health care system. Older people with chronic and complex health conditions that are most likely to have multiple transitions of care across sectors are particularly at risk from adverse events.

The impact of problems identified at the acute/primary care interface(s) in the literature are:

- Increase in mortality
- Increase in morbidity (temporary or permanent injury or disability)
- Increase in adverse events
- Delays to appropriate treatment and community supports
- Additional primary health care or emergency department (ED) visits
- Additional or duplicated tests
- Preventable readmissions to hospital
- Additional costs to consumer, family, health system and community
- Emotional and physical pain and suffering for consumers, carers and families

¹ Transition of care here is defined from a broader systems viewpoint in line with the American Geriatrics Society definition... "a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Representative locations include (but are not limited to) hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs." APHCRI 2013

- High level of consumer and provider dissatisfaction with coordination of care across primary care / hospital interface (Russell et al., 2013b).

All of these problems are relevant to the ACT to varying degrees. By far the most significant issue raised by patients and clinicians alike was the lack of communication between systems, sectors, health professionals and patients/carers.

Key Issues

Communication breakdown at the public/private health care interface

Poor communication between different parts of the health system often results in delays in appropriate treatment or community supports, duplication of diagnostic tests and in some cases re-hospitalisation (Muecke et al., 2010). The quality of communication between different parts of the health system has considerable implications for patients, the health care system and health care costs (Oliver-Baxter and Bywood, 2013). The transfer of information between care providers is an essential component of any transfer to ensure patient safety (Russell et al., 2013b). Apart from the risk of achieving sub-optimal outcomes, poor communication wastes both patients' and clinicians' time and ultimately health system resources. Clinicians have a duty of care to ensure that they communicate with current care team members and subsequent care providers.

“The care is not bad once patients get into the system – it is the in-between that is the problem and potentially dangerous.”

(GP, Health Interaction Survey, 2013).

Poor communication also impacts on the need to improve integration between primary/acute and specialist care to facilitate a seamless patient journey. Good communication facilitates integration of care and, in particular, prevention of the need for acute care, ensures care is provided in the most appropriate setting, improves transitions of care and builds better working relationships between GPs and hospitals (Russell et al., 2013b).

Opportunities for improvement in increasing communication and engagement between primary care clinicians and public health services were highlighted in recent surveys of ACT clinicians (ACT Medicare Local, 2014c). In relation to communications with the acute system regarding results of investigations, 33% of GP respondents said that it was rarely or never clear who was responsible for following up the results and 47% said that this usually resulted in clinical consequences to the patients (GPLU, 2015a).

Outpatient clinic communication issues were particularly prominent, with GP comments about delays in receiving responses, difficulties in accessing clinicians required and the general sense that the system was overburdened and unable to respond effectively.

The same transition of care communication issues are also mirrored in the management of patients from surrounding NSW², although these are often further exacerbated by remoteness from support services which is not an issue in the ACT.

There is still clear evidence in the ACT that general practice staff and allied health professionals are often frustrated and feel removed from the care continuum when their patient enters an acute care setting. However, communication issues are by no means solely a public acute sector problem as in some areas tertiary services report difficulties in engaging with general practices, or where that engagement occurs, there is a lack of consistency of approach across the primary health care sector.

One mechanism for bridging the communications gap between sectors has been the GP Liaison Units (GPLU) located at both hospitals. There is a high level of awareness of these services and a significant majority of GPs consider the services they provide as excellent and very helpful (GPLU, 2015a).

Working with General Practice to manage transitions between hospital and community more effectively....some suggestions from clinicians...

- Improve eReferral programs, with standard referrals on GP and allied health professions practice software
- Discharge patients from clinics to allow GPs to continue care
- Reduce burden on outpatients departments by sharing care, communicating knowledge
- Identify individuals to help guide most appropriate referral pathway
- Access for GPs to various specialists for advice over phone (rather than junior medical staff)

(ACT Health Interaction Survey, 2013)

Priority Issues

Lack of consistency in discharge planning processes

One of the most critical communication issues is the efficacy of the discharge planning process. There are two broad aspects to discharge planning that contribute to the effective coordination of

² ACTML developed a joint report on cross border issues with SNSWML.

services – the process of discharge planning itself and the communication that takes place with a patient’s GP, usually in the form of a discharge summary that is required to be sent within 48 hours.

Effective discharge planning supports the continuity of health care, between the health care setting and the community, based on the individual needs of the patient. It is the critical link between treatment received in hospital by the patient, and post-discharge care provided in the community (Discharge Planning Association, 2016) and emphasises identifying patient needs prior to discharge and implementing interventions (Burke et al., 2014).

Hospital discharge is an inherently risky transition of care into the community setting and discharge summaries may not reach the patient’s GP or may be compromised by significant delays or poor quality. Information loss may affect patient safety through medication errors, failure to follow up results or management changes. This increases the risk of adverse events or re-admission, as well as inefficiencies in health services (Belleli et al., 2013).

Some patients are especially vulnerable to misadventures occurring at discharge, particularly those who are unable to advocate for themselves, have cognitive or physical impairments such as the elderly, are Aboriginal and Torres Strait Islander people or people from different cultures, or have complex problems and require multidisciplinary care (McGowan, 2014, Muecke et al., 2010). Anecdotal evidence from a number of areas in primary care have indicated that Friday afternoons are a particular pressure point which reinforces views that “hospitals are geared to getting people out” because of bed management pressures. This can be a particular issue for the aged who make up 36% of patients as well as an issue for both primary health care providers and patients alike.

Discharge planning continues to be an issue, particularly at Canberra Hospital. This is most manifest in the lack of clearly articulated arrangements with regard to follow-up post discharge and highlights poor systems that appear to be in place in at least some clinical units. In particular, there appear to be issues in recording specialty team and allied health input as well as providing comprehensive details, or in some cases any details, about follow up appointments. The most recent audit (ACT Health, 2014b) showed that 12% of discharged patients did not have any information that follow-up appointments were required, while only 16% had any evidence that these appointments had been made and only 20% included clear and comprehensive details of appointment time/date and location.

While there is no recent local research on the effectiveness of discharge planning processes, there is anecdotal evidence that significant fragmentation in approaches exist. Health Care Consumers’ Association (HCCA) has pointed out concerns that patients and carers often leave hospital with little

understanding of underlying health problems, particularly for the aged, which contributes to unplanned readmissions (McGowan, 2014).

While timeliness of discharge summaries was improving considerably, recent data (ACT Health, 2015b, Calvary, 2016) is showing that only 61% of Canberra Hospital and 74% of Calvary discharge summaries were sent within 48 hours of discharge, the generally accepted standard target³. For Canberra Hospital this is a very significant decrease from the 96% completion rates that were evident in 2014 and 94% in 2013.

Other problem areas in the quality of discharge summaries that could be symptomatic of system issues were:

- 22% of summaries at Canberra Hospital and 16% of summaries at Calvary had an incomplete or incorrect principal diagnosis
- 33% at Canberra Hospital and 26% at Calvary had additional diagnosis incomplete or not recorded
- when there were complications only 57% had these accurately recorded at Canberra Hospital and 92% at Calvary
- 10% of medications at Canberra Hospital and 16% at Calvary were not being accurately recorded
- the reasons that medications were prescribed was only provided in 16% of cases at Canberra Hospital, a considerable decrease from 48% in 2013
- at Calvary the reasons why medications were changed was documented in only 54% of summaries

Given the high rates of hospitalisation due to medication misadventure, particularly among the elderly, these results are concerning, particularly since GPs will rely on this information to manage medications post discharge.

The auditor's overall conclusion on the Calvary results was that only 70% of summaries were adequate for the GP to continue care.

These results are reflected in feedback from GPs, with about 1/3 of GPs rating the Canberra Hospital discharge summaries as average or below average, and 43% for Calvary (GPLU, 2015a). Information about changes to medication was rated as below average or poor by 19% of GPs for Canberra

³ However the new EQuIP standard requires discharge summaries at time of discharge.

Hospital and 71% for Calvary. 65% of GPs rated clarity about follow up requirements as average or below at Canberra Hospital and 69% for Calvary.

It is clear that this level of performance with regards to discharge information poses safety and quality risks for patients and makes continuity of care a major challenge. While the reasons for the variable quality seem to be multifaceted and will vary between hospitals, the principal reasons appear to be:

- There is no single central discharge planning administration system in either hospital, with clinical units largely being responsible for the discharge of their patients. Under these circumstances, the quality of planning and summaries produced will inevitably be variable.
- The design of some aspects of the current processes appears to not be in line with what would reasonably be required to provide a comprehensive set of clinical information to GPs and other members of the primary care team e.g. routine capture of changes in medication or recording of allied health services while in hospital, limitations about what fields can be added into summaries.
- The quality of information provided for discharge summaries by Junior Medical Officers (JMOs) who are tasked with completing them. It appears that JMOs are not perhaps specifically trained or necessarily aware of the paramount importance of accurate clinical handover notes for high quality continuity of care and patient safety.
- The lack of knowledge or understanding of the services that are available in the community to support patients. This issue is further discussed below.

Strategy

A system level response (involving both the acute and primary care sectors) is required that supports the continuity of care and safe care transition. A recent review of the research on communication between health professionals across sectors has concluded that strategies to address these require system and structural support reinforced by benchmarks for minimum required communication between sectors (Oliver-Baxter and Bywood, 2013).

Audit evidence shows that there is discharge summary performance metric variability between hospital clinical units with regard to quality. At a minimum, more detailed specific unit audits should be conducted to establish the root cause of poor performance and for any barriers to be specifically addressed. Some of these may involve relatively simple “fixes” or uncomplicated

changes in procedure (e.g. document that patient has received the discharge summary). However, the evidence appears to show broader systematic issues that result in poor communication in care transition. No single solution is likely to rectify complex issues, but multiple strategies are more likely to be successful.

- Getting key executive endorsement that effective discharge planning processes are a non-negotiable part of core business that affect the quality and safety of patient care, and that high quality discharge summaries are a key performance and accountability metric for all clinical units.
- Development of a mandatory uniform discharge summary system across all clinical units in order to improve efficiency and useability and to minimise training that would be required across multiple systems. Invariably, this will mean the need to establish a centralised infrastructure to support the capability of clinical units to implement and integrate discharge planning and summaries into standard work flows.
- Development of a system-wide standard around key performance metrics such as timeliness, accuracy and completeness of a range of data that forms critical information about a patient's ongoing care.
- Development of routine audit tools that measure the key performance metrics in close to real time, with flags to ensure that any significant drop in performance results in immediate management intervention.
- Moving to an electronic discharge summary system (including integrated electronic medication management) that would facilitate the improvement of completion and delivery rates. In the longer term this should be part of a whole of system electronic health record.
- Systematic (i.e. not one-off) targeted training of JMOs supported by continual feedback on performance metrics. The targeted audit and feedback cycle has been shown to result in considerable improvements across a number of discharge functions (Dinescu et al., 2011).

- Integrating requests for follow-up appointments for outpatient clinics into work flows and/or electronic systems as an integral part of the discharge process, along with clear documentation on discharge summaries.

Consideration should be given to approach ACT Health to establish and resource a 'whole of system' working party (comprised of senior operational managers in the acute system, key primary health care representatives and consumers) tasked with the review and development of a uniform discharge planning system based on good practice coordinated care principles and a well-developed understanding of the roles and capacity of each sector. This would include a standardised approach to discharge summaries and a centralised system for outpatient clinic appointments. The latter would also be of significant benefit to patients from NSW, particularly those that require appointments in more than one clinic. The working party would be tasked to develop an overarching framework for the redesign of the discharge planning process in ACT public hospitals.

Variable access to outpatient services

Over recent years there has been a significant build-up of demand for public specialist outpatient services at Canberra Hospital. At the same time, due to the increasing burden of complex and long term chronic disease, greater focus has been placed on delivering optimal, patient-centred care outside of acute settings (NSW Health, 2015). Outpatient services are an essential part of the health services infrastructure as they can provide specialist follow up post hospital discharge when this is required as well as important specialist consultations at no cost to the patient, for conditions that GPs consider need specialist advice. In some cases these are chronic conditions that require specialist input to be able to develop tailored management plans.

Current growth in demand for outpatient services is unsustainable and is already well beyond capacity. As of January 2016, overall waiting list numbers stood at over 13,000. ENT, urology, vascular, general surgery, orthopaedics and plastic surgery currently have the largest waiting lists. This has resulted in a large number of patients waiting beyond target timeframes for appointments in many specialities, which in many cases leads to suboptimal management of a particular condition or delayed diagnosis. An overwhelmed outpatient service also results in a constrained ability to deal with the highest priority patients and a great deal of frustration from GPs and patients regarding the status of patients at any particular time. This particularly affects older patients who are more likely to have had a complex acute care treatment due to comorbidities and may require review by multiple specialist clinics (COTA ACT, 2016).

The 2015 annual survey of GPs undertaken by the hospital GPLUs found that 65% of GPs rated clarity about post admission follow up requirements as average or below at Canberra Hospital and 69% for Calvary. Recent data from Canberra Hospital GPLU enquiries shows that almost half of the 2,500 GP enquiries over the past year related to outpatient issues. In 2014, only 16% (down from 24% in 2013) of discharge summaries have evidence of outpatient appointments being made and the majority of patients without appointments but needing them, appear not to have been given clear instructions about how to make such appointments. Very few of these contained clear details of the appointment date/time and location. This significantly increases the risk of patients not being seen within clinically appropriate times (ACT Health, 2013b).

A number of issues are apparent:

- There is variability in how referrals to outpatient clinics are organised as part of the discharge process from both hospitals. There is no centralised management of demand and appointment allocation. Both GPs and patients often do not know whether a referral has already been made as part of discharge or whether there is an expectation that GPs make the referral. There is no documentation as to whether the patient has received a copy of the discharge summary, which often does contain useful and comprehensive information.
- There is variability in the quality of GP referrals to outpatient clinics, both in terms of appropriateness or completeness. This includes referrals prior to appropriate initial exploration and/or completion of primary care treatments and tests. This has system efficiency impacts which are exacerbated by long waiting lists for many medical and surgical specialist clinics. It also results in tertiary resources being utilised when patients should have been appropriately managed by their GP (ACT Auditor-General's Office, 2014).

Evidence from the National Health Service (NHS) suggests that there is likely to be significant variation between GPs on referral rates, a substantial proportion of referral activity is discretionary and could be avoided or redirected and the absence of key information can make it difficult to triage referrals appropriately (Naylor et al., 2013). Late referrals, particularly for some diseases, may also impact on health outcomes in some cases.

- GPs, patients and specialists do not always share a common understanding of why a referral is being made. Recent administrative audits have revealed that in many cases, patients are not aware that a referral has been made, or for what purpose. This underscores the importance of looking at a higher degree of partnership with patients and where possible

supporting a patient's own personal "expertise", particularly in managing chronic conditions (McGowan, 2014).

- A lack of an effective eReferral system has been problematic for many years (GPLU, 2015b). A streamlined referral system is a fundamental requirement for efficient and safe transfer of patients between health service providers. To date the design of the eReferral system has not adequately taken into consideration technical compatibility issues with common GP desktop patient management systems resulting in an inability of many referrals to be read at the hospital end. This has undoubtedly been caused by "hospital-centric" design specifications, even though in the case of eReferrals the main patient referrers are GPs.

Business processes at the hospital end are still not reliable to guarantee that eReferrals are being received and that there is eMessaging back to the referrer. Many examples have been reported of "lost referrals" as a result of these compatibility issues.

This has resulted in workarounds and multiple systems in place to manage eReferrals (ACT Health, 2016h) including going back to direct faxing into the clinical portal which allows tracking and fewer "lost referrals", but makes it difficult to send additional information without creating duplicates. It is reported that specialists are not happy with either the current eReferral system nor the current faxing arrangements. Some GPs also include information that is superfluous to the referral requirements, further complicating the operation of a streamlined referral process. Consequently few general practices now actually use the eReferral system.

- There are multiple referral pathways including a variety of potential intake points. This is confusing both for GPs and patients and adds another level of complexity into the referral process.
- The appropriate and timely referral of patients to GPs rather than to outpatients clinics appears to be a continuing problem. This generally occurs at two points of the patient journey. Firstly, upon discharge from hospital where the need for a specialist medical or post surgical review may not always be necessary. Secondly, there appears to be a natural tendency for "patient capture" by specialist clinics, that for whatever reason, do not transition patients back to GPs as early as it is clinically safe to do so. The consequence is that outpatient clinics are more crowded than they should be, delaying initial appointments to what in some cases are likely to be higher acuity patients.

There are likely to be a number of reasons for this including:

- a lack of clarity and or confidence about what conditions can be managed by GPs or other primary care providers, particularly among registrars and JMOs
- no clear referral pathways out of the acute hospital system
- general lack of familiarity with the primary health care system.

Strategy

Improving the quality and appropriateness of referrals would have an impact on patient experience by avoiding unnecessary visits and improving the timeliness of treatment (Naylor et al., 2013).

The significant issues with the operation of the Outpatient's Department have been more recently recognised by ACT Health. A review was conducted in 2014-15 to redesign an administrative structure for ambulatory services for Canberra Hospital and Health Services, although the way referrals are received, recorded, triaged, appointments made and then how information should be provided back to the GP in a timely manner to support ongoing care still needs to be addressed adequately. An Outpatient Waiting List Reduction Strategy to address these system issues at Canberra Hospital has been implemented from the beginning of 2016, aimed at providing "better access to coordinated, integrated, and accessible ambulatory care services that support highest priority health needs of the community" (ACT Health, 2016h).

To address many of the issues identified above, key aspects of the strategy need to include:

- whole of system orientation of referral management and intake
- building real time dashboard reporting capability at clinical unit level to monitor waiting lists, appointment timeframes, capacity and resource usage, "new/review" ratios and conversion to surgery rates
- standardised timelines and communication points so that primary care referrers are kept updated as to progress with a patient's referral
- redesign of referral pathways in conjunction with primary health care clinicians, including the development of clear referral (including required work-ups) and exclusion criteria for each specialty clinic and alternate options for particular conditions
- guaranteed access for GPs to specialist advice for conditions that can be managed in community settings

- targeted education and support resources for primary health clinicians on the management of “excluded” conditions
- implementation of a whole of system eReferral module that will standardise both internal ambulatory care referral management process and seamlessly integrate with GP and allied health desktop patient management systems and link providers across all settings.

NSW Health is currently completing a Specialist Outpatient Services Strategic Framework (NSW Health, 2015) that articulates the policy, standards, and processes for the optimal delivery of specialist outpatient services and consideration should be given to adapting a similar approach in the ACT to apply across both hospitals.

To complement the above approach, improving the quality and appropriateness of referrals would have an impact on patient experience by avoiding unnecessary visits and improving the timeliness of treatment (Naylor et al., 2013). A combination of strategies may be required and two in particular have been referenced in recent literature on referral management, both of which require strong clinical leadership from both the primary and acute care sectors. These are:

- the development and systematic use of comparative information about GP referral rates and practices by speciality, supported by more detailed audits at practice level
 - This is a longer term strategy that requires a high degree of collaboration between hospital specialists and GPs, but could be developed starting with some of the “pressure point” outpatient clinics, triggered by internal hospital audits.
- the development of coordinated patient care pathways for entire episodes of care by multi-disciplinary groups/clinical networks involving all providers (primary health, specialist and community care) and consumers to optimise care across the continuum (Nicholson et al., 2013, Timmins and Ham, 2013). These are effectively local agreements on best clinical and referral practice in the context of available resources to be delivered through the HealthPathways program.
 - To the extent that these pathways include ambulatory care, HealthPathways can facilitate agreement on and support system changes to ensure a seamless referral system both into and out of ambulatory services.

Lack of knowledge and awareness of support services

The general lack of knowledge and awareness about what support services were available in the community was a universal and high priority issue that was raised in many forums. This issue has been raised by GPs, specialists, allied health providers, alcohol and drug service stakeholders, mental health providers, Aboriginal and Torres Strait Islander community representatives and refugee advocates.

“Most key informants indicated that their clients or members are simply not aware of the kinds of services that are available to them, and what assistance they may be eligible for..... navigating the health system proved one of the most troubling barriers to access care.”

(McGowan, 2014)

HCCA reported that most consumers still rely on their GP to perform the role of service coordinator, however the ability of GPs to have a good understanding of health and support services provided in the community was recognised as being problematical. Nevertheless, there was a firm view that general practices should keep themselves informed of how to access support services and this view is supported by the health care home model.

This lack of knowledge of service availability and capacity is not unique to the health sector and has also been raised in the context of social services. However, a system that facilitates a high degree of the right kind of information is a fundamental building block for coordination of care and the development and up-to-date maintenance of referral pathways. Recent research has highlighted that active integration of community and social support networks addressing needs of patients discharged from hospital was one of the top three Ideal Transition of Care domains associated with success in reducing re-admissions (Burke et al., 2014). Put simply, if the information is not available in the right place and at the right time, then that service is not accessible to a patient with the likelihood of sub-optimal outcomes and inefficient use of available resources.

Poor information infrastructure to support shared care planning and transition of care

An issue that is integrally related to both communication between sectors and care coordination is the need to improve information infrastructure to connect clinicians to support both transition of care and support shared care planning. A key underlying theme that emerged from the ACT Health Interaction Survey was the need for increased communication, not only across health care sectors but also between clinicians. There is significant evidence that shows the importance of

communication among multi-disciplinary care teams and the negative effect that fragmentation can have (Maneze et al., 2014).

The importance of a chronic care model delivery system involving planned care, regular follow-up and review, up-to-date information about a patient's status and multidisciplinary team care has been well established for many years (Coleman et al., 2009) and there seems to be agreement that a coordinated approach provides optimal management of chronic disease (Anikeeva and Bywood, 2011, Dawda, 2014) (see further discussion in section 2 on Chronic Disease). Care coordination problems are greatest at the interfaces between health care sectors and between providers and multidisciplinary care is critical to overcoming some of these barriers (Page et al., 2014). Promotion of local integrated information communication technology and eConnectivity has also been noted as a key element and significant enabler in integrating patient care and assisting in inter-professional communication across organisational boundaries – a move to “one patient, one chart” (Nicholson et al., 2013).

In recent years, shared care software tools have become available that provide a range of functions to improve care delivery and coordination. Their functions include the generation of patient summaries and management plans in line with Medicare items, ongoing review with guideline based alerts and targeting of high risk patients and shared access to data for different health care providers to better coordinate multidisciplinary care. Such delivery systems have not been taken up to any significant extent as part of routine practice in the ACT. This is also reflected in the relatively low uptake rates of CDM allied health services in the ACT compared to other states (discussed further in chronic disease section).

Shared care software tools have been associated with process level improvements, but there is a lack of evidence of positive impact at the patient level, possibly because chronic disease interventions need a longer time to achieve outcomes than short term pilots ever allow (Suter et al., 2009, Anikeeva and Bywood, 2011). Nevertheless, improvements in process parameters are likely to be an important basis for achieving improved whole of system health outcomes in the future. In addition, systems to manage the more complex chronic disease patients in particular are likely to become a larger part of routine practice as enablers that support GPs and other treating team members in proactive patient management. Further, both public and private health service managers need to think beyond immediate business needs and be cognisant of emerging technology trends that may increase the productivity of service delivery and promote integration of services.

In the context of this emerging environment, the barriers to use may need to be addressed.

User engagement

Concerns about data security and the storage and transfer of personal health information have been raised in the past and may be the primary driver around relatively low uptake. Other barriers identified by health professionals include lack of training, cost and potential increase in workload. For some it is the perceived negative impact of computers in the doctor-patient relationship during consultation (Primary Health Care Advisory Group, 2015). In the case of implementing the national personal health record system in Denmark, while technical challenges featured highly as the contributing factor for low adoption rate, it was clear that the real missing piece was around intensive engagement with the frontline clinicians and patients (Jolly, 2011).

The pace of technological changes is always more rapid than the clinicians' ability to adapt, as clinicians are primarily interested in the clinical aspect of their work. Without targeted education on the use of new digital technologies, clinicians will quickly lose interest in them and miss the opportunity for transformation (Deloitte Centre for Health Solutions, 2015).

Increasing health literacy and patient engagement is also a challenge. The My Health Record (which superseded the Personally Controlled Electronic Health Record - PCEHR) is designed to provide a single repository of all essential health information that can be accessed by both patients and health professionals. Through control of their own electronic health record, patients may take a stronger interest in their own health status and the operation of relevant aspects of the health system. Health professionals benefit from having access to the right level of information for making informed decisions on the care of their patients. The openness in sharing information between patients and service providers can facilitate shared decision-making.

Strategy

The "opt in" arrangement may effectively address the issue around low adoption. The Primary Health Networks will work closely with the health care workers in supporting consumers build trust with My Health Record and eventually use it to manage their own health care.

CHN, as the catalyst for system-level changes at the regional level, has the potential for nudging the primary health care sector in the direction of becoming more technologically capable. Given the resistance of adapting their models, primary health care services may respond better to incentives – both financial and non-financial – that are tied to the sustainable adoption and competent use of digital technologies. This will require setting targets in service commissioning, financial rewards for actual use of the My Health Record (Department of Health, 2013), change

management and transition support, and development of implementation strategies in collaboration with clinicians and patients (Jolly, 2011).

CHN will need to consider funding of a specialist resource to support the effective engagement of general practice and allied health providers in a range of interrelated local and national eHealth programs and digital enabling infrastructure.

Whole system platform

While there is some utility in considering the intrinsic benefits of communication enablers such as shared care platforms and personal electronic health records in their own right, the overarching issue is the need to develop an integrated electronic health record system that supports the seamless transfer of patient data, referrals and related documents between the primary care and acute care system. Robust and complete patient information is the key enabler to integrated care.

Adoption of shared electronic health record systems in hospitals, outpatient clinics and primary and community care settings is accelerating with a number of jurisdictions currently making substantial investments⁴. Shared electronic health records can support and revolutionise the way information is stored, accessed, shared, and analysed for patients, patient cohorts, and organisations, creating a foundation for potentially dramatic improvements in quality of care, patient safety, public health monitoring, and research (Lowry et al., 2014).

In the ACT public sector, design flaws, insufficient attention to the requirements of referrers, and poor interface issues with existing systems have affected useability and integration into workflow at both the GP and hospital and ambulatory care end and have contributed to slow and disrupted rates of adoption. Further, in the case of the long running eReferral implementation, workflow and technology problems have resulted in “workarounds” that sit outside of the design of the system and introduce an additional range of risks around the integrity of the system and ultimately patient safety. This has left many GPs and specialists alike sceptical about such systems and there has been reversion back into paper-based systems.

The ACT is a small and compact enough jurisdiction to provide significant leadership in the design and implementation of a jurisdiction-wide system, as well as the all-important change and adoption strategies that will be required.

⁴ For example see NSW HEALTH 2016. eHealth Strategy for NSW Health 2016-2026: A Digitally Enabled and Integrated Health System Delivering Patient-Centred Health Experiences and Quality Health Outcomes. NSW Health.

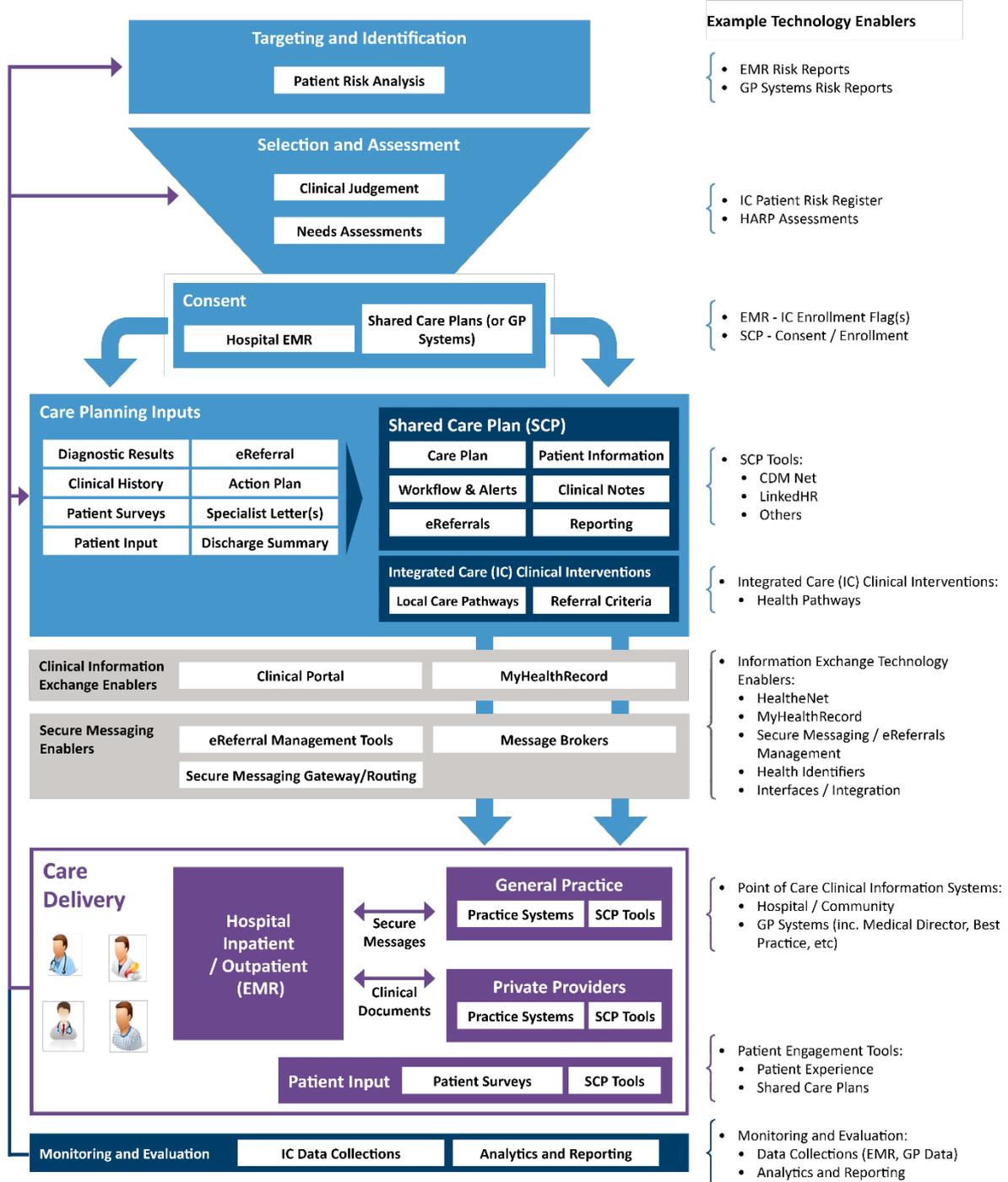
Strategy

The criticality of local integrated information communication technology and eConnectivity as a key element and significant enabler in integrating patient care and assisting in inter-professional communication across organisational boundaries makes this a high priority area. ACT Health has, since late 2015, indicated that it is seeking a completely new strategy to be in place for the rollout of its eHealth systems over the next decade. This provides the primary care sector with a significant opportunity, for the first time, to jointly design a joined-up whole of system electronic health record platform that will be able to enable future models of coordinated care, particularly for higher risk patients (see Chronic Care Model in section 2) and specific targeting and identification of these within the primary health and acute/sub-acute care sectors. This will allow the sharing of comprehensive health records across the care team, including GPs, specialists, local hospital networks and allied health providers.

The conceptual outline of the key components, functions and technology enablers of such a model are set out in Figure 1.1 below. CHN will need to engage with ACT Health to ensure that whole of system connectivity and particularly connectivity to primary care is integrated into future ACT eHealth strategies.

Figure 1.1: Integrated Care Model – Key components, functions and technology enablers

Integrated Care Model - Key components, functions & technology enablers



Adopted from NSW Health

Potentially preventable hospitalisations

Reducing rates of potentially preventable hospitalisations is a key performance indicator set by DoH and is also a part of a range of government health care agreements. At the outset it is necessary to acknowledge that there are a number of limitations pertaining to potentially preventable hospitalisation data, including technical ones such as variations in coding between hospitals, difficulty in determining which hospitalisations are truly avoidable. In particular there needs to be caution around the reliability of the data as an indicator of primary health care access issues. The role of other factors such as personal level variables (age, gender, ethnicity, and socio-economic status) and health characteristics (self-reported health, greater number of comorbidities) have been shown in a number of studies to be major drivers of preventable hospitalisations (Katterl et al., 2012, Falster et al., 2015).

Potentially preventable hospitalisations (PPHs) are admissions to hospital that may have been prevented through timely and effective use of non-hospital or primary health care (National Health Performance Authority, 2015c). It is important to note that a potentially preventable hospitalisation does not mean that the person admitted did not need to be hospitalised at that time, but that the admission may have been prevented by managing the condition appropriately out of hospital. There are 22 conditions for which a hospitalisation is classified as potentially preventable and these are grouped into three main types: Vaccine-preventable, chronic and acute conditions (Katterl et al., 2012). Potentially preventable hospitalisations for these conditions can be used as a measure of the performance of primary health care and other out-of-hospital care, as the admission may have been avoided with the delivery of optimal care in the community (National Health Performance Authority, 2015c). A reduction in preventable hospitalisations will reduce costs and demand associated with hospitalisations and alleviate the distress that patients experience when they are hospitalised for a condition that has reached a level that requires an acute care response (Katterl et al., 2012).

While rates of potentially preventable hospitalisations are reported internationally as an indicator of health system performance, with the underlying rationale that variation in admission rates is related to accessibility or quality of primary care, based on measures such as the density of the general practitioner (GP) workforce, perceived availability of health services, the presence of community health centres or having a regular source of care, it has been shown that personal sociodemographic and health characteristics are major drivers of preventable hospitalisations (Falster et al., 2015).

For Aboriginal and Torres Strait Islanders in 2013-14, the rate of overall PPHs per 1,000 population was over three times the rate for other Australians. It was also seen that residents of remote and very remote areas had a higher rate of PPHs compared to residents of major cities. And the rate of

PPHs generally decreased with increasing levels of socioeconomic advantage (Australian Institute of Health and Welfare, 2015a).

Potentially preventable hospitalisations are commonly reported in two main ways: the number of separations/hospitalisations and the number of hospital bed days. Nationally, in 2013-14, there were 600,266 hospitalisations for the conditions considered potentially preventable, representing 6.2% of the total hospital admissions in that year, 8.1% of public hospital separations and 3.4% of private hospital separations (Australian Institute of Health and Welfare, 2015a). Potentially preventable hospitalisations also accounted for nearly 2.4 million bed days, approximately 8% of all hospital bed days in the same year (National Health Performance Authority, 2015c).

Nationally, in 2013-14, there were five main conditions; chronic obstructive pulmonary disease (COPD), diabetes complications, heart failure, cellulitis and kidney and urinary tract infections, that accounted for almost half (47%) of all potentially preventable hospitalisations and almost two-thirds (62%) of bed days for these admissions (National Health Performance Authority, 2015c).

In 2013-14 the ACT had a lower age-standardised rate per 100,000 for potentially preventable hospitalisations when compared to Australia, 1,845 and 2,436 respectively, and the second lowest rate in Primary Health Network (PHN) areas in Australia, behind Northern Sydney (1,702) (National Health Performance Authority, 2015c). The ACT had the lowest rate among states and territories for the proportion of all hospital admissions that were potentially preventable, 4.8% compared to 6.2% nationally (Australian Institute of Health and Welfare, 2015a).

Kidney and urinary tract infections (UTIs) were the most common cause of hospitalisations accounting for 11.7% of all potentially preventable hospitalisations in Australia in 2013-14. However, this percentage was higher in the ACT, accounting for 14.4% of all potentially preventable hospitalisations, which was the highest percentage for all PHNs.

The ACT ranked in the top five of all PHNs when examining age-standardised rates of PPHs per 100,000 people, excluding kidney and urinary tract infections, where it ranked 13, however, this was still lower than the Australian rate (Table 1.1).

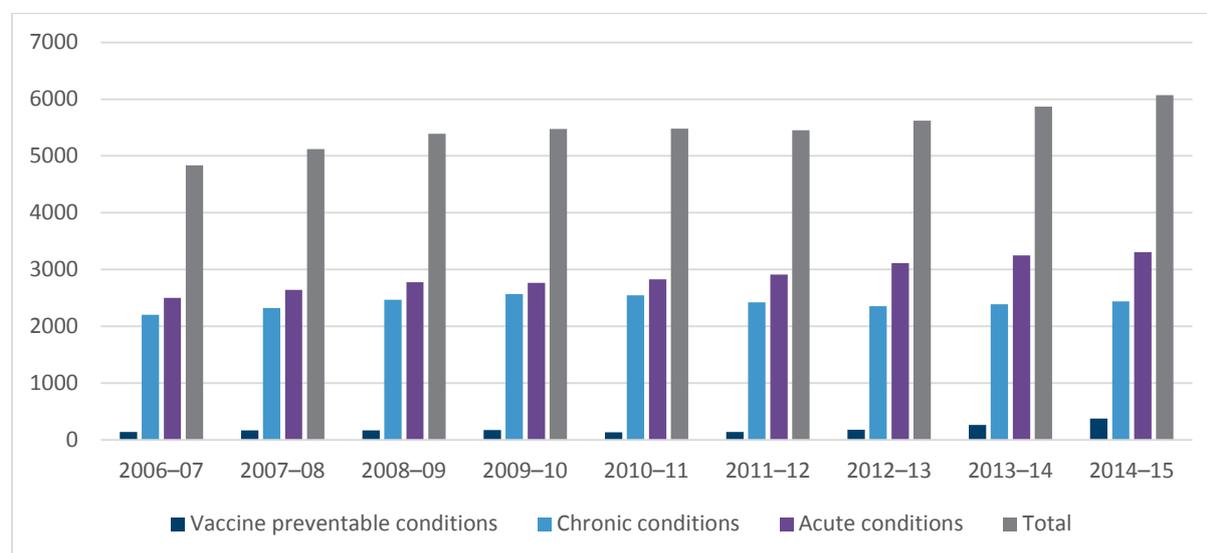
Table 1.1: ACT compared to Australia (and ranked against PHNs) for rates of chronic, acute and vaccine-preventable conditions and the five main potentially preventable hospitalisation conditions in 2013-14

	ACT	Australia	ACT Ranking (out of the 31 PHNs)
	PPH per 100,000 people (age-standardised)		
Chronic	813	1,122	1
Acute and Vaccine-preventable	1,039	1,325	Equal 1
Cellulitis	169	237	Equal 4
Heart Failure	149	195	2
COPD	190	239	5
Diabetes complications	119	166	3
Kidney and UTIs	264	279	13

Source: (National Health Performance Authority, 2015b)

The rate of potentially preventable hospitalisations in the ACT has been increasing since 2006-07, with over 6,000 separations occurring in 2014-15 (Figure 1.2). Overall, in 2014-15, acute conditions accounted for 54% of the total potentially preventable hospitalisations, with 40% being chronic conditions and 6% vaccine preventable conditions.

Figure 1.2: Changes in the rates of potentially preventable hospitalisations over time in the ACT



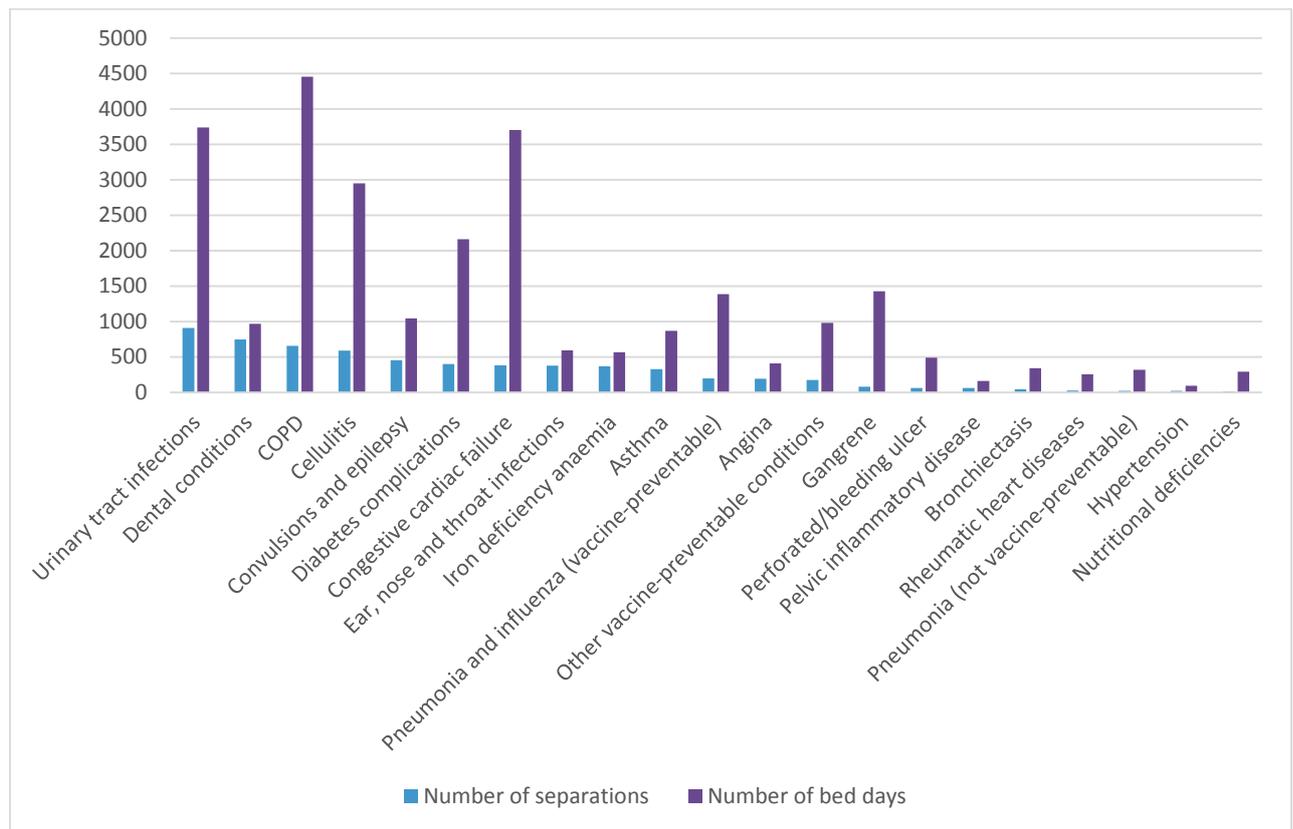
Source: (ACT Health, 2016i)

Urinary tract infections, dental conditions, COPD, cellulitis and convulsions and epilepsy were the most common conditions of potentially preventable hospitalisations in the ACT in 2014-15 (Figure 1.3). However, COPD, UTI's and congestive heart disease had the highest rates of bed days, followed by cellulitis and diabetes complications. Consistent with Australian data (National Health

Performance Authority, 2015c), these five conditions accounted for almost two-thirds (62%) of total ACT PPH bed days in 2014-15.

While nutritional deficiencies, pneumonia (not vaccine-preventable) and gangrene had low rates of hospitalisations they had the highest rates of average length of stay in hospital.

Figure 1.3: Number of hospitalisations and bed days per potentially preventable condition in 2014-15



Source: (ACT Health, 2016i)

When comparing the rates of potentially preventable hospitalisations in areas of the ACT, North Canberra had the highest age-standardised rate for total hospitalisations in 2013-14 followed by Tuggeranong and Belconnen (Table 1.2). North Canberra had the highest rate for three out of the five main conditions, cellulitis, COPD and diabetes complications.

Table 1.2: Potentially preventable hospitalisations in the ACT by Statistical Area Level 3 (SA3) per 100,000 people (age-standardised), 2013-14

	TOTAL PPH	Chronic	Acute & vaccine preventable	Cellulitis	Heart failure	COPD	Diabetes complications	Kidney & UTI
North Canberra	2,097	892	1,218	213	110	243	152	297
Tuggeranong	1,935	902	1,039	154	155	212	150	262
Belconnen	1,905	879	1,033	194	174	220	126	263
South Canberra	1,798	687	1,115	143	173	107	NP	300
Gungahlin	1,773	751	1,030	171	NP	206	92	300
Woden	1,739	750	993	139	163	148	106	258
Weston Creek	1,683	611	1,073	147	116	143	NP	235
Cotter - Namadgi	NP	NP	NP	NP	NP	NP	NP	NP
Fyshwick - Pialligo - Hume	NP	NP	NP	NP	NP	NP	NP	NP

NP: Not for publication.

Source: (National Health Performance Authority, 2015b)

Strategy

Accessibility to primary health care has been shown to strongly associate with the rates of hospitalisations for avoidable conditions. Higher rates of preventable hospitalisations have been seen when there is poorer self-reported access to medical care, higher costs for the consumer, lower ratios of GPs to population, lower numbers of GP consultations and greater remoteness (Katterl et al., 2012). Other factors associated with increasing rates of potentially preventable hospitalisations are age (over 65 years); lower socioeconomic status; ethnicity, including Aboriginal and Torres Strait Islander people; comorbidity and prior hospitalisations (Katterl et al., 2012). A study examining preventable hospitalisations in over 20,000 adults in NSW found personal sociodemographic and health characteristics, rather than GP supply, are major drivers of preventable hospitalisations (Falster et al., 2015).

Nevertheless, hospital admissions for chronic conditions may be more amenable to disease management strategies across the entirety of the health system as multi-morbid patients require complex case management, with self-management often being poor and medication related hospitalisations being common (Falster et al., 2015). A comprehensive review on avoidable readmissions undertaken by the Primary Health Care Research and Information Service (PHCRIS) indicated that while evidence is relatively sparse, common characteristics of promising interventions included high-risk identification; patient education; comprehensive discharge planning and scheduled follow up (Katterl et al., 2012). A more recent international systematic

review of the evidence on reducing readmissions has supported most of the above themes and has shown that systems for managing and monitoring symptoms after discharge were most successful, along with educating patients to promote self-management and the provision of social and community supports could also be effective (Burke et al., 2014).

Evidence suggests that interventions to reduce PPHs are more effective when they target specific conditions, rather than taking a large-scale policy approach (Katterl et al., 2012).

One area of targeted focus is avoidable readmissions to hospital, which are common, costly and often preventable. A review of published evidence regarding cost-effectiveness of multi-component COPD programs showed that programs that used three (decision support, self-management and delivery system design) or all four components of the Chronic Care Model (CCM) (Wagner et al., 2001) showed statistically significant lower rates of hospitalisations (Steuten et al., 2009).

Targeting the reduction of potentially preventable hospitalisations aims to improve patient outcomes, reduce pressure on hospitals and enhance the health systems efficiency and cost-effectiveness (Katterl et al., 2012). Common characteristics of effective initiatives to reduce potentially preventable hospitalisations include:

- Early identification of patients who are at risk of hospitalisation
- Care coordination and integration of services
- Enhanced access to primary health care and focus on equity
- Multidisciplinary care team
- Disease management, particularly for medium to long-term.

[Specific initiatives are further discussed in section 2 on chronic disease]

2. Chronic Disease

Overview

Chronic disease has become the main cause of illness and death and the most significant burden on the Australian Health System (Australian Institute of Health and Welfare, 2014b). While the life expectancy for those aged 65 years and over has increased, expected years of life with a chronic disease or disability have also increased.

Primary health care has a significant role in effective chronic disease prevention and management: identifying those at risk of developing chronic disease and working with individuals and families to both address risk factors and strengthen protective factors, and; working with individuals and the extended chronic care team to provide comprehensive care and achieve better health outcomes.

In the ACT in 2014 the five leading causes of death were ischaemic heart disease, malignant neoplasms of digestive organs, cerebrovascular diseases, other forms of heart disease and organic (including symptomatic) mental disorders (Australian Bureau of Statistics, 2016b). These leading causes however vary by sex and age.

A comparison of deaths and Years of Life Lost (YLL) in the ACT against national comparators (2014) paints a mixed picture with 57% of all deaths attributed to cancers and circulatory diseases (Australian Bureau of Statistics, 2016b) and significant variance in YLL in terms of circulatory conditions and cancers (Table 2.1).

Table 2.1: Comparison of deaths and Years of Life Lost, 2014

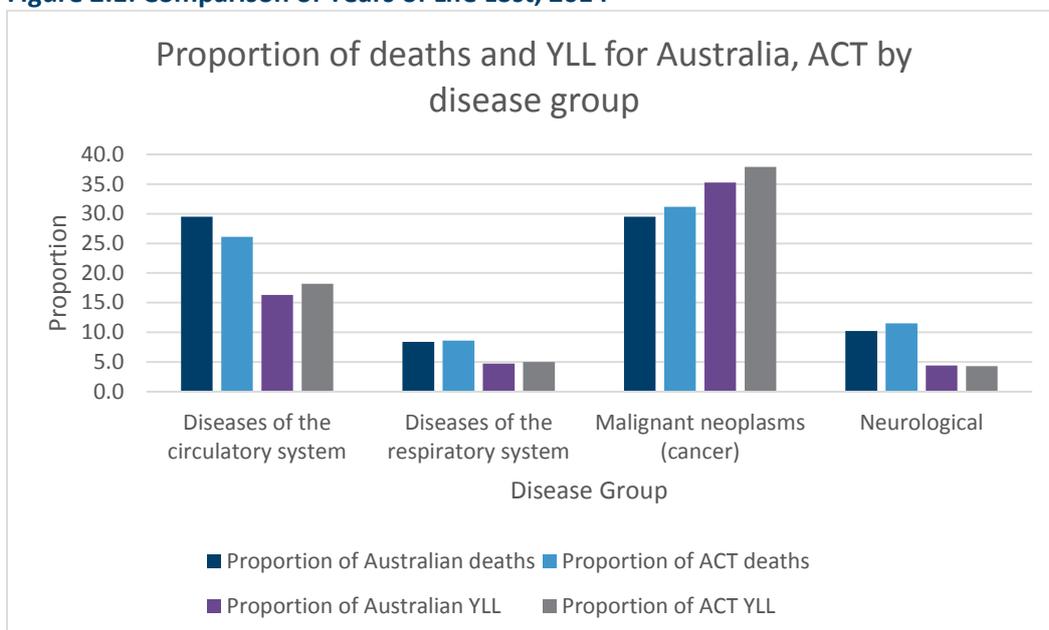
<u>Condition</u>	<u>Proportion of Australian deaths</u>	<u>Proportion of ACT deaths</u>		<u>Proportion of Australian YLL</u>	<u>Proportion of ACT YLL</u>	
Diseases of the circulatory system	29.5	26.1	▼	16.3	18.2	▲
Chronic ischaemic heart disease	7.3	7.1	▽	5.1	5.1	▶◀
Cerebrovascular diseases	7.1	6.4	▼	2.7	3.2	▲
Hypertensive disease	1.5	1.6	▶◀	0.5	0.3	▽
Diseases of the respiratory system	8.4	8.6	△	4.7	5.0	△
Chronic obstructive pulmonary disorder	3.8	3.2	▼	1.9	1.1	▼
Asthma	0.3	0.4	▶◀	0.5	0.2	▼
Malignant neoplasms (Cancer)	29.5	31.2	▲	35.3	37.9	▲
Breast	2.0	3.4	▲	3.5	5.8	▲
Prostate	2.1	1.9	▶◀	0.9	1.0	▶◀
Lung	5.6	4.9	▼	6.4	5.1	▼
Colorectal	1.8	2.8	▲	1.8	2.8	▲

Neurological	10.2	11.5	▲	4.4	4.3	▶▶
Dementia	5.1	6.4	▲	0.5	0.7	▶▶
Alzheimer disease	2.3	1.5	▼	0.2	0.3	▶▶
Parkinson	1	1.4	▲	0.2	0.5	▲

Source: (Australian Bureau of Statistics, 2016b)

Years of life lost (YLL) and disability adjusted life years (DALYs) are often considered a more appropriate measure of the burden of disease given chronic disease is often not the primary recorded cause of death and people are able to live longer with the disease. In 2014, 59.1% of all YLL were due to four disease groups: cancer, circulatory conditions, neurological conditions and respiratory conditions. Cancer alone accounted for most years of life lost with 33.8% of the total YLL (see Figure 2.1) (Australian Bureau of Statistics, 2016b).

Figure 2.1: Comparison of Years of Life Lost, 2014



Source: (Australian Bureau of Statistics, 2016b)

Prevalence of chronic disease

Cancer (malignant neoplasms) – In 2014-15, approximately 1.8% of the ACT population reported at least one form of cancer (Australian Bureau of Statistics, 2015c).

The most common forms of cancer include breast, prostate, colorectal and lung cancer. Although the mortality rate has been decreasing over time, in 2014 cancer was the most common cause of death in the ACT (28.7% of all deaths). The ACT has a higher proportion of cancer deaths compared to the whole of Australia (31.2% and 29.5% respectively).

Recent burden of disease estimates have yet to be published, however in 2011 cancer made up 19% of the ACT's burden of disease (Begg et al., 2007).

Cardiovascular disease (CVD) – According to the National Health Survey (ACT sample size - 1,708) the ACT has the second lowest proportion of cardiovascular disease (i.e. coronary artery disease, heart failure, atrial fibrillation, CVD and peripheral artery disease) and hypertension in Australia (Australian Bureau of Statistics, 2015c).

In Australia as a whole, cardiovascular diseases kill more people but accounts for a lower percent of YLL. In 2014-2015, approximately 3.7% of the ACT population self-reported having cardiovascular disease (excluding hypertension), while 12.1% self-reported having hypertension (Australian Bureau of Statistics, 2015c). In 2014, CVD was the second leading cause of death in the ACT, being the main contributing factor towards 27.9% of all deaths, and accounting for 2,025 YLL (15.7% of total YLL) (Australian Bureau of Statistics, 2016b). The main risk factor is age however it is more common in men, people of low socio-economic backgrounds, and people of Aboriginal and Torres Strait Islander descent (ACT Health, 2014a, Australian Institute of Health and Welfare, 2014d).

Chronic kidney disease (CKD) – In 2011-12, around 1.7 million people or 10% of the Australian adult population aged 18 years and over had indicators of CKD while only 1% of the population self-reported that they knew they had the condition (Australian Institute of Health and Welfare, 2014c). In 2014-15, 0.9% of the Australian population self-reported CKD, while 3.6% of people aged 75 and over reported CKD (Australian Bureau of Statistics, 2015c). In the ACT, 1.3% of the population self-reported CKD in 2014-15, with 5.6% of those 65 years and over reporting this condition (Australian Bureau of Statistics, 2015c). Importantly, biomedical information from the Australian Health Survey (2011-12) suggests these figures are likely an underestimate of the true prevalence (Australian Bureau of Statistics, 2013b).

Chronic respiratory disease (COPD) – In 2014-15, 2.6% of Australians reported having COPD, with 7.8% of Australians over 65 years old reporting the condition (Australian Bureau of Statistics, 2015c). In 2014, 4.1% of deaths in Australia were attributed to COPD (Australian Bureau of Statistics, 2016b). In 2014-15, 2.1% of ACT residents self-reported COPD, with this figure increasing to 6.7% in those aged 65 years and over (Australian Bureau of Statistics, 2015c).

Australia has the highest prevalence of asthma in the world with approximately 40% living with asthma at some point during their life. In 2014-15, 11.5% of the ACT population reported asthma (Australian Bureau of Statistics, 2015c). The ACT also has the highest proportion of hay fever and

allergic rhinitis in Australia, with over one quarter of the ACT population being affected (Australian Bureau of Statistics, 2015c).

Chronic respiratory diseases are the fourth largest cause of death, accounting for 8.6% of ACT deaths in 2014. While causing fewer deaths than neurological diseases, they account for more years of life lost with 5% of the total YLL (Australian Bureau of Statistics, 2015c).

Endocrine, nutritional and metabolic diseases – In 2014-15, 4.3% of the ACT population reported diabetes (type 1 and type 2) (Australian Bureau of Statistics, 2015c) and this figure is expected to keep increasing. People with diabetes often have many comorbidities and it is suspected that the prevalence of type 2 diabetes could be reduced by 40% if obesity was eliminated (ACT Health, 2014a).

The 2014-15 ABS National Health Survey found the ACT had a higher proportion of people with high cholesterol (8.6%) compared to other states (NSW, 7.2%, Victoria, 7.3%, QLD, 6.4%, WAS, 6.0%, NT, 4.4%). It should be noted however that high cholesterol levels may often be underreported, as individuals may not be aware that they have high cholesterol or see it as a long-term health problem.

Mental illness – While mental illness is considered a chronic condition it is not covered in this section but discussed in detail in Section 8.

It should be noted that there is a direct relationship between physical health and people with mental illness often adopting poor lifestyle behaviours and demonstrating high chronic disease risk factors (e.g. prevalence of smoking) and/or conversely people diagnosed with a chronic and life limiting disease often experiencing anxiety and depression.

Musculoskeletal diseases (MSK) – In 2014-15, 29.4% of people in the ACT reported having a musculoskeletal disease. That number doubles for those 65 years and older (Australian Bureau of Statistics, 2015c). In Australia, rheumatoid arthritis is twice as likely and osteoporosis four times as likely to affect women (Department of Health, 2015a).

Chronic pain – While difficult to quantify, it is estimated that chronic pain affects approximately 19.2% of Australians, with one in five GP patients suffering from chronic pain (Henderson et al., 2013). Chronic pain is a complex condition that affects mood and behaviour and can lead to isolation, immobility and drug dependence. An Australian study found that chronic pain is associated with increased GP visits (i.e. five-fold increase), and increased possible avoidable ED presentations

and hospitalisations compared to those with no chronic pain (Blyth et al., 2004). Further studies confirm (Blyth et al., 2001, Elliott et al., 1999):

- Women are more likely to experience pain than men.
- Chronic pain is more common with increasing age with prevalence peaking at 65-69 years for males and 80-84 years for females.
- Younger adults are most likely to report interference with daily activities associated with pain.
- Chronic pain is strongly associated with markers of social disadvantage e.g. lower levels of education, being unemployed for health reasons, in receipt of disability or unemployment benefit, and no private health insurance.

Neurological – Neurological diseases accounted for 11.5% of ACT deaths in 2014 but only 4.3% of the YLL (Blyth et al., 2001). In 2015, 10% of Australians 65 years and over had dementia, rising to 31% for those 85 years and over. The prevalence in Australia is expected to increase more than 2.5 times by 2050 (Australian Institute of Health and Welfare, 2012b).

In 2011, 4,400 people were estimated to have dementia in the ACT (approximately 1% of the population) (Alzheimer's Australia ACT, 2016). In 2014, 6.4% of all deaths in the ACT were attributed to dementia compared to 5.1% nationally (Australian Bureau of Statistics, 2016b).

Parkinson disease is another neurological disease that results in loss of body control. While the prevalence is unknown because there is no definitive diagnostic test, some 5% of Australians in residential aged care facilities in June 2011 had a diagnosis of Parkinson disease (Australian Institute of Health and Welfare, 2012a).

Comorbidity – Over 80% of the Australian population over the age of 65 years reported they had three or more chronic conditions, leading to an increase in years of life lost and higher prevalence of disability (Australian Bureau of Statistics, 2015c). In 2014-15, 47.5% of the ACT adult population reported three or more chronic conditions, compared to 42.1% of the Australian population.

Based upon a recently published Australia-wide study, the most common combination pattern for three conditions is hypertension plus hyperlipidaemia (e.g. high cholesterol) plus osteoarthritis. While the most common combination of three body systems affected was circulatory plus musculoskeletal plus endocrine/nutritional/metabolic systems (Harrison et al., 2016).

Diabetes is a major underlying cause of death for circulatory and heart disease: people with diabetes are two to four times more likely to develop CVD and about two-thirds die from it (Australian

Institute of Health and Welfare, 2014e). Similarly, undiagnosed kidney disease is common amongst people with diabetes: around 40% of people with type 2 diabetes have kidney disease and a 23% higher risk of dying than people without diabetes (Afkarian et al., 2013). The likelihood of developing and dying from CVD and CKD is therefore significantly higher amongst those people with diabetes and many people living with all three diseases.

As a result, comorbidity exacerbates the complexity of management of chronic disease(s). As such, warrant comprehensive chronic disease management strategies. These strategies encompass higher levels of self-care and clinical management, inter-professional collaboration, team-based care and care coordination often resulting in the need for higher health care utilisation.

Risk factors

There are a number of risk factors that contribute to chronic diseases:

1. **Overweight and obesity:** Being overweight or obese is a risk factor for many other chronic diseases, causing comorbidities. In 2014-15, 63.5% of the ACT adult population was classed as overweight or obese (Australian Bureau of Statistics, 2015c). That includes almost one quarter (23.9%) of the ACT adult population which was classified as clinically obese. Importantly, 57% of those aged 25-34 years old, and 63.5% of those aged 35-44 years old are reported to be overweight or obese in the ACT (Australian Bureau of Statistics, 2015c), indicating that the health needs of this group is likely to increase in the future. In 2013-14, 26.3% of ACT children aged 5-17 years old were overweight or obese, highlighting that this is an ongoing issue in today's society (ACT Health, 2016f).
2. **Smoking:** The number of Australians smoking has almost halved in the past 20 years with daily smokers making up 14.5% of the Australian population 15 years and older in 2014-15 (Australian Bureau of Statistics, 2015c). In the ACT, smoking rates are lower with only 12.4% of people 15 years or over smoking daily in 2014-15 (Australian Bureau of Statistics, 2015c). However, it remains a huge problem for Aboriginal and Torres Strait Islander people as the rate of smokers in Australia in 2008 was 47% (Department of Health, 2015b).
3. **Harmful alcohol use:** While the legal drinking age in Australia is 18 years, many children are introduced to alcohol much earlier. In 2010, the average age for the initial use of alcohol was 14.8 years. Drinking is more prevalent in the ACT compared to across Australia with 82.7% of those 15 years and over who reported drinking in the past 12 months, compared to 78.2% nationally (Australian Bureau of Statistics, 2015c). However, the prevalence of those 15 years and over who

reporting drinking in the past week in the ACT was similar to the Australia wide prevalence (56.0% compared to 55.4% nationally) (Australian Bureau of Statistics, 2015c). While the ACT has a similar prevalence for drinking at levels that would produce long-term effects, the ACT does have a slightly lower proportion of “risky drinkers”. In the ACT 15.1% of those aged over 15 years exceeded the 2009 NHMRC lifetime risk guidelines in 2014-15, compared to 16.7% of all Australians (Australian Bureau of Statistics, 2015c).

The Burden of Disease

Health is the biggest sector in the ACT economy. ACT Government expenditure on health care is estimated to be 31% of the total budget and growing. ACT’s own source expenditure on health has risen 78% over five years to 2012-13 and is expected to continue to accelerate in line with national trends and reduction in Commonwealth allocations at a rate significantly higher than GDP and the ACT’s revenue base (ACT Government, 2013a, Council of Australian Governments, 2016).

In addition, the ACT has twice the relative level of unexplained hospital costs than the next highest State (after wage differentials are considered) (Figure 2.2) (Duckett et al., 2014).

Figure 2.2: Average state unexplained costs (relative to Australia) with and without adjustments to average wages, 2010-11 i.e. cost per admission relative to national average (\$)



Source: (Duckett et al., 2014)

Given this outlier position and that hospital activity is a dominant budget item, there is clearly a need to focus on whole system effectiveness and service efficiencies for the benefit of consumers and the health system alike.

The cost burden is, however, not just a hospital based issue. The National Health Performance Authority confirms that general practice and MBS face increasing challenges in managing demand and the rising cost of primary health care with (National Health Performance Authority, 2015a):

- 12.5% of GP-attenders (i.e. ‘very high’ (more than 20 visits per year) and ‘frequent fliers’ (12-19 visits per year)) responsible for 41% of Medicare out-of-hospital expenditure, and
- very high GP-attenders seeing on average 4.8 GPs across 2012-13 – this demonstrating little continuity of care which potentially leads to duplicated tests and treatments.

The report confirms that people who see the doctor most often tend to have more health problems and chronic conditions and a greater level of disadvantage than low-attenders. It concludes that high GP-attenders need team-based and better coordinated care to address health needs, enhance the consumer experience, and make appropriate, efficient and effective use of health care.

Key Issues

Whole of system approach to chronic disease prevention and management

Given the predicted population growth and increase in the proportion and the associated health status of older people including the higher prevalence of chronic disease, cost pressures will continue to be placed on the ACTs health system. There will be increasing demand for health care services unless we start to consider how we do things differently, shifting emphasis upstream to both prevent the onset of chronic disease and placing emphasis on comprehensive management of chronic disease within the primary health care setting in partnership with active health care consumers.

The above provides an overview of the current state of health of the ACT population, the prevalence of chronic conditions and the increasing impact on the health system.

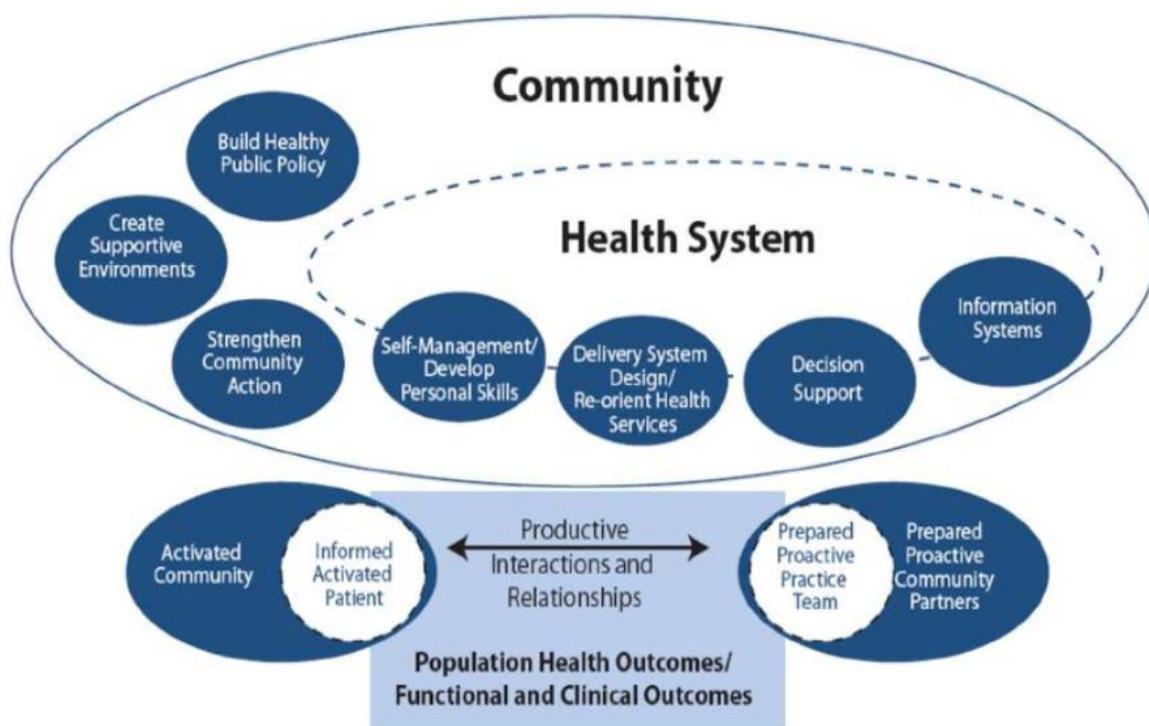
Given the increasing burden of disease and complexity of the challenge at hand, a strategic and joined up approach to the development of comprehensive chronic disease prevention and management is required.

It is imperative that all strategic partners come together to co-design and develop a whole of system approach to chronic disease management spanning the spectrum of care which maximises the benefit of the whole health system and drives system effectiveness and efficiencies.

The Expanded Chronic Care model (ECCM) (Barr et al., 2003) is widely accepted as the universal best practice model for integrated chronic disease prevention and management (Figure 2.3). This model focuses on delivering better health outcomes and reducing the burden of disease for the benefit of people at risk of or living with chronic and complex conditions. The model adopts both:

- a population approach encompassing effective public health measures and the identification and stratification of cohorts of consumers at risk of developing chronic conditions who may benefit from health promotion and disease prevention measures (e.g. lifestyle modification), and;
- an individual approach - an appreciation of the holistic health care needs of the individual consumer, often spanning multiple chronic conditions, and the tailoring of individualised clinical regimens, packages and coordination of team-based care and supports that address personal health and social care needs. Ensuring people understand their health conditions, how best to self-manage chronic disease and make appropriate use of health services and supports, i.e. an emphasis on quality of life and keeping people well and out of hospital.

Figure 2.3: Expanded Chronic Care Model



Source: (Barr et al., 2003)

Evidence of best practice models of care, including the patient-centred health care home model, build on the ECCM above and consistently confirm that core components of a comprehensive and integrated chronic disease prevention and management model of care, regardless of condition, encompass (NSW Agency for Clinical Innovation, 2013b, Department of Health and Human Services, 2009, Barr et al., 2003, Page et al., 2014, Katterl et al., 2012, Alderwick et al., 2015, Feyer et al., 2014, Dorling et al., 2015, The Health Foundation, 2014):

- **Activated consumers:**
 - **Prevention and health promotion** – Reducing the risk and rates of ill health in a given population and/or when established, reducing the severity of chronic disease and preventing complications.
 - **Health and health system literacy** – Increasing knowledge of health risk factors and enhancing people’s ability to find and understand basic information about their health and how to make appropriate use of local health services.
 - **Lifestyle modification and supported self management** – Supporting individuals in positive behaviour change and enabling them to better understand and self-manage their chronic condition.
 - **Supported decision-making** – Ensuring people with impaired decision making capability (due to age, disability, acquired brain injury or mental illness) have access to support to make personal and informed decisions e.g. advanced care planning (ACT Disability Aged and Carers Advocacy Service, 2016).
- **Comprehensive and integrated care:**
 - **Targeted enrolment of patients at general practice** – Patients identified at risk of, or living with, complex and chronic conditions establish a therapeutic relationship through voluntary enrolment with a named GP or practice for comprehensive chronic disease management services (Scott et al., 2008).
 - **Screening, risk stratification and early identification of at risk individuals** – population wide screening activity (e.g. cancer screening services), effective lifestyle (and risk factor) reporting and recording, standard application of risk assessment protocols/tools, application of risk stratification methods utilising practice and hospital data, and predictive modelling techniques to identify potential hospital ‘frequent fliers’ (Capital Health Network, 2016b, Haas et al., 2013, Department of Health, 2016c).
 - **Comprehensive assessment** – appropriate and timely access to diagnostics (including diagnostic imaging and pathology) and specialist outpatient services.

- **Timely access to care and supports** – including appropriate and timely access to team-based care encompassing both health and social care components e.g. general practitioners and primary health care practitioners, clinical specialists, reablement or end of life services (e.g. outpatient referrals, specialist clinics, acute services and reablement), welfare and social care supports focused on individualised needs and comprehensive care plans.
- **Evidence-based clinical management and clinical pathways** – Adherence to evidence-based clinical guidelines and localised clinical pathways that address individual needs and comorbidities (including access to self management and rehabilitation/reablement services and encompassing transitions of care and effective medicines management) and the psychosocial impact of chronic disease (Starfield, 2010, NSW Agency for Clinical Innovation, 2013a).
- **Primary health care led shared care, care coordination and continuity of care** – The development of holistic individualised care plans and team-based packages of care, the provision of care coordination encompassing both health and social care services and supports (often general practice based), step-up/step-down capability (to respond to changing needs), effective discharge planning and transitional supports across the health and social care system, including hours and out of hours services and supports (Watson and Meyers, 2010).
- **Effective monitoring and review** – The proactive monitoring and management of symptoms, post transition/discharge follow-up and supports, management of complications, secondary and crisis prevention e.g. medicines review/management and encompassing the use of telehealth communication and monitoring systems (Commonwealth of Australia, 2016).

This evidence base also affirms that singular approaches are not effective. Successful chronic disease prevention and management programs utilise multi-faceted evidence-based approaches, often recognising the relationships between such components (e.g. effective discharge planning, community service supports, immediate post-acute transition services and monitoring (e.g. Home from Hospital) and ongoing self-management capability) and the critical role of the GP and general practice in providing clinical leadership, team-based care and care coordination (Dorling et al., 2015).

The ACT health system has a significant benefit in terms of shared population base and jurisdictional boundaries, and local decision authority vested in ACT Health and CHN. The development of a joint collaborative working agreement on Primary Care and Chronic Conditions (including the

establishment of a joint Coordinating Committee) with ACT Health, Calvary Health Care and Health Care Consumers' Association ACT provides a platform from which to drive cross sector activities. Joint initiatives need to be based on the Expanded Chronic Care Model.

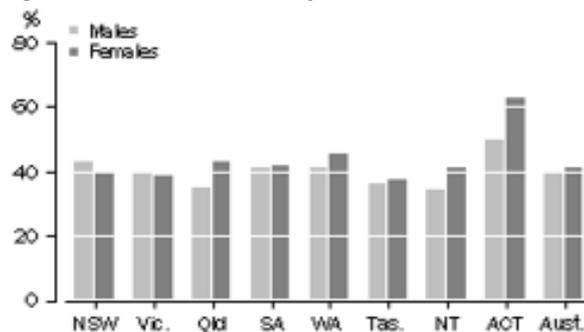
Activated consumers

Health literacy - Patients' understanding of chronic disease and self-management, and how to make best use of an often complex and fragmented health care system, is a core challenge for people with low health literacy. Such people are typically of low SES status, often from marginalised and disadvantaged communities, e.g. those at risk of developing a chronic condition and poor health outcomes including potential ED/hospital 'frequent flyers'.

The Australian Bureau of Statistics (ABS) estimates that approximately 60% of Australians aged 15–74 years do not have adequate health literacy to enable optimal health outcomes (Australian Bureau of Statistics, 2008). While there were no outstanding differences in health literacy between states and territories, the exception to this was the ACT, with the proportion of skills level 3 or above (the minimum required for individuals to meet the complex demands of everyday life and work in the emerging knowledge-based economy) being 56% (65% for women) (Figure 2.4).

Health literacy is generally lower amongst people with low educational attainment, who are unemployed and/or experience lower levels of income and SES status, are aged 15-19 years old, older Australians, people who speak a language other than English and those who have poorer health status.

Figure 2.4: Health Literacy Skill level 3 or above



Source: (Australian Bureau of Statistics, 2008)

Low health literacy perpetuates health inequality. Evidence (primarily from the USA and Canada) shows that low individual health literacy is independently associated with poor health status and higher utilisation of services. Low health literacy has been associated with significant health care costs in the USA and has also been found to (Keleher and Hagger, 2007):

- predict less healthy behaviours
- generate higher rates of hospitalisation
- reduce capacity for self-management of chronic conditions
- create poorer health status generally.

While nationally health literacy is considered a foundational component of the health equity and safety and quality agendas, limited priority appears to be attached to this in the primary health care setting. The Australian Commission on Quality and Safety in Health Care (ACQSHC) are committed to embedding health literacy into health care systems, ensuring effectiveness of communications and integrating health literacy into education. ACQSHC calls on health care providers, managers, policy makers and consumers to take action to address health literacy (Australian Commission on Safety and Quality in Health Care, 2014). For example, ACT Health has developed a range of resources and supports for clinicians and hospital services to ensure that services and staff are equipped to communicate and engage effectively with consumers (ACT Health, 2016g).

Actions are required to improve health literacy at multiple levels across the whole health system spanning the consumer, health care professionals, organisations that provide health care services at a local level, organisations that support health care providers, and government organisations, regulators and bodies that advise on health policy.

This also reinforces the ECCM where consumers are considered equal partners in the co-creation of health supported by a sustained therapeutic relationship with a family GP (as the lead health care professional), the multi-disciplinary care team, care coordinators, specialist services and supports.

At an individual level, health literacy strengthens the effectiveness of health interventions, contributing to better health outcomes through the development of therapeutic relationships between individuals and health professionals that facilitate better clinical care, quality and safety, better medicines and self-management, and an enhanced consumer experience.

Self-management and health coaching – Enhancing self-management capability through, for example, the Stanford Chronic Disease Self-Management Program (small group focused) (Stanford Medicine, 2016) and the ‘Flinders Model’ of chronic disease self-management (individual focused) (Flinders Human Behaviour and Health Research Unit, 2016), ongoing behavioural change support and health coaching (e.g. HealthChange encompassing lifestyle modification founded on motivational interviewing, goal setting and cognitive behavioural approaches (HealthChange Australia, 2016) utilised by Medibank’s Care Connect suite of programs) empowers people to better understand and manage their conditions, thereby improving health outcomes and the patient experience of care, and promoting more efficient use of health care resources through greater self-awareness of when and how to make best use of health services.

While the ACT has a range of self-management and health coaching programs spanning public health and community based services, and the local peak body SHOUT proactively promotes such programs

and supports (Self Help Organisations United Together, 2016), there is limited awareness of these amongst consumers and clinicians alike, their eligibility criteria and access routes, and limited follow up to reinforce adult learning, sustain participant interaction and enhance peer support (ACT Medicare Local, 2014b). While a key component of best practice chronic disease prevention and management, such services and supports are not well integrated into localised health pathways and not often considered a core component of individualised care planning.

Opportunity exists to mainstream self-management programs and supports into care planning and chronic disease management and care coordination, integrate into clinical protocols established in HealthPathways (and potentially a consumer health information portal), strengthen referral routes and access to local services and supports to enhance self-management capabilities amongst people with chronic and complex conditions.

Supported decision-making – The United Nations Convention on the Rights of Person’s with Disability calls for the adoption of supported decision making to ensure individuals are able to access their right to decide, enjoy autonomy and inclusion and live equal and active lives (United Nations, 2006). The principles of supported decision making apply to the ACSQHC National Standard on Partnering with Consumers (Australian Commission on Safety and Quality in Health Care, 2016). Effective chronic disease prevention and management requires a beneficial relationship between consumers and their personal support networks and clinicians alike.

Supported decision making is aimed at people with impaired decision-making capacity due to age, disability, acquired brain injury or mental illness e.g. those people typically at risk of chronic, comorbid and complex conditions.

ACT Disability, Aged and Carer Advocacy Service (ADACAS) has undertaken a number of projects to raise awareness of supported decision making and provides training and support to guide decision supporters (potentially including clinicians) in their role (ACT Disability Aged and Carers Advocacy Service, 2016).

Decision supporters should be considered key members of the extended health care team as set out in the patient-centred health care home. Knowledge of such supports is currently limited and such support not universally accessible nor mainstreamed within and across health care services.

Opportunity exists to inform the ACT’s health workforce on individual’s rights and the principles of supported decision-making, mainstream this important initiative and integrate it into clinical protocols established in HealthPathways, strengthen referral routes and enhance access to decision support for people with chronic and complex conditions.

Strategy

Strategies to promote health, increase health literacy, self-management and determination include:

- Implement a HealthPathways linked consumer health information portal that provides an accessible repository of validated local health information on service and access options, locally endorsed condition treatment fact sheets and other local resources.
- Providing patient education and self-management support as an integral part of the cross-sector chronic disease management programs, care planning processes and care coordination services, and integrate into local HealthPathways.
- Integrating supported decision making (for people whose decision making capacity is impaired) information, tools and resources into HealthPathways clinical and consumer portals.

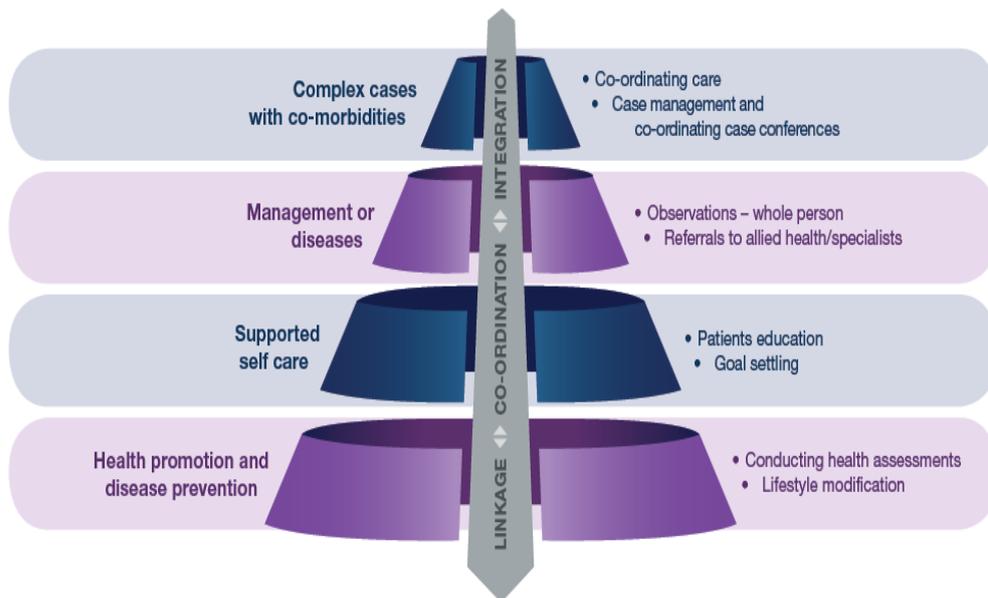
Early identification, assessment and intervention for patients at risk of poor health outcomes

General practice and Allied Health practitioners play a fundamental role in the identification of those at risk of chronic disease. As a foundational element of high performing primary health care the collection of basic health data to inform the identification of those at risk of chronic disease and clinical decision making is crucial. Basic recording and reporting of health data (i.e. height and weight, BMI, waste to hip ratios, fold measures etc.) and lifestyle factors (i.e. smoking, nutrition, physical activity, alcohol and drug use, and gambling) is important in the assessment, screening and identification of patients at risk of developing chronic disease. However, there appears to be a lack of consistency in the collection, recording and reporting of such data as routine within and across general practice and a lack of understanding of barriers to such data collection (Capital Health Network, 2016b).

Risk stratification and patient segmentation

The risk stratification of population cohorts (or consumer segmentation) is a core element of comprehensive chronic disease prevention and management programs and a prerequisite to the identification of patients likely to benefit from tailored care programs including, for example, care coordination.

Figure 2.5: Adapted from Kaiser Permanente - Risk Stratification Pyramid



Source: Adapted by CHN from Taylor (2007)

The Kaiser Permanente model of risk stratification provides a model to segment whole populations into different groups contingent on needs, determine the appropriate level of intervention proportionate to that need, and tailor services and health care resources accordingly (Taylor, 2007).

Tier 1 includes people with highly complex needs and frequent users of unplanned hospital services (5% of the population), Tier 2 encompasses people with chronic conditions who are considered at risk of deterioration (15-30% of population) which would benefit from structured support and Tier 3 (65-80% of the population) who have relatively manageable chronic conditions who on the whole are capable of self-management (see Figure 2.5).

While traditionally health and care resources have been focused on those with the highest levels of need (e.g. Tier 1 - those patients who require the highest intensity hospital services, as represented in both the Chronic Disease Management Unit's chronic care program and Medibank's Care Point program), increasingly research affirms the benefit of supporting people at an earlier stage (e.g. Tier 2/3 – typically those people with chronic disease whose health condition is considered unstable or are at risk of deterioration) who could benefit from planned, structured and coordinated support and who currently consume the majority of total health care costs, to better manage chronic disease and prevent deterioration, crisis and peak hospital utilisation, and reduce overall costs (McKinsey & Company, 2016, Feyer et al., 2014, Haas et al., 2013).

Identification of such patients can't be achieved by the acute sector alone but requires a realignment of the current health care system with an emphasis on high performing primary health

care e.g. “enrolling patients at early stages of disease and identifying people who can benefit from hospital avoidance strategies” and the adoption of a jurisdictional and whole of system approach to integrated care (Feyer, 2016). McKinsey’s report that an unpublished report by the National Health Service (UK) found that the identification of at risk patients and a focus on integrating services, the utilisation of intensive primary health care to reduce hospital admissions, and the active management of patients by GPs, reduced the number of bed days required for asthma, bronchitis, COPD and stroke by 75% among people over the age of 65 years (Dorling et al., 2015).

Risk stratification which utilises patient and administrative data across both primary health care and hospital settings can be utilised to identify ‘high-risk’ patients. To date risk stratification and consumer segmentation has been minimal, largely limited to research and service pilots. Presently the Australian health system does not systematically group health care consumers into different segments based on assessment of future health care needs. The ability to do so is compounded by the omission of patient ‘enrolment’ at general practice level, limitations of fragmented data sets, health data collection and analysis, and limited interoperability of information systems.

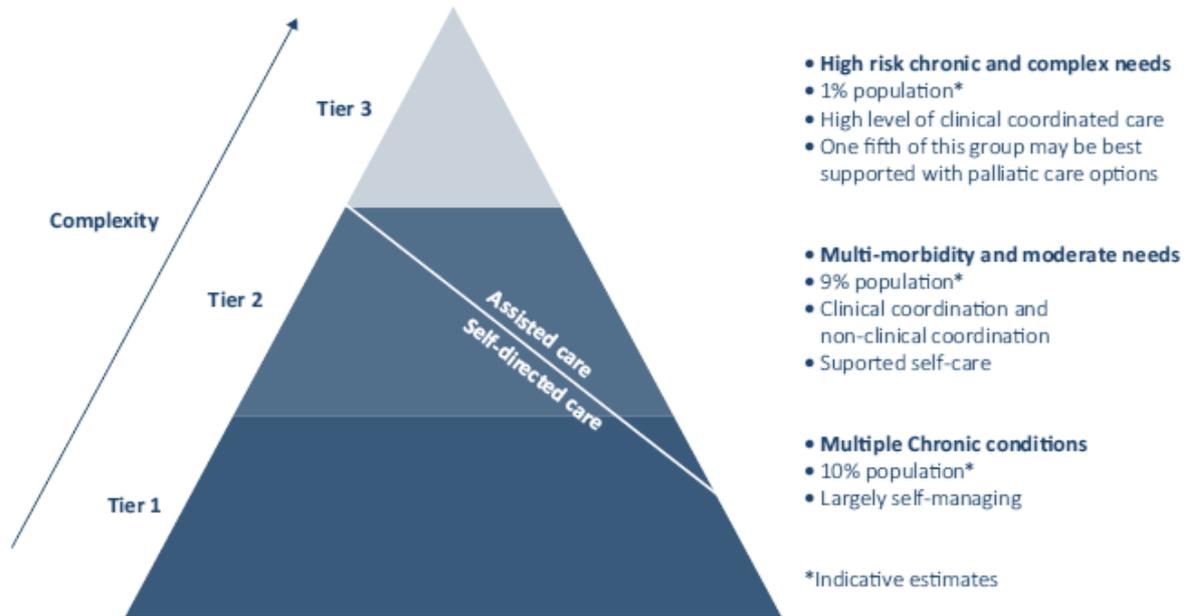
While most hospital avoidance, care coordination and chronic care programs identify patients through physician referrals, this approach doesn’t necessarily focus on patients who could benefit most from comprehensive chronic disease prevention and management programs. For example,

- a recent study of the use of MBS items amongst people with diabetes suggests that they are not targeted to those people who are likely to benefit the most (Department of Health, 2011b). However, this evaluation of the Diabetes Care Project concluded that the combination of an improved IT platform and data collection and analysis, and alternative funding models based on risk stratification had a positive impact on clinical outcomes.
- results of the NSW Chronic Disease Management Program (an initiative aimed at reducing potentially preventable hospitalisations) suggest people with chronic disease need to be recruited to community based programs before their conditions deteriorate to the point that they need hospitalisation and that patients (e.g. Tier 2 patients) were being enrolled onto the program too late (e.g. Tier 1 patients). The program has now been adjusted to identify people with chronic diseases earlier and services and supports put in place to help them better manage their conditions in the community setting.

The recent Primary Health Care Advisory Group (PHCAG) recommendations to Commonwealth on Better Outcomes for People with Chronic and Complex Health Conditions (2015) acknowledges that

“linking the patient with the right intensity of treatment is important” (Primary Health Care Advisory Group, 2015).

Figure 2.6: Chronic disease by complexity in Australia



Note: * estimates based in analysis of available population, hospitalisation and Medicare data. Accurate estimates of population sub groups are limited due to limited national data to support such analysis.

Source: (Primary Health Care Advisory Group, 2015)

For illustrative purposes, the PHCAG draws from existing utilisation data to segment populations and identify the intensity of care that should be offered in the proposed ‘*Healthier Medicare*’ patient-centred health care home trials (Department of Health, 2016f) and calls on the Department of Health to “identify suitable case finding processes, drawing on existing validated Australian and international risk stratification tools to identify patients requiring high levels of coordination and team (based) care” (Primary Health Care Advisory Group, 2015).

Strategies

There is evidence of the increasing interest at both state and national levels in the application of risk stratification in the Australia health care system.

The Commonwealth Government has recently announced the development of a risk stratification framework as part of the Healthier Medicare initiative to be rolled out from July 2017. It is anticipated that this tool will draw on current data sets (Including MBS chronic disease item utilisation), will be trialled in the patient-centred health care home pilots and will inform the classification of individual need, eligibility and access to packages of care and 'bundled payments', and the development of practice based 'at risk' and chronic disease registers.

Risk stratification is clearly contingent on access to timely and relevant data. CHN has a key role in informing the development of a stratification tool, supporting general practice in the application of the tool and integrating the tool into the local QiData quality improvement program.

CHNs QiData initiative encourages participating general practices to capture such information and supports them to utilise information to:

- identify those people who could benefit from health assessment, screening and/or immunisation, to determine those at risk of developing chronic disease and consider preventative measures.
- undertake quality improvement initiatives aimed at enhancing individual health outcomes and the consumer experience with a focus on better use of MBS chronic disease management items (e.g. call and recall) to provide comprehensive and continuous cycles of care.

CHN should therefore look to:

- extend the QiData initiative to support practices to stratify patient cohorts/identify people at risk of chronic disease and/or poor health outcomes
- work with ACT Health to apply a consistent approach to the stratification of patients and identification of those people who would benefit from care coordination and tailored chronic disease management programs.

Health assessment and screening

Screening for chronic disease or the identification of those at risk of chronic disease is undertaken through chronic disease related Medicare activities specified under the Medicare Benefits Scheme (MBS) and a number of national cancer screening programs:

MBS health assessment activity (Department of Human Services, 2016) – Health assessments are generally made up of information taking, examination and/or investigations; making an overall patient assessment; recommending appropriate interventions (including e.g. referrals) and providing advice/information to patients as well as keeping a record of the assessment and offering both the patient and/or carer a written report with recommendations about matters covered by the assessment. There are four time-based MBS health assessment items ranging from brief to prolonged assessments (Items 701, 703, 705 and 707) which can be undertaken for the following target groups:

- people aged 45-49 years who are at risk of developing chronic disease
- a type 2 diabetes evaluation for people aged 40-49 years considered to be at high risk of developing diabetes
- people aged 75 years and older (see Table 2.3)
- a comprehensive medical assessment for permanent residents of residential aged care facilities (RACFs)
- a health assessment for people with intellectual disability
- a health assessment for refugees and other humanitarian entrants
- an Aboriginal and Torres Strait Islander people's health assessment for children, adults and older people (Item 715).

Note: Further analysis of item 715 is provided in Section 4. Consideration of Mental Health assessments (not detailed above) is included in section 8.

Commonwealth advises that a health assessment should not take the form of a health screening service but may well confirm the need for health screening (see below). Health assessment is a prerequisite to risk stratification, early identification of people at risk and those with chronic disease and comorbidity and therefore access to timely and appropriate care.

MBS data demonstrates that general practice in the ACT underperforms in the utilisation of MBS health assessment related activity (Table 2.2 and Table 2.3).

Table 2.2: MBS Health Assessment Rates – All Target Groups – 2014-15

MBS Item		ACT*	Aus*	% of Aus	Rank
701	Brief Health Assessment	87	287	30%	LAST
703	Standard Health Assessment	627	1,002	63%	7
705	Long Health Assessment	377	903	42%	7
707	Prolonged Health Assessment	866	1,221	71%	7
715	Aboriginal and Torres Strait Islander Health Assessment	356	715	50%	7

Source: (Department of Human Services, 2016)

With similar results demonstrated for health assessment activity for those over the age of 75 years:

Table 2.3: MBS Health Assessment Rates – Over 75 years – 2014-15

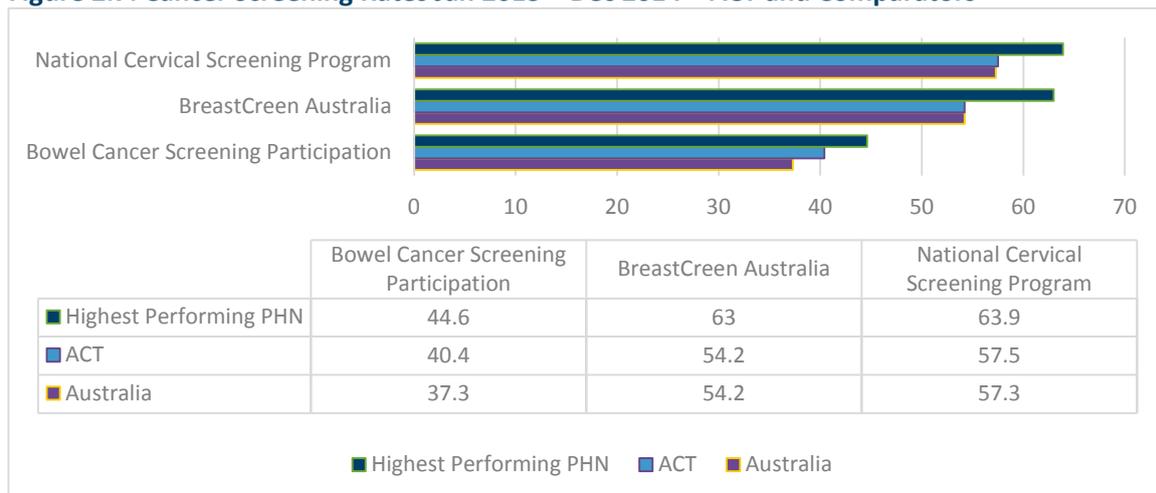
MBS Item		ACT*	Aus*	% of Aus	Rank
701	Brief Health Assessment	172	749	23%	LAST
703	Standard Health Assessment	5,250	6,285	84%	4
705	Long Health Assessment	4,196	8,474	50%	LAST
707	Prolonged Health Assessment	11,966	15,978	75%	7

Source: (Department of Human Services, 2016)

These results demonstrate the continuing and historic low utilisation of such MBS item numbers within the ACT.

Cancer screening rates – While cancer screening rates within the ACT are in line with national averages, they are significantly lower than the highest performing PHNs in breast and cervical screening (8.8% and 6.6% variation) and also lower in terms of bowel cancer screening (4.2% variation) with rural and remote areas outperforming the ACT across the period 1 January 2013 and 31 December 2014 (Figure 2.7) (Australian Institute of Health and Welfare, 2016c). Given the concentration of the ACT population within the jurisdiction and relative ease of access to screening services, these results are somewhat concerning.

Figure 2.7: Cancer Screening Rates Jan 2013 – Dec 2014 – ACT and Comparators



Source: (Australian Institute of Health and Welfare, 2016c)

Complacency is not appropriate when evidence confirms that early identification of cancers and timely access to specialist care leads to better survival rates and health outcomes, and a reduced burden of disease (Australian Health Ministers’ Advisory Council, 2008). Screening plays a significant role in detecting many cancers.

Strategies

The accomplishment of higher levels of participation in health assessment and screening activities should be encouraged particularly within and across ACT’s vulnerable and at risk populations, including those people with poor health literacy.

Strategies to support protection and early identification through effective screening include:

- Continuing to promote national immunisation/vaccination and screening programs.
- Supporting primary health care providers to record as routine basic health and lifestyle factors.
- Conducting research to determine why ACT’s general practices underperform in MBS related health assessment activities and ascertain what could be done to overcome this and ensure equitable access to such health assessment measures. (Note: Health assessment informs risk stratification and eligibility to packages of care).
- Supporting general practice in the quality use of data and improvement initiatives aimed at improving practice effectiveness and the use of MBS related health assessment and screening measures, call and recall capabilities.

Comprehensive shared and coordinated care to patients with complex and chronic conditions

Ineffective management of chronic conditions leads to worse health outcomes and higher health care costs (Swerissen et al., 2016).

A proactive approach to chronic disease management encompassing preparing, coordinating, reviewing or contributing to health planning and consumer focused team-based care is a core component of all best practice chronic disease management initiatives.

Chronic disease related Medicare items specified under the MBS assist GPs to manage the health care of people with chronic or terminal medical conditions, including those requiring multidisciplinary, team-based care from a GP and at least two other health or care providers. These items are designed for patients who require a structured approach to chronic disease management and enable GPs to plan and coordinate the care of patients with complex needs requiring ongoing and multidisciplinary care.

MBS data demonstrates the level of associated MBS utilisation and patient coverage within the ACT (Table 2.4).

Table 2.4: MBS Chronic Disease Management – Provider Information 2014-15 and Practice Nurse Item (PNIP) Numbers as of November 2015

MBS Item		ACT*	Aus*	% of Aus	Rank
721	GP Management Plan (GPMP)	4053	8565	47%	LAST
723	Team Care Arrangement (TCA)	3292	7952	47%	LAST
732	Review of GP Management Plan and/or Team Care Arrangement	4675	10698	44%	LAST
729	GP Contribution to, or Review of, Multidisciplinary Care Plan	5	12	42%	6
731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	171	415	41%	7
10978	Follow Up Health Services for Indigenous people	32	515	6%	LAST
10997	Practice Nurse Monitoring and Support	1520	5137	30%	LAST

*Services per 100,000 population

Source: (Department of Human Services, 2016)

These results demonstrate the low utilisation of chronic disease MBS item numbers within the ACT.

Given the prevalence of chronic disease is on the whole comparable with the rest of Australia and the benefit of adopting a structured approach to chronic disease management and team-based care, it remains unclear why this is case in the ACT. It should be noted that non-utilisation of a GPMP/TCA

does not necessarily mean that individual GPs are not following good practice with regard to chronic disease management. What is not clear is the reason why GPMP/TCAs are being significantly underutilised compared to elsewhere in Australia.

Further analysis of such data demonstrates the low number of patients who complete a cycle of care, represented by those who receive a GPMP/TCA review (item 732; n: 8602, actual activity) compared with the number of patients who receive a GPMP (item 721; n: 16051, actual activity) and TCA (item 723; n: 13026, actual activity) e.g. at best only 30% of the eligible population. (The recommended frequency of item 732 is every 6 months - actual GPMP/TCA review activity (item 732) could therefore be considered to be 15% of the eligible population). At face value this demonstrates a lack of monitoring/review of health outcomes achieved and continuity of care for people living with complex and chronic conditions. Reasons for the low utilisation of GPMP/TCA reviews are also unclear.

Shared care and allied health

Shared care related MBS items can be utilised by GPs and allied health practitioners when addressing comprehensive needs of individuals with chronic or terminal conditions or complex care needs requiring services from the usual GP and at least two other health or care providers. There is no list of eligible conditions, although these items are designed for patients who require a structured approach.

MBS data on GP multi disciplinary case conferencing which allow GPs to plan and coordinate the multidisciplinary team-based care of patients in the community, those discharged from hospital or people living in RACFs, and allied health professionals, home and community service providers and care organisations to participate in case conferences, again demonstrates low levels of utilisation of MBS item numbers (Table 2.5).

Table 2.5: GP Multidisciplinary Case Conferences 2014-15

MBS Item		ACT*	Aus*	% of Aus	Rank
735	Organise and coordinate a case conference – at least 15 and less than 20 minutes	26	91	29%	6
739	Organise and coordinate a case conference – at least 20 and less than 40 minutes	15	55	27%	7
743	Organise and coordinate a case conference – at least 40 minutes	17	30	57%	LAST
747	Participate in a case conference - at least 15 and less than 20 minutes	34	51	67%	7

750	Participate in a case conference - at least 20 and less than 40 minutes	112	17	659%	1
758	Participate in a case conference - at least 40 minutes	11	12	92%	3

*Services per 100,000 population

Source: (Department of Human Services, 2016)

Analysis of MBS data on chronic disease management related allied health activity for people with chronic or terminal conditions and complex care needs, demonstrates low levels of access and utilisation (Table 2.6). Such activity again correlates with the low level of GPMPs and TCAs (Table 2.4) e.g. prerequisites to MBS allied health chronic disease services. While in the case of dietetics the availability of services in ACT Health may explain this low level, this is not the case for podiatry and physiotherapy.

Table 2.6: Annual Number of Allied Health CDM Services (per capita) – ACT and Australia 2014-15

MBS Item		ACT*	Aus*	% of Aus	Rank
10951	Diabetes Educator	83	357	23%	LAST
10952	Audiology	3	6	50%	LAST
10953	Exercise Physiologist	727	871	83%	5
10954	Dietetics	940	1504	83%	7
10956	Mental Health Worker	5	26	19%	LAST
10958	Occupational Therapy	55	222	25%	7
10960	Physiotherapy	1614	6961	23%	LAST
10962	Podiatry	1883	10456	18%	LAST
10964	Chiropractic	242	1188	20%	7
10966	Osteopathy	108	562	19%	5
10968	Psychology	30	84	36%	LAST
10970	Speech Path	127	591	21%	LAST

*Services per 100,000 population

Source: (Department of Human Services, 2016)

Strategies

The Primary Health Care Advisory Group report on Better Outcomes for People with Complex and Chronic Conditions (2015) places increasing emphasis on the role and contribution of effective general practice in best practice chronic disease prevention and management, while the draft National Strategic Framework advocates the provision of effective and appropriate care. Yet given the level of chronic disease within the ACT and low levels of private health insurance utilisation it is unclear why ACT's primary health care services continue to underutilise the MBS scheme for the benefit of patients.

Further analysis of levels of activity and reasons for such underperformance is required to gain a broader insight into the impact on patients health and wellbeing of local people, the impact on the health system (e.g. preventable ED presentations and avoidable hospitalisations) and supports required to improve performance.

It is clear that individualised chronic disease management and shared care arrangements are critical to best practice comprehensive chronic disease prevention and management. These are also a key component of high performing primary health care and will continue to be a key element of the Australian health care system. In order to provide more effective support to primary care practices, CHN will consider undertaking research into the local factors that have resulted in such low levels of chronic disease management MBS Item uptake.

Care coordination

All best practice chronic disease prevention and management models, regardless of setting, include care coordination as a critical component of comprehensive and consumer focused care.

Hass et al (2013) note that "Patients with multiple chronic conditions may see many providers, often in an uncoordinated manner, adding to their increasing risk of high health care utilization through test duplication, medication management conflicts, and medical errors. These patients are also at increased risk for hospital admissions and emergency department (ED) visits. Primary care doctors may not routinely have the time or the resources to properly manage these complex patients who have multiple chronic health problems. Thus, care coordination for the right patients could decrease unnecessary care and prevent perverse outcomes" (Haas et al., 2013).

National examples of care coordination in the primary health care setting include:

- **Department of Veteran Affairs (DVA), Coordinated Veterans' Care (CVC) program (Department of Veterans' Affairs, 2014)** – The CVC is a longstanding team-based care program aimed at improving the management of chronic conditions for DVA Gold Card members with one or more targeted chronic conditions or complex care needs (e.g. congestive heart failure, coronary artery disease, pneumonia, COPD and/or diabetes), and those at risk of an unplanned hospitalisation.
- **Victoria Health Department, Hospital Admissions Risk Program (HARP) (Department of Health & Human Services, 2011)** – The HARP program aim is to decrease hospital demand through the use of comprehensive assessment, care coordination and a timely response to specialist care in the community setting for people with complex needs or chronic conditions who frequently present to hospital or are at risk of doing so. Eligibility is founded on patient segmentation based on the Kaiser Permanente triangle of risk stratification.
- **Medibank Private – Care Connect (Medibank Private, 2015)** – Medibank Private has developed a suite of three integrated chronic disease management programs targeting fund members, identified through analysis of patient data, who have chronic and complex conditions (e.g. Diabetes, COPD, oesteo arthritis, CVD and asthma). One of these, CarePoint, provides care coordination to people with multi-morbidity and complex needs. This service offer has recently been introduced to the ACT and is currently being rolled out via direct marketing to eligible fund members.
- **Tasmania PHN – Care Coordination Services (Primary Health Tasmania, 2016)** - Primary Health Tasmania delivers and commissions some 31 organisations to provide care coordination services to help ensure elderly people, people with chronic health conditions (e.g. neurodegenerative disorders, COPD, heart disease, diabetes and musculoskeletal disorders and kidney disease) and Aboriginal and Torres Strait Islander people receive connected care across a range of services. Care coordinators work with individuals, their carers, GPs, hospitals and other service providers to assess care needs, develop tailored care plans, help people understand their condition and better self-manage, arrange and access the services people need to stay healthy and independent. In addition, the service aims to assist health care providers adopt a person-centred and holistic approach.

Evidence on effective care coordination affirms the criticality of both the identification of eligible patients through risk stratification, the enrolment of patients with an emphasis on Tier 2 patients, the provision of care coordination in the primary health care setting and the ability to broker/coordinate both health and social care services aimed at keeping people well and out of

hospital, including managing the successful and sustained transition of patients from hospital to their home setting (Timmins and Ham, 2013, Russell et al., 2013b, Oliver-Baxter and Bywood, 2013).

Despite the current and projected burden of disease, the Integrated Team Care (building on Closing the Gap and Care Coordination and Supplementary Services) and CVC programs are the only integrated care coordination models operating within the primary health care setting in the ACT providing support to targeted and eligible 'at risk' patients.

The ***Chronic Disease Management Unit (CDMU, Canberra Hospital)*** delivers an alternative approach providing specialist nurse support and care coordination services from an acute hospital setting to people with CHF, COPD, obesity, Parkinson's disease and other movement disorders. This is typically provided for complex Tier 1 level patients who frequently present to ED, use specialist and hospital services often on an unplanned basis. The service offers self-management education and strategies, facilitation and coordination of community and other support services, communication and advocacy and assistance with completing Enduring Power of Attorney and Advanced Care Plan documentation (ACT Health, 2016b).

A joint review of the Canberra Hospital and Health Services Chronic Disease Management Unit and Chronic Care Coordination program conducted in 2014-15, encompassing feedback from key stakeholders, identified limitations of the current model (ACT Medicare Local, 2015b):

- A focus on hospital 'frequent flyers' (e.g. predominantly the acutely ill and/or complex Tier 1 patients) including identified patients who have repeatedly been admitted to hospital across the previous two years and those nearing end of life stage
- A limited cohort of eligible clients e.g. covering only four defined chronic conditions and not encompassing Aboriginal and Torres Strait Islander communities
- Lack of clarity of primary focus e.g. whether this was an acute hospital support service, a transitional support service (hospital to home) or a community and/or primary health care support service housed in an acute setting.
- Limited relationships and system integration across acute specialists and hospital services, community services and general practice e.g. limited engagement in discharge planning or the development of GPMPs and continuity of care in the primary health care setting through coordination of TCAs.
- Limited ability to step down or discharge patients from the program.

As a result of this initiative, key design features were agreed in principle, providing the foundation for next steps and development of a whole of system model of care coordination.

Strategies

Building on the groundwork already done, opportunity now exists for CHN, ACT Health and other key stakeholders to consider new ways of working and developing a best practice approach to care coordination in the ACT.

Strategies to promote targeted planning and coordination of care to patients with complex chronic conditions what would most benefit include:

- Providing more targeted education and support to general practice on the appropriate use of GPMPs and Team Care Arrangements (TCAs) (as above)
- Researching the cause of the under-utilisation of chronic disease related MBS item numbers and multi-disciplinary team care arrangements in the ACT and develop a strategy to address any identified barriers (as above)
- Co-design, develop and implement a proof of concept service model for transitions of care coordination for targeted (e.g. Tier 2) chronic and complex hospital inpatients to successfully transition to a supported primary care setting, integrating multi-faceted evidence based approaches such as effective discharge planning, immediate post-acute transition support and monitoring (e.g. GRACE – see Older People), self-management and community services supports.

Medication management

Medication management is a critical component of chronic disease management, ensuring individuals benefit from their medication regimen and medication-related risks and identified problems are addressed. This is increasingly important when considering the level of comorbidity amongst the ACT population, the need to optimise patient safety and the medication regimen to address multiple chronic conditions, and the likelihood of patients being discharged with alternate medication following hospitalisation. Older Australians in particular are at a higher risk with approximately 1 in 3 unplanned hospital admissions in this group related to medicines. Two thirds of Australians over 75 years are on 5 or more medications (NPS MedicineWise, 2013).

The role of the Pharmacist is integral to comprehensive chronic disease prevention and management and the extended health care team, serving to enhance safety and quality (and reduce risk) and patient health outcomes. However, MBS data again demonstrates low levels of utilisation of MBS items to optimise medication management (Table 2.7).

Table 2.7: Medication management 2014-15

MBS Item		ACT*	Aus*	% of Aus	Rank
900	Home Medicines Review (HMR)	158	266	59%	LAST
903	Residential Medication Management Review (RMMR)	113	228	50%	LAST

*Services per 100,000 population

Source: (Department of Human Services, 2016)

The Pharmaceutical Society of Australia (PSA) recognises the Sixth Community Pharmacy Agreement which provides opportunity to optimise the pharmacists contribution for improved primary health care, particularly for those with chronic conditions requiring multiple medications (Pharmaceutical Society of Australia, 2014b). Both the Australian Medical Association (AMA) and the PSA recognise the need for a more collaborative primary health care system and advocate a willingness to develop a more integrated role for pharmacists in the general practice setting (Pharmaceutical Society of Australia, 2014a).

Various models of pharmacists within general practice exist, with benefits including improved clinical regimens and health outcomes of selected patients with chronic conditions, such as diabetes and osteoporosis (Tan et al., 2014b, Tan et al., 2014a), the ability to review and maximise drug therapies accordingly to best practice clinical guidelines and facilitate the safe and sustained transition of patients from hospital to community settings e.g. post discharge medication reviews.

Strategies – Pharmacy in General Practice

CHN recognises the opportunity to optimise both clinical and medication regimens for people with chronic conditions and comorbidities through the development of advanced primary health care encompassing team-based care, and the integral contribution of pharmacists within general practice and Aged Care services.

CHN has invested in a pilot study to determine the effectiveness of the role and contribution of pharmacists operating within general practice and the targeted role of the pharmacists in the effective medication management of older people with chronic and complex conditions. An evaluation of the three pilot sites will be completed in December 2016 and will inform the development of future models of person-centred and general practice led advanced primary health care.

An evaluation of the CHN sponsored Pharmacists within General Practice and Aged Care pilot to be reported in December 2016 to inform future strategies for quality and safety in high performing primary health care.

3. Workforce

Overview

The Mason Review, a seminal national workforce study of Australian Government health workforce programs in 2013, outlined the current challenges for Australia's health workforce, the importance of refocusing the system to primary health care and the need to change our work strategies and approaches (Mason, 2013). Pivotal to this is the requirement for health workers to ensure that their work meets the health care needs of the population. It identified key features of workforce reform:

- refocusing service delivery to develop a workforce that meets the health care needs of consumers, not just practitioners
- a move from acute models of care to a community driven population and a primary health care approach
- retention of the existing workforce and increased productivity with an emphasis on expanded scopes of practice and generalist roles
- use of technology, role re-design and greater flexibility and inter-professional learning
- improved distribution of the health workforce particularly to rural and remote areas and to populations of extreme disadvantage
- increased participation rates of Aboriginal and Torres Strait Islander people in the health workforce.

Similar to other Australian jurisdictions, the ACT faces difficulty attracting qualified health staff (ACT Health, 2014a). Coupled with this is the demand for health services, particularly primary health services, which is expected to continue to increase as the population ages and the incidence of chronic diseases rises. The ageing of the population is also impacting on labour supply and it is projected that by 2050 there will only be 2.7 people of working age for each Australian aged 65 years and over, as compared to five working age people per aged person in 2010 (ACT Health, 2013a). Compounding this further is the finding that the average age of the health workforce is higher than for the workforce overall (Parliament of Australia, 2005).

CHN needs to develop a workforce development strategy which will focus on building the strengthening the primary health care workforce in line with community needs. This will encompass:

- supporting practices to transition towards a service delivery model based on the ten building blocks of high performing practices (Bodenheimer et al., 2014)

- ensuring that the workforce development strategy is aligned to achieving the services identified from the comprehensive health needs assessment of the community
- supporting the workforce at each stage of their training and promoting primary care as a positive career option.

Workforce statistics

Full-time Workforce Equivalent (FWE) figures published by the Australian Government Department of Health for 2012-2013 indicate that the ACT had 71.6 GP FWE per 100,000 population compared with the National figure of 96.4 per 100,000 population. These figures are more typical of a regional centre than a metropolitan area and while the ACT figures have improved significantly over recent years, there still is an underlying undersupply of GPs. The tables below display characteristics of the health workforce in the ACT.

Table 3.1: Health workforce characteristics in the ACT, 2014

	Total Number	Male:Female ratio	% aged over 55 years	% Clinician*	% intending to work 5 years or less
Medical Practitioners (all)	1896	55%:45%	26%	81%	15%
General Practitioners	445	48%:52%	42%	96%	25%
Nurses and Midwives (all)	5721	10%:90%	24%	79%	24%
Practice Nursing	212	2%:98%	31%	91%	29%
Pharmacists	459	37%:63%	16%	68%	15%
Chiropractors	62	52%:48%	18%	94%	0%
Optometrists	76	49%:51%	14%	89%	0%
Osteopaths	29	53%:47%	21%	100%	0%
Occupational Therapists	273	10%:90%	12%	77%	16%
Physiotherapists	515	30%:70%	15%	76%	17%
Podiatrists	58	47%:53%	14%	92%	10%
Psychologists	754	22%:78%	28%	79%	14%

*Those who aren't clinicians are administrators, teacher/educators, researchers or 'not applicable'
Source: (Department of Health, 2016e)

Table 3.2: GPs job setting and job role in the ACT, 2014

	Clinician	Administrator/ Teacher/ Educator/ Researcher
Solo private practice	8%	0%
Group private practice	74%	2%
Locum private practice	2%	0%
Aboriginal health services	2%	0%
Other community health care service	2%	0%
Hospital (excluding outpatient services)	2%	1%
Residential aged care facility	1%	0%
Commercial/business service	1%	0%
Tertiary educational facility	1%	1%
Defence forces	3%	0%
Other government department or agency	1%	1%
Other	1%	0%

Source: (Department of Health, 2016e)

Table 3.3: Number of General Practitioners and Practice Nurses in the ACT, 2013 to 2015

	2013	2014	2015
General practitioner (GP)	413	445	477
Practice Nurses	186	212	213

Source: (Department of Health, 2016e)

Table 3.4: Practice Nurses job setting and job role in the ACT, 2014

	Clinician	Administrator	Other
Locum private practice	3	0	0
General practitioner (GP) practice	119	3	0
Other private practice	35	3	3
Hospital (excluding outpatient service)	9	0	0
Residential health care facility (other)	3	0	0
Tertiary educational facility	3	0	0
School	0	0	0
Correctional service	3	0	0
Defence forces	10	5	0
Other government department or agency	3	3	0
Other	4	0	0
Not applicable / Unknown	5	0	0

Source: (Department of Health, 2016e)

Of general practice based staff, the following characteristics are evident (Department of Health, 2016e):

GPs

- there has been a significant increase in the number of GPs over recent years
- 74% of GPs were in group practices in 2014 – a further increase in this is expected
- 42% of GPs are over the age of 55
- 25% are intending to work 5 years or less

Practice Nurses

- the number of practice nurses plateaued between 2014 and 2015.
- 31% of practice nurses are over the age of 55
- 29% are intending to work 5 years or less
- Based on 2013 BEACH data (Britt et al., 2013), the proportion of GP-patient encounters practice nurses are involved in is stable at 7.4% and the proportion of problems managed with a practice nurse has steadily increased to 6.1% and appears to be plateauing, with no significant change from the previous year.

The significant ageing of the GP workforce is of particular concern, particularly given anecdotal information about the aspirations of many medical students to become specialists rather than to enter general practice.

Key Issues

Workforce sustainability

CHN recognises that a workforce that is sufficient, capable and sustainable is a critical success factor towards an integrated health care system. Primary care is one component of a complex inter-dependent system. There is a need to support a sustainable workforce supply of primary health care clinicians in order to deliver the health care needs for the population, which will be impacted by the ageing of the population, an increase in the prevalence of chronic diseases and more informed consumers. In addition, the ageing of the current health workforce and the decrease in workforce participation will require a greater number of health professionals to meet the required supply needs.

Provision of a health workforce that has capacity to meet community needs is a vital element of workforce planning. The increased demand for health services, including the management of chronic diseases, coupled with the reduced supply of health practitioners, places increased emphasis on the need to focus on multidisciplinary models of care, and reform in the way services are delivered including new models of care. Skills acquisition and skills utilisation are both important elements of maximising the available workforce.

Primary health care also needs to be grounded in a philosophy of continuous quality improvement. This requires a leadership striving to achieve “a workforce capable of setting bold aims, measuring progress, finding alternative designs for the work itself, and testing changes rapidly and informatively. It also requires a high degree of trust in many forms, a bias toward teamwork, and a predilection toward shouldering the burden of improvement, rather than blaming external factors.” (Berwick, 2003)

The changing population demographics, the drive to create more sustainable health care systems and focus on prevention and the growing emphasis on effective management of chronic disease is sharpening the focus on primary care. Primary care and current service delivery models were essentially designed in a time period when episodic illness e.g. infections were most prevalent. The current situation, however, is that chronic diseases are more prevalent and hence there is recognition that service delivery model needs to be fundamentally different.

International evidence demonstrates that primary health care has the potential to be a solution to support the health system in meeting those needs. However, it requires a paradigm shift and transformational change in the service delivery model for the sector, and the individuals working within the sector.

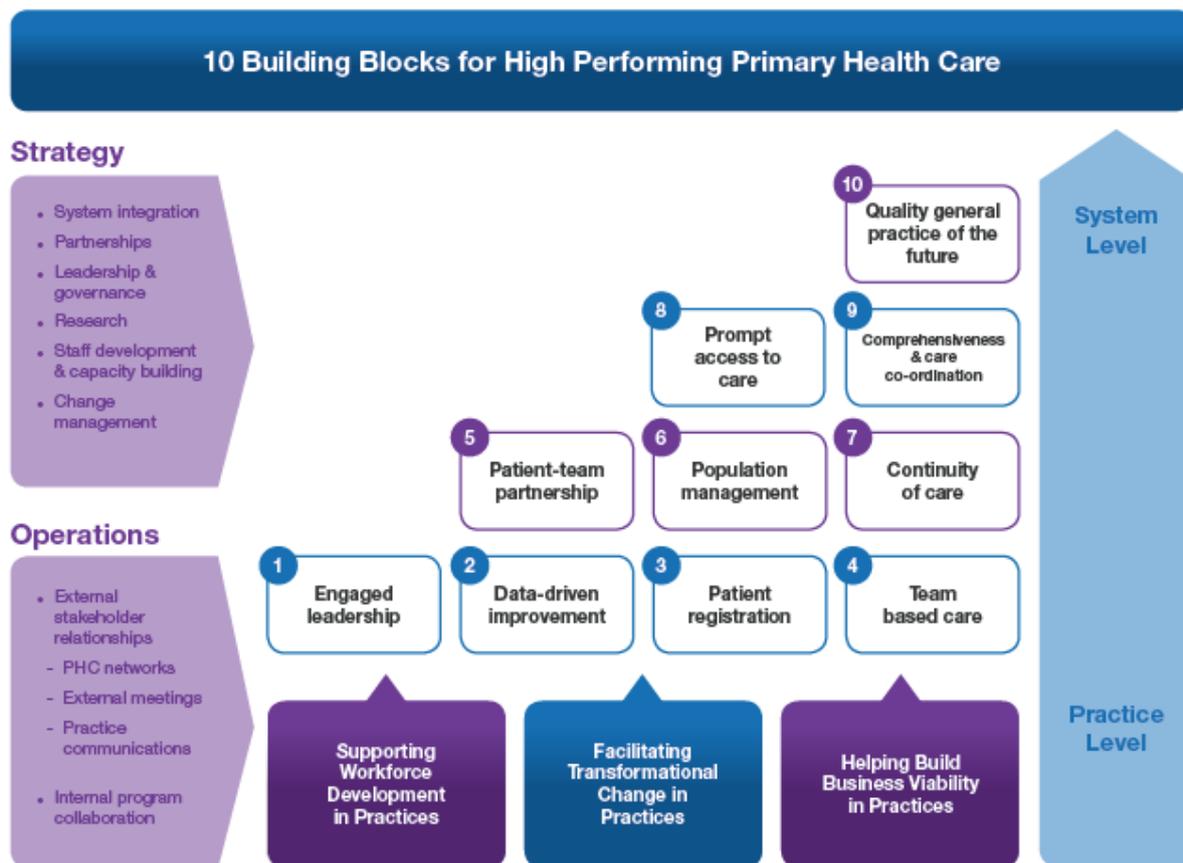
Priority Issues

High performing primary health care

Advanced or high performing primary health care is a prerequisite for best practice chronic disease prevention and management and, the foundations of an efficient and effective health care system (Australian Centre for the Medical Home, 2016, Van Weels, 2014).

The elements for achieving a high performing primary health care capable of meeting these future needs have been described by Bodenheimer et.al. (2014) (Figure 3.1).

Figure 3.1: 10 Building Blocks of High Performing Primary Care



The 10 building blocks depict the capabilities required to deliver both the patient-centred health care home model of care as well as ECCM. The four foundational blocks are considered critical as they underpin all other elements with high performing practices focusing on the accomplishment of comprehensive and coordinated care for the benefit of consumers and striving towards continuous improvement in all areas.

The 10 building blocks support the principles of effective general practice (The Royal Australian College of General Practitioners, 2014b), traditional models of the four pillars of primary care practice (i.e. first contact care, continuity of care, comprehensive care and coordination of care) (Starfield, 1992), the RACGP standards for general practice and vision of quality general practice of the future (The Royal Australian College of General Practitioners, 2013, The Royal Australian College of General Practitioners, 2012).

In the Australian context each one of these elements present a workforce development opportunity.

Strategy

CHN will support practices to transition towards a service delivery model based on the building blocks of high performing primary health care.

New and emerging workforces

Provision of a health workforce that has capacity to meet community needs is a vital element of workforce planning. The increased demand for health services including the management of chronic diseases, coupled with the reduced supply of health practitioners (Mason, 2013) places increased emphasis on the need to focus on multidisciplinary models of care, and reform in the way services are delivered including new models of care. Skills acquisition and skills utilisation are both important elements of maximising the available workforce (Skills Australia, 2012).

The ACT has three universities and an Institute of Technology, through which students can access a range of programs for preparation to practice including in medicine, nursing, allied health and personal care roles. CHN will have a key role in working with these training providers, not only to support clinical training, but also to influence course and curriculum development in line with the identified health needs of the community, and to advise on the changing workforce demands.

Maximising the skills of the workforce, skills utilisation, has the potential to drive innovation, reduce workforce pressures, and increase worker satisfaction. Our workforce development activities will focus not only on training, but also to support the change processes that need to occur in the workplace that can contribute to the greater use of skills, extended roles and new models of multidisciplinary care.

Clinical training and clinical placements for health professionals

All university-based health qualifications and some VET sector qualifications include a compulsory component of clinical training. Some disciplines, such as medicine and psychology, also require a compulsory requirement of post graduate clinical training to meet registration requirements.

Historically, clinical training has principally been undertaken in public hospitals and health services; although in recent years this has extended to primary care settings including general practice. Over recent years, competition for clinical placements has become intense due to a variety of factors, including the increase in numbers of many undergraduate programs with the lifting of the cap on enrolments, the increase in medical student numbers and the resource restraints on health services affecting their capacity to support student placements.

General practice and other primary care settings offer a fertile environment for health care students to apply and consolidate their knowledge regarding the importance of prevention, early intervention, and first line care. This opportunity can be a key factor in influencing the career/speciality decisions of students and as such is an important element in attracting new graduates into primary health care roles.

Strategy

CHN is strategically placed, through our practice development team, to work collaboratively with universities and other training providers to identify, coordinate and support flexible clinical practice placement and pre-vocational training opportunities for medical, nursing and allied health students.

CHN will also need to promote primary care as a positive career option at various points in workforce training and develop structured programs and systems to support newly graduated health care professionals transition into primary care.

Aboriginal and Torres Strait Islander workforce

The 2005 Productivity Commission Report identified the need to increase Aboriginal and Torres Strait Islander participation in the health workforce (Productivity Commission, 2005). Aboriginal and Torres Strait Islander health professionals are seen to be more readily accessible and able to provide more culturally sensitive care to their communities. In addition, they can play an important leadership role in influencing health care matters within these communities.

Strategy

CHN will support the following initiatives to support Aboriginal and Torres Strait Islander people into the health workforce:

- Assist in identifying Aboriginal and Torres Strait Islander leaders/champions who can provide advice to our workforce development team, to deliver culturally appropriate mentoring and support to local Aboriginal and Torres Strait Islander health students.
- Work with education providers to facilitate and support culturally safe and appropriate clinical placements for students in primary care.

Collaboration within the current workforce

One aspect of commissioning is to specify the service design or re-design that supports optimal delivery of health care to meet identified population needs. The redesign of services may require a need for workforce development to support new ways of working. Re-design initiatives offer multiple potential benefits including the recruitment and retention of experienced clinicians by facilitating their development of a special interest, prevention of burnout, provide timely and responsive service to patients, most likely lower overall cost, and with the appropriate clinical governance arrangements improve clinical quality and patient safety. An example of the potential of such redesign is in the case of heart failure. The National Heart Foundation has provided a consensus statement for management of heart failure (National Heart Foundation of Australia, 2013). This includes a need to “develop workforce capacity across health services to deliver evidence-based care, appropriate to the local population” and “examine mechanisms to empower general practitioners and healthcare professionals in primary care to deliver evidence based care for chronic heart failure.” Further, a study in Canberra concluded “diagnosed heart failure cases represent the ‘tip of the iceberg’.....and clinically identifiable cases can remain undiagnosed” (Abhayaratna et al., 2006). A survey of Australian GPs identified multiple barriers to delivering optimal heart failure care including ease of access to diagnostic tools such as echocardiograms (Phillips et al., 2004). Examples from overseas suggest that by aligning system needs with workforce development it is possible to successfully address such challenges.

One such approach is to have GPs with a special interest delivering an intermediate tier of service between the specialist and usual GP. The GP with special interest provides capacity for a specific service e.g. diagnosis and echocardiography of patients with suspected heart failure. The GP with special interest can provide recommendations back to the usual GP; however, should a need for cardiologist opinion be deemed necessary then provide a streamlined referral pathway to a cardiologist.

The development of the GP with special interest would require the collaboration of a number of stakeholders including professional colleges and ACT Health. This trend is already underway, for example GPs that take a special interest in aspects of dermatology. This will become even more critical as the range of conditions that will be seen in hospital outpatient services will decrease over time as the acute system realigns its own services against capacity constraints.

Strategy

CHN will develop a program to support the upskilling of GPs in areas of special interest.

Leadership and change management

Health Workforce Australia advocated that effective leadership is a crucial factor in successful innovation and reform and is vital when an organisation faces the need to mobilise a workforce in a new way towards a vision, a set of values, or changing workforce practice. This is the case for General Practice and an effective and engaged GP leadership is considered a prerequisite to high performing primary health care and as such imperative to the success of the broader health system (Bodenheimer et al., 2014). Different health care systems and leadership programs have placed emphasis on different purposes of leadership. These have included leadership for quality and patient safety improvement, patient centred leadership, leadership for patient engagement, leadership for medical engagement and leadership for whole systems.

As articulated in the Institute for Healthcare Improvement's leadership's framework "value driven, high-reliability health care, sustained by improvement and innovation, requires leaders at all levels to think with new mental models about the challenges and their role and practice high impact leadership behaviours to achieve better health, better care and reduced costs for the populations(s) they serve."

Strategy

There is great benefit in adopting a regional (rather than national) focus, including the ability to:

- Develop and tailor GP leadership and development programs to meet the needs and circumstances of local clinicians
- Enhance joint working relationships between the CHN, general practice community and appointed training providers
- Align the leadership development program with system improvement and the translation of localised Comprehensive Needs Assessment and strategic priorities into action.

In keeping with the widespread evidence for the need for effective leadership at all levels CHN will invest in a regional clinical leadership development program together with other interested PHNs and training providers.

Team working

The complexity of health care, particularly to patients with chronic disease or multiple conditions increases the need for team-based approaches to health service delivery. Relationships between physicians, practice nurses, pharmacists, relevant allied health clinicians and social care service providers are vital in addressing the varied health care needs of patients with complex needs. In team working members are held mutually accountable to achieve shared goals, their interactions and working together will impact the team's results.

Bringing together the knowledge and expertise of various disciplines offers the benefit of multiple perspectives on care and treatment, however, without high quality teamwork, it can pose increased risk to patient care. Team members must be able to work collaboratively with each other across settings and with the patient and their family/carers to accomplish shared goals and achieve coordinated, high quality care.

Strategy

CHN recognises there are a number of opportunities to enable practices to improve team culture and in turn deliver improved outcomes for patients and also improve staff experience, contributing to improved recruitment and retention.

Those opportunities to improve teamwork include:

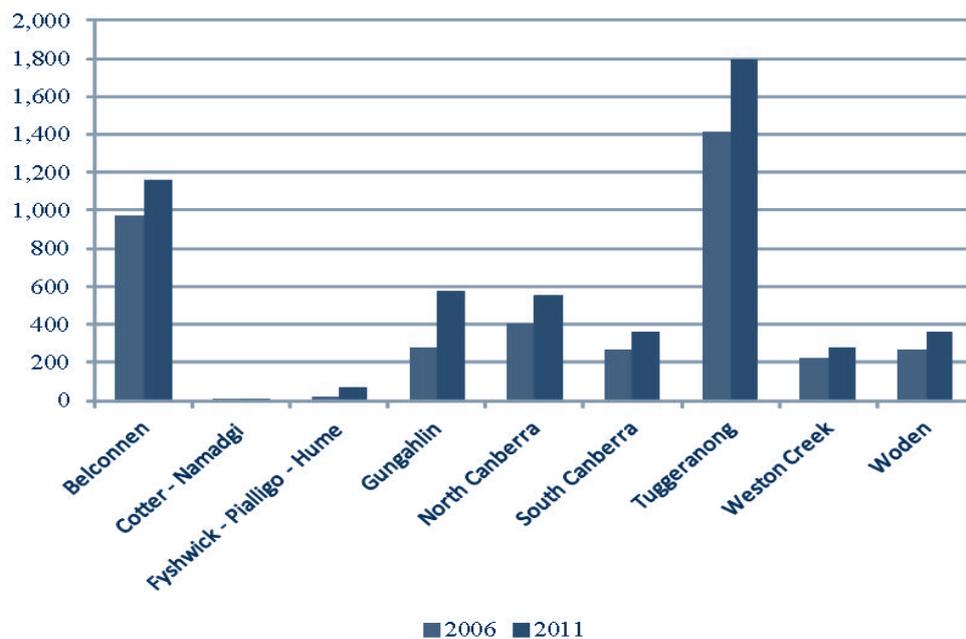
- Multi-disciplinary inter-professional events facilitating networking
- Events for attendance by practice teams
- Multi-disciplinary speakers and facilitators
- Supporting and facilitating communities of interest
- Incentivising and motivating improved team work through a number of strategies including recognition of outstanding teamwork e.g. through an awards process, offering accolades for team-working, facilitating and supporting practices going through other accreditation systems, e.g. Investors in People - Australia (<http://iipaustalia.com>), that value investment in people and teamwork.
- Specific team development activities for practices as an additional service.

4. Aboriginal and Torres Strait Islander Health

Overview

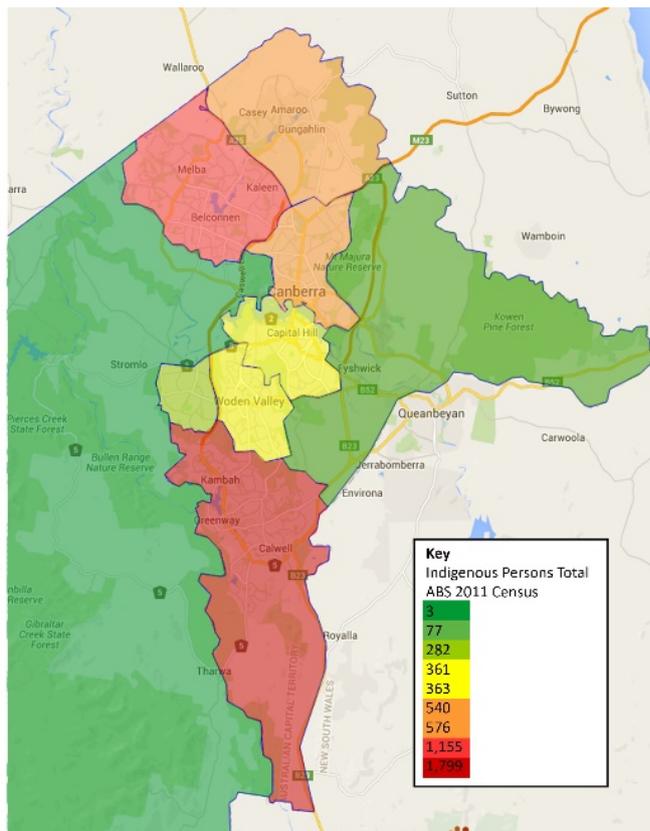
In 2011, the ACT had an Aboriginal and Torres Strait Islander population of 5,185 people, representing 1.5% of the total ACT population and 1.0% of the total Aboriginal and Torres Strait Islander population of Australia (Australian Bureau of Statistics, 2012b). A more recent report estimated there to be 6,902 Aboriginal and Torres Strait Islander residents of the ACT (Australian Bureau of Statistics, 2013f). The areas with the largest population of Aboriginal and Torres Strait Islanders are Tuggeranong (34.6% of all Aboriginal and Torres Strait Islander residents of the ACT) and Belconnen (22.5%) (Figure 4.1 and Figure 4.2) (Australian Bureau of Statistics, 2012b).

Figure 4.1: Distribution of Aboriginal and Torres Strait Islander people, ACT districts (SA3s), 2006 and 2011



Source: (Australian Bureau of Statistics, 2012b)

Figure 4.2: Map of Aboriginal and Torres Strait Islanders, ACT districts (SA3s), 2011



Source: (Healthdirect, 2016)

The ACT Aboriginal and Torres Strait Islander population has a much younger age structure than the total population in the ACT. In 2011, over half (55%) of Aboriginal and Torres Strait Islander people were aged 24 years and under compared to 33% of the non-Indigenous Australian population (Australian Bureau of Statistics, 2012b). Two per cent of Aboriginal and Torres Strait Islander people in the ACT were aged over 55 years compared to 11% of the non-Indigenous Australian population. The median age for ACT Aboriginal and Torres Strait Islander residents was 22 years, 13 years younger than that for non-Indigenous Australian ACT residents (35 years) (Australian Bureau of Statistics, 2012b).

Significantly more Aboriginal and Torres Strait Islander ACT residents reported fair or poor health (20%) compared to non-Indigenous ACT residents (12.5%) (Epidemiology Section ACT Health, 2013). There are many inter-related factors contributing to the poorer health status of Aboriginal and Torres Strait Islander people, many of which can be associated to socio-economic inequalities (Carson et al., 2007). It is important to recognise the role social determinants of health play in the health of Aboriginal and Torres Strait Islanders (e.g. historical factors, education, employment,

housing, environment factors, racism) and that addressing these factors will be critically important to closing the gap between Aboriginal and Torres Strait Islanders and non-Indigenous Australians.

While areas of health inequalities between Aboriginal and Torres Strait Islander and non-Indigenous Australian people will be explored in this section, the ACT has made progress in closing the gap in key areas. ACT Aboriginal and Torres Strait Islander residents reported higher median personal and household income compared with Aboriginal and Torres Strait Islander people nationally (Epidemiology Section ACT Health, 2013). However, income for Aboriginal and Torres Strait Islander ACT residents remains less than that for non-Indigenous ACT residents. In the 20-24 year old age group, 79.9% of ACT Aboriginal and Torres Strait Islanders reported completing Year 12 or equivalent or certificate III compared to 53.7% of Aboriginal and Torres Strait Islanders nationally, the highest rate in Australia, and comparable to the national rate of non-Indigenous Australians (85.2%) (Australian Bureau of Statistics, 2016c). The ACT Aboriginal and Torres Strait Islander population has the highest rate of employment (60.5%) of all states and territories in Australia and is higher than the national average of 46.0% (Australian Bureau of Statistics, 2016c). However, ACT Aboriginal and Torres Strait Islander people still rated higher than the national average for financial stress (Australian Bureau of Statistics, 2016c). This is highlighted by ACT Aboriginal and Torres Strait Islanders having the second highest rate of people who had experienced homelessness in Australia (36.9%), which is higher than the national rate for Aboriginal and Torres Strait Islanders (29.1%) and non-Indigenous Australians (13.4%)(Australian Bureau of Statistics, 2016c).

ACT Aboriginal and Torres Strait Islander peoples had the lowest smoking rates for Aboriginal and Torres Strait Islander people nationally (35.7% compared to 40.6%) in 2014-15 (Australian Bureau of Statistics, 2016c). This is still significantly more than non-Indigenous ACT residents (11.9%), and there has only been a marginal reduction in the smoking rate from 36.2% in 2008.

The immunisation rate for 1 year old ACT Aboriginal and Torres Strait Islander children has increased from 89.6% in 2013-14, to 92.9% in 2014-15, the highest rate of 1 year old immunisations for Aboriginal and Torres Strait Islanders in all PHNs and an equal rate with all 1 year old children in the ACT (National Health Performance Authority, 2016b). Immunisation rates for 5 year old ACT Aboriginal and Torres Strait Islander children has also increased from 93.6% (2013-14) to 95.1% (2014-15) and is higher than the ACT rate for all children aged 5 years who were fully immunised in 2014-15 (93.2%). However, the rates for 2 year olds has decreased (from 94.7% to 84.7%). This is likely due to a change in the definition of 'fully immunised' for 2 year olds which occurred on 31 December 2014. The inclusion of three additional vaccines has caused a decrease in the reported immunisation coverage rates for 2 year olds. Along with the change in definition, the low numbers of

Aboriginal and Torres Strait Islander children in the ACT indicate that caution should be used when interpreting these numbers. Overall, in 2014-15 there were only 34 Aboriginal and Torres Strait Islander children under 5 years in the ACT that were not fully immunised.

Life expectancy rates are not available for the ACT Aboriginal and Torres Strait Islander population as the number of deaths of Aboriginal and Torres Strait Islander ACT residents was too small to allow reliable calculation. Nationally, life expectancy at birth for Aboriginal and Torres Strait Islander males is estimated to be 69.1 years and for females it is estimated to be 73.7 years (Australian Bureau of Statistics, 2013d). In the ACT, non-Indigenous males have a life expectancy of 81.4 years and life expectancy for females is slightly higher at 85.2 years, the highest life expectancy rates in Australia (Australian Bureau of Statistics, 2015b).

ACT Aboriginal and Torres Strait Islander Health Plan

The ACT Government is currently developing the ACT Aboriginal and Torres Strait Islander Health Plan for the next five years 2016-2020. The plan's intent is to outline the objectives and priorities for closing the life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians in the ACT and set strategic direction for services to improve access to health care for Aboriginal and Torres Strait Islanders.

While the health plan is yet to be finalised, consultations with the community to date have identified five areas for priority focus:

- Mental health and social and emotional wellbeing;
- Chronic disease;
- Community health (i.e. maternal and child health, older people's health, disability and carer support, young people's health, women's health, men's health);
- Cooperation and sustainability, service delivery, culturally skilled workforce, and;
- Health performance, quality improvement and reporting.

Some of these areas are discussed in more detail below.

Key Issues

Given that the Aboriginal and Torres Strait Islander population has in general poorer health and social outcomes than the non-Indigenous Australian population, an array of issues can be described. The health disadvantages experienced by Aboriginal and Torres Strait Islander people are shaped by the broader social and economic conditions and contexts in which they live. There is a clear

relationship between the social disadvantages experienced by Aboriginal and Torres Strait Islander people and their current health status (Carson et al., 2007). These social disadvantages are reflected in education, employment, housing and income. While this is acknowledged, the following sections will provide a focus on issues that reflect the current priorities that emanate from the experiences of Aboriginal and Torres Strait Islander people of the health system identified by the local stakeholders and that can be supported from local data and research evidence.

Pre and post natal healthy lifestyle support for mothers

The younger age profile of the Aboriginal and Torres Strait Islander population requires a focus on well-designed and implemented antenatal care and early childhood programs, along with effective interventions to support young adults to adopt healthy lives.

The total fertility rate in Australia is 1.9 children per woman, while the total fertility rate for Aboriginal and Torres Strait Islander women is 2.6 children per woman (Family Planning NSW, 2014). In 2014, the median age of Aboriginal and Torres Strait Islander mothers was 25.1 years, compared with 30.9 years for all mothers, with the fertility rate of teenage Aboriginal and Torres Strait Islander women (57.3 babies per 1,000 women) over four times that of all teenage women (13 babies per 1,000) (Australian Indigenous HealthInfoNet, 2016). These rates highlight the importance of sexual education in Aboriginal and Torres Strait Islander people. This is also highlighted by the higher rates of Sexually Transmitted Diseases (STIs) among Aboriginal and Torres Strait Islander people nationally, including gonorrhoea (18 times higher), syphilis (3 times higher) and chlamydia (3 times higher) (Family Planning NSW, 2013). Contraceptive use among Aboriginal and Torres Strait is reported as being lower than non-Indigenous Australians (64% compared to 71%) (Family Planning NSW, 2013).

On average, in 2013, pregnant Aboriginal and Torres Strait Islander mothers attended one less antenatal visit than non-Indigenous mothers (9 and 10 visits respectively) (Australian Institute of Health and Welfare, 2015c). Fewer Aboriginal and Torres Strait Islander women attended their first antenatal visit in the first trimester of pregnancy (less than 14 weeks), 52% compared to 60% of non-Indigenous Australian mothers. This rate has increased for Aboriginal and Torres Strait Islander women since 2010 (50%), but decreased for non-Indigenous women (67%) (Australian Institute of Health and Welfare, 2015c).

In 2012, the average birthweight of babies born to Aboriginal and Torres Strait Islander mothers was 3,211 grams, 162 grams less than the average birthweight for babies born to non-Indigenous

mothers (Hilder et al., 2014). Of these babies, 11.8% were of low birthweight (less than 2,500 grams) compared with 6.1% of babies of non-Indigenous Australian mothers. The ACT had the highest rate of low birthweight babies born to Aboriginal and Torres Strait Islander women (14.9%). However, it was noted that 24.2% of Aboriginal and Torres Strait Islander women who gave birth in the ACT were non-ACT residents and the rate of low birthweight specifically for ACT Aboriginal and Torres Strait Islander residents was 6.5% (Hilder et al., 2014). The Winnunga Nimmityjah Aboriginal Health Service (ACT) Annual Report for 2014-15 stated of the 61 births recorded at their facility 11% were of low birth weight (Winnunga Nimmityjah Aboriginal Health Service, 2015). There are several significant risk factors for low birthweight which includes maternal smoking; the weight, age and nutritional status of the mother; excessive alcohol consumption during pregnancy; and poor antenatal care (Australian Health Ministers' Advisory Council, 2015). Low birthweight is associated with a number of poor health outcomes in the short term (e.g. death during first year of life, ill-health in childhood, psychosocial problems, difficulties at school) and later in life (e.g. lower achievement on intellectual measures, chronic diseases in adulthood) (OECD, 2011, Scott, 2014, Australian Institute of Health and Welfare, 2011c).

Consultation with local stakeholders identified young women who are pregnant and those with children in the 0-5 year age group as requiring support in relation to the following issues:

- Follow up on immunisation
- Maintaining healthy eating
- Understanding the risks of smoking during pregnancy
- Regular check-ups in relation to their own and their children's health
- Dental issues due to poor nutrition

A literature review conducted by the Primary Health Care Research and Information Service (PHCRIS) on the health of Aboriginal and Torres Strait Islander mothers, babies and young children made the observation of poor data collection and program evaluation resulting in the difficulty to assess program effectiveness. It recommends the use of high-level principles that are similar to the principles for designing any health or social programs (Bywood et al., 2015).

Crystal methamphetamine use among Aboriginal and Torres Strait Islander youth

While the national monitoring system for methamphetamine use among the Aboriginal and Torres Strait Islander population is inadequate, there is some evidence to suggest that the Aboriginal and

Torres Strait Islander individuals in urban and regional areas are more likely to use methamphetamine than non-Indigenous individuals (MacLean et al., 2015). Local consultation on this issue highlighted the severity of drug overdose and its detrimental impact on family wellbeing. Despite the issue being framed as an “ice epidemic” in the media, there is no robust evidence to suggest the number of methamphetamine users has increased significantly over the years; however, methamphetamine was being used more frequently and therefore the harm in terms of treatments due to substance dependence and hospitalisation due to drug overdose has increased. Access to methamphetamine treatments was particularly concentrated among the Aboriginal and Torres Strait Islander youth aged 15-24 when compared with the non-Indigenous population of all ages (Roche et al., 2015).

Children and youth

Aboriginal and Torres Strait Islander children and youth are over-represented in statistics that include living in poverty, statutory child protection, out-of-home care, juvenile justice and leaving school early, compared to their non-Indigenous Australian peers. Nationally the rate of Aboriginal and Torres Strait Islander children in out of home is 9.5 times the rate of non-Indigenous Australian children (Australian Institute of Health and Welfare, 2016a). In the ACT this rate is higher, at 13.1 times (i.e. 74.8 per 1,000 Aboriginal and Torres Strait Islander children compared to 5.7 per 1,000 non-Indigenous children)(Australian Institute of Health and Welfare, 2016a). The ACT has the highest proportion of Aboriginal and Torres Strait Islander children in out of home care nationally. In 2014-15, ACT Aboriginal and Torres Strait Islander children were 10.4 times more likely to be receiving child protection services than non-Indigenous children, higher than the national rate of 7 times more likely (Australian Institute of Health and Welfare, 2016a). Similarly, ACT Aboriginal and Torres Strait Islander children were 13 times more likely to be on care and protection orders than non-Indigenous children, with the national rate at 9.2.

Children in out of home care are a vulnerable and at-risk group in the population, and although existing data is limited, they are likely to have poorer physical, mental and developmental health than their peers (Royal Australasian College of Physicians, 2006). Exposure to trauma and neglect and experience of out of home care is associated with suicidal behaviour and contact with the criminal justice system and increases the risk of experiencing family violence as an adult (Atkinson J, 2013, Wong and Mellor, 2014). Trauma in these children and youth (as a result of being removed from families, family violence and family breakdown) is an issue often overlooked.

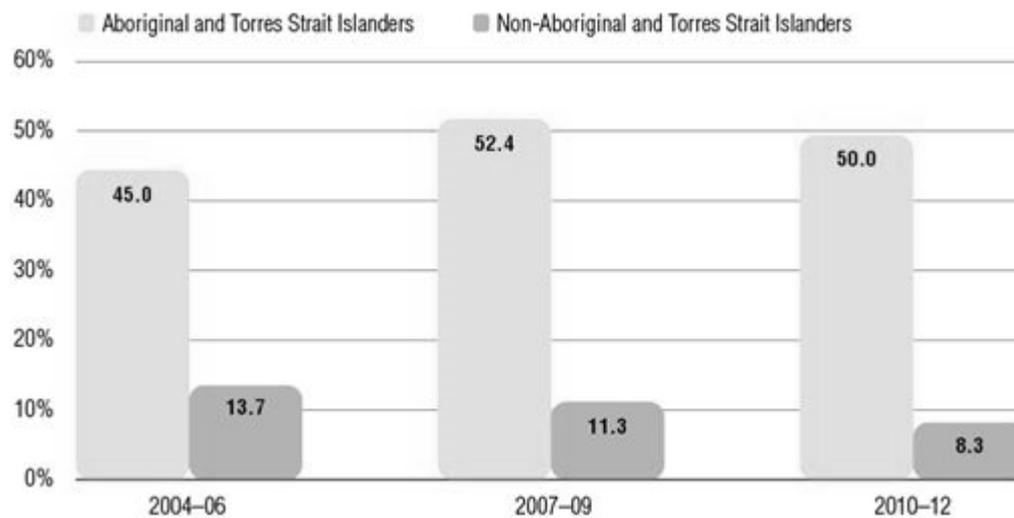
Consultation identified the need to support these children and youth, particularly in relation to support and advocacy when accessing health care services. Support and mediation around general practice medical appointments has been identified as an important issue to support the needs of Aboriginal and Torres Strait Islander youth and to improve the effectiveness of communication between staff and Aboriginal and Torres Strait Islander patients. The need to support parents and grandparents who are caring for young Aboriginal and Torres Strait Islander people was also identified.

Priority Issues

Smoking during pregnancy

ACT Aboriginal and Torres Strait Islander women are 6 times more likely to smoke during pregnancy (48%) than non-Indigenous women (8%) (ACT Health, 2016f). Nationally, smoking during pregnancy has declined in Aboriginal and Torres Strait Islander women between 2005 and 2011 (54% to 50%) (Australian Health Ministers' Advisory Council, 2015). In the ACT the percentage of Aboriginal and Torres Strait Islander women who reported smoking during pregnancy increased from 45.0% to 52.4% between 2004-06 and 2007-09, and then decreased to 50.0% in 2010-12 (Figure 4.3) (ACT Government, 2013c). This rate is significantly higher than non-Indigenous Australian women in the ACT (8.3% in 2010-12). There is a dose-response relationship between number of cigarettes smoked and the likelihood of giving birth to a low-birthweight baby. Between 2001-2009 the average birthweight of babies born to Aboriginal and Torres Strait Islander women in the ACT who smoked during pregnancy (2,979 grams) was significantly lower than the average birthweight of babies born to Aboriginal and Torres Strait Islander women who did not smoke during pregnancy (3,317 grams) (Epidemiology Section ACT Health, 2013). A multivariate analysis of national data from 2009 to 2011 showed that 51% of low birth weight births to Aboriginal and Torres Strait Islander mothers were attributable to smoking during pregnancy, compared with 19% for other mothers (Australian Health Ministers' Advisory Council, 2015). Babies born to Aboriginal and Torres Strait Islander women in the ACT were significantly more likely to be low birthweight compared with babies born to non-Indigenous Australian women (Epidemiology Section ACT Health, 2013).

Figure 4.3: Proportion of women who smoked during pregnancy by Aboriginal and Torres Strait Islander status, ACT residents, 2004-06 to 2010-12.



Source: ACT Health, Epidemiology Section. Maternal and Perinatal Data Collection, unpublished data.
<http://www.children.act.gov.au/Indicators/Smoking%20during%20pregnancy.html>

A project on pregnant Aboriginal and Torres Strait Islander women in the ACT found some young women wanted to receive support to quit smoking for the sake of their baby, while others were not ready to or interested in quitting and some were reluctant to disclose their smoking status (van der Sterren and Fowlie, 2015). In some cases women had heard about the negative effects of smoking, but found it difficult to believe that this applied to them, as they or other family members had smoked when pregnant and their children are ‘OK’ (van der Sterren and Fowlie, 2015). Other barriers included the lack of support of family and household members to encourage pregnant women to quit and also the high levels of stress among pregnant Aboriginal and Torres Strait Islander women and using smoking as a way to manage this (van der Sterren and Fowlie, 2015).

Strategy

ACT Health is undertaking a project (Smoking in Pregnancy Project) dedicated to this issue for both Aboriginal and Torres Strait Islander and non-Indigenous populations focussing on social marketing and individual education.

Social, emotional and cultural wellbeing

Social, emotional and cultural wellbeing, which results from a network of relationships between the individual, their family and the community, is the basis for Aboriginal and Torres Strait Islander peoples, physical and mental health (Department of Health and Ageing, 2013). A positive sense of

social and emotional wellbeing is essential for Aboriginal and Torres Strait Islander people to lead successful and fulfilling lives. Aboriginal and Torres Strait Islander people with poor social and emotional wellbeing are less likely to participate in employment, consume higher levels of alcohol and other substances and are also less likely to access health services (Department of Health and Ageing, 2013). Aboriginal and Torres Strait Islander peoples experience higher levels of morbidity and mortality from mental illness, psychological distress, assault, self-harm and suicide than other Australians (Australian Health Ministers' Advisory Council, 2015). It was reported that in 2003, about 10% of the health gap between Aboriginal and Torres Strait Islanders and non-Indigenous Australians was linked to mental health conditions (including depression, anxiety and substance misuse disorders), with another 4% attributed to suicide (Vos et al., 2007). Rates of intentional self-harm among young Aboriginal and Torres Strait Islander people aged 15-24 years are 5.2 times the rate of non-Indigenous Australian young people (Dudgeon et al., 2014).

In the ACT in 2012-13, almost one third (30%) of Aboriginal and Torres Strait Islanders aged 18 years and over reported having a high/very high level of psychological distress, being nearly three times as likely as non-Indigenous people to have experienced high/very high levels of psychological distress (rate ratio of 2.7) (Australian Bureau of Statistics, 2013a). The ACT rate of hospitalisation for principal diagnosis of mental health related conditions is 23 per 1,000 population which is 2.3 times higher than the non-Indigenous population. The Aboriginal and Torres Strait Islanders in the ACT accessed the community mental health services at a rate of 1711 contacts per 1,000 population – 2.6 times higher than the non-Indigenous Australian population (Australian Institute of Health and Welfare, 2014a).

The ACT Human Rights Commission undertook a community engagement activity in 2014 designed to gain a more detailed understanding of the ACT Aboriginal and Torres Strait Islander community's views about which services for Aboriginal and Torres Strait Islander children and young people in the ACT work well and which services don't work so well, as well as ideas for service improvement (Roy et al., 2014). In terms of mental health, which is an important aspect of wellbeing, participants reported ongoing issues around accessing support services for children and young people who have mental health issues. A concern was that the Child and Adolescent Mental Health Service (CAMHS) was unable to support them as the children and young people did not meet the criteria for referral, and that the Trauma Recovery Centre only takes referrals from Care and Protection Services. Participants reported that accessing private practitioners was not financially viable (Roy et al., 2014). A number of participants also reported that the practitioners at CAMHS were not always supportive or understanding of the issues particular to the Aboriginal and Torres Strait Islander community, and

as a result they felt culturally unsafe and unsupported there. Further reported areas for development included a lack of qualified Aboriginal and Torres Strait Islander mental health practitioners in the field, with participants reporting that they would be more likely to access support services in the mental health area if they were facilitated by Aboriginal and Torres Strait Islander workers (Roy et al., 2014).

The local Aboriginal Community Controlled Health Organisation, Winnunga Nimmityjah Aboriginal Health Service, has been providing a range of health services to meet the health needs of the community they serve. While the majority of their clients live in the ACT (79%), many also live in surrounding areas, including Queanbeyan, Karabar and Jerrabomberra. While Winnunga Nimmityjah Aboriginal Health Service has had a significant increase in Aboriginal and Torres Strait Islander Health Assessments, GP management plans, team care arrangements, and care plan reviews in recent years, the number of mental health plans, reviews and consultations conducted have plateaued since 2012-13 (Winnunga Nimmityjah Aboriginal Health Service, 2015). Half of the Winnunga clients with a psychological condition had depression, almost one third of them had anxiety, and a quarter had both depression and anxiety. Slightly more than half of their clients with a chronic condition had a comorbidity of psychological condition (Winnunga Nimmityjah Aboriginal Health Service, 2015).

Strategy

It is widely acknowledged that the provision of mental health services for Aboriginal and Torres Strait Islander people is both inadequate and inappropriate. Effective strategies need to be explored. Programs that show promising results for Aboriginal and Torres Strait Islander social and emotional wellbeing are those that encourage self-determination and community governance, reconnection and community life, and restoration and community resilience. Important program features include: a holistic approach; a focus on recovery and healing from stress and trauma; a means of empowering people to regain a sense of control and mastery over their lives; strategies that are Aboriginal and Torres Strait Islander-led, family focused, culturally responsive, and context specific; interdisciplinary approaches that provide outreach services and transport; partnerships with the Aboriginal Community Controlled Health Services sector and local communities (Dudgeon et al., 2014).

Local strategies are proposed to be developed during 2016 in association with Aboriginal Community Controlled Health Services sector through the mental health and alcohol and drug planning processes.

Access to services

There are two main Aboriginal and Torres Strait Islander-specific services in the ACT. Winnunga Nimmityjah Aboriginal Health Service is an Aboriginal Community Controlled Health Service located in Narrabundah, and Gugan Gulwan Youth Aboriginal Corporation, located in Wanniasa.

The barriers that some Aboriginal and Torres Strait Islander patients and families experience when trying to access mainstream primary health care services which emerged during the CNA consultations include (Cranny, 2013):

- Waiting times for GP appointments
- Lack of bulk billing in the majority of general practices and the need for upfront co-payments for adults. This can result in delays in seeking treatment or episodic use of ED as an alternative for primary medical care
- Lack of information about which practices are “incentivised” to provide primary care to this population group
- Lack of transport
- Some GPs may not provide the types of services required by many Aboriginal and Torres Strait Islander clients with complex needs, resulting in clients needing to travel some distance for appropriate services (Ware, 2013)

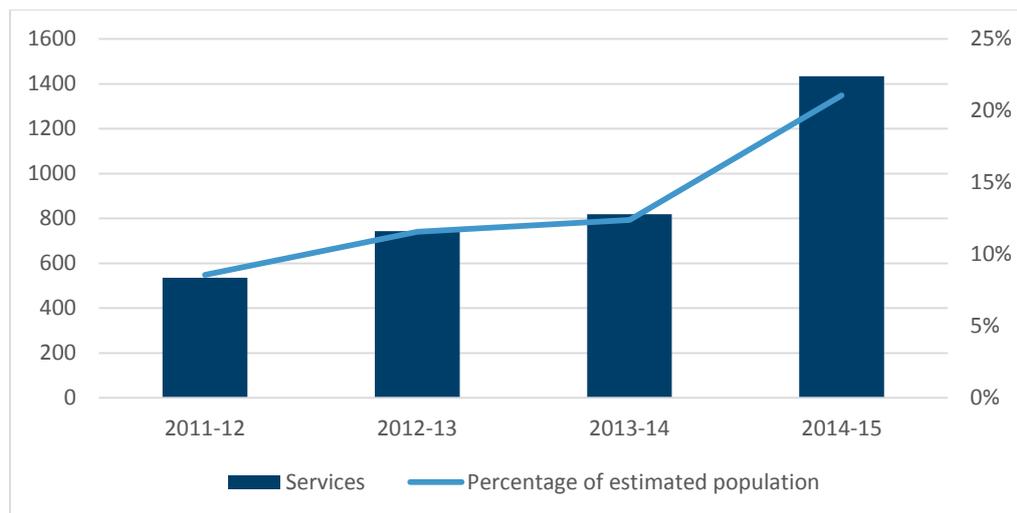
Poor linkages, communication and coordination between primary health care services can also contribute to a lack of availability. Given the lower average income of Aboriginal and Torres Strait Islander families, there is higher sensitivity to the costs of medical services and medications, including MBS and PBS co-payments (Scrimgeour and Scrimgeour, 2007).

Further, whether or not a health care provider recognises, respects or incorporates Aboriginal and Torres Strait Islander cultural values in the design and delivery of its services is a factor that affects whether Aboriginal and Torres Strait Islander people access that provider (Lumby and Farrelly, 2009). Ignoring or offending cultural values in the provision of health care can be a significant disincentive to access.

The use of MBS Aboriginal and Torres Strait Islander Health Assessment items is low, despite the opportunities for health improvements that they offer (DiGiacomo et al., 2010). However, usage rates in the ACT have increased in the past few years from only 8.6% of the Aboriginal and Torres Strait Islander population in 2011-12 to 21.0% in 2014-15, with almost double the number of health checks performed from 2013-14 to 2014-15 (819 and 1434 respectively), see Figure 4.4 (Department

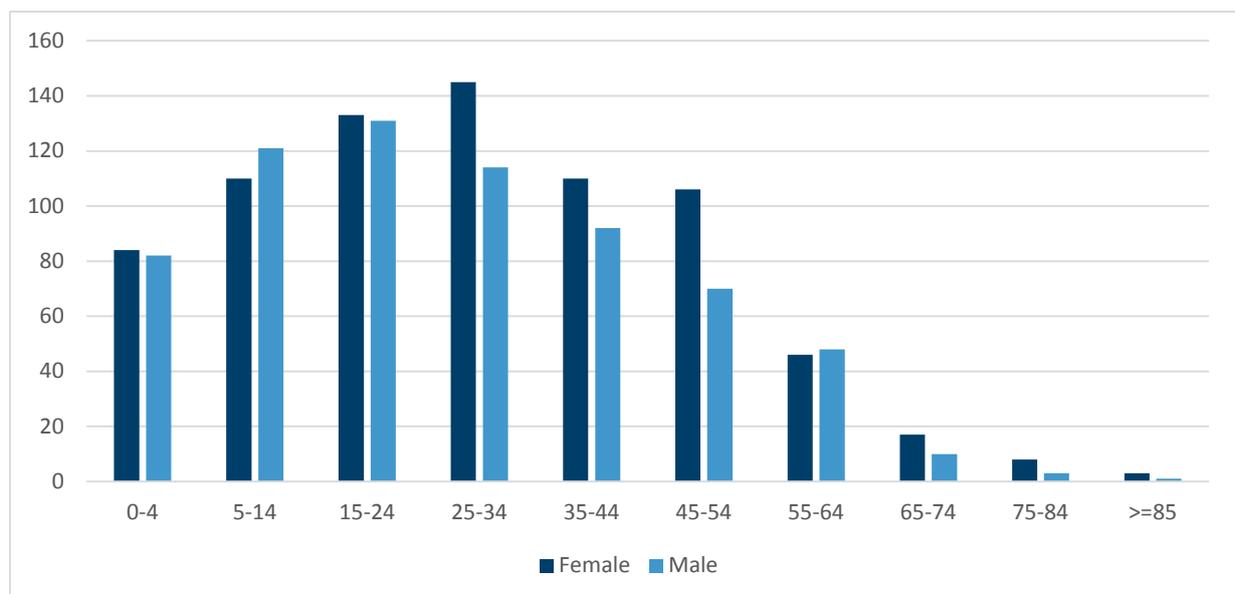
of Human Services, 2016). In the ACT in 2014-15, 53% of those who completed an Aboriginal and Torres Strait Islander Health Assessment were female (see Figure 4.5). Winnunga Nimmityjah Aboriginal Health Service conducted approximately 87% of all Aboriginal and Torres Strait Islander health checks in the ACT in 2012–13, 79% in 2013-14 and 83% in 2014-15.

Figure 4.4: Number and percentage of population of ACT Aboriginal and Torres Strait Islander Medicare Health Assessments (item no. 715), 2011-15



Source: (Department of Human Services, 2016)

Figure 4.5: Number of ACT Aboriginal and Torres Strait Islander Medicare Health Assessments (item no. 715) by sex in 2014-15



Source: (Department of Human Services, 2016)

The ACT Human Rights Commission community engagement in 2014 found that when asked about how accessible current services are for the community, 58% of participants rated accessibility as 'poor' or 'fair'; 41% rated it as 'good'; and nobody thought it was 'very good' or 'exceptional' (Roy et al., 2014). Participants also reported that health services in the ACT can be difficult to engage with for Aboriginal and Torres Strait Islander families. They also reported that some mainstream services, such as GPs, did not understand the unique experiences of Aboriginal and Torres Strait Islander people (Roy et al., 2014). Some participants reported that it was difficult to access Winnunga for those that reside in the Belconnen or Gungahlin areas and that accessing these services was difficult, particularly if they or the children and young people they care for were unwell at the time, and that it would be good to establish another site. Participants also reported that outreach services may be beneficial and could be established in partnership with other services such as the Child and Family Centres (Roy et al., 2014).

Strategy

Access to primary health care for Aboriginal and Torres Strait Islander people needs to be understood in terms broader than just physical or geographical access, to also include economic, social and cultural dimensions, which all have an impact on the opportunities and decisions of Aboriginal and Torres Strait Islander people to utilise primary health care services.

The following strategies have been successfully used to improve the physical availability of health services for Aboriginal and Torres Strait Islander clients:

- Provision of transport (Barwick, 2000)
- Comprehensive health care services in one location (Barwick, 2000)
- Home visitation (Barwick, 2000)
- Provision of services in non-traditional settings (Barwick, 2000)
- Flexibility in appointment systems allowing Aboriginal and Torres Strait Islander clients to access services at appropriate times (Herceg, 2005)

Best practice in promoting access to primary health care for Aboriginal and Torres Strait Islander people includes:

- services that are reachable and available (outreach and community visiting; Aboriginal Health Workers to facilitate the journeys of Aboriginal and Torres Strait Islander people between the range of health services they need; the integration of Aboriginal and Torres Strait Islander-specific and mainstream services);

- services that are culturally sensitive and acceptable (Aboriginal and Torres Strait Islander doctors, nurses or health care workers on staff; respecting gender-based cultural values and practices in clinical approaches; having access to interpreter services; recognising cultural conceptions of health and wellness in clinical practice); and
- health-aware communities (community capacity building to encourage health-seeking behaviour; liaison and ongoing relationships between primary care services and Aboriginal and Torres Strait Islander communities) (Australian Medical Association, 2011, Osborne et al., 2013).

CHN aims to commission a model of service provision and cultural support to improve access to general practice for vulnerable populations– this model will address cultural sensitivity for Aboriginal and Torres Strait Islander people as well as the difficulties/barriers typically experienced by vulnerable populations.

Need for an integration of early childhood services

As defined by UNICEF, early childhood development is a comprehensive approach to policies and programs for children from before birth to 8 years of age, their parents and caregivers. It is aimed at ensuring all children have an equal chance to thrive and grow. It encompasses the interrelated or holistic aspects of children’s development, which includes the physical, social-emotional and language-cognitive domains. Early childhood development is aligned to, and complements, agendas and priorities for child health, pre-primary education, maternal and child health, quality early childhood care and education as well as child and family welfare (United Nations Children’s Fund, 2001).

Child mortality rates, the prevalence of emotional and behavioural disorders, deficits in language and cognitive skills, and poor health outcomes highlight the gap in early life outcomes between Aboriginal and Torres Strait Islanders and non-Indigenous Australians (Wise, 2013). A higher percentage of ACT Aboriginal and Torres Strait Islander children scored in the developmentally vulnerable category in all domains on the Australian Early Development Index than non-Indigenous ACT children. This was significantly higher for physical health and wellbeing, language and cognitive skills and communications and general knowledge domains (Epidemiology Section ACT Health, 2013).

Aboriginal and Torres Strait Islander children and youth are over-represented in statistics that include living in poverty, statutory child protection, out-of-home care, juvenile justice and leaving

school early, compared to their non-Indigenous peers. Children in out-of-home care are a vulnerable and at-risk group in the population, and although existing data is limited, they are likely to have poorer physical, mental and developmental health than their peers. Trauma in these children and youth (as a result of being removed from families, family violence and family breakdown) is an issue often overlooked.

Strategy

CHN will actively engage with the newly formed ACT Early Childhood and Families Working Group (sponsored by the joint ACT Aboriginal and Torres Strait Islander Forum) that will be developing a position on specific needs including system enablers and service specific issues.

Chronic disease management

Chronic disease is known to be a major contributor to the gap in life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians people, accounting for about 80% of the mortality gap in those aged 35-74 years (Australian Institute of Health and Welfare, 2010). The main contributors to this mortality gap are ischaemic heart diseases (22%), diabetes (12%), liver diseases mainly from alcoholic liver disease (11%), other forms of heart disease (6%), chronic lower respiratory disease (6%) and cerebrovascular diseases (5%) (Australian Institute of Health and Welfare, 2010). Many of the diseases that contribute to this mortality gap are associated with risk behaviours and issues related to service provision and access, and disease treatment and management among Aboriginal and Torres Strait Islander people. These factors are often also affected by the social determinants of health, including housing, education, employment and access to services.

Chronic diseases, which are rarely cured, occur more often among Aboriginal and Torres Strait Islanders at a much younger age than non-Indigenous Australians, leading to reduced quality of life and a greater amount of potential years of life lost (Australian Institute of Health and Welfare, 2010). Comorbidity is also more frequent, with 38% of Aboriginal and Torres Strait Islander adults with CVD, diabetes or chronic kidney disease having 2 or more conditions, compared with 26% of non-Indigenous Australians (Australian Institute of Health and Welfare, 2015d). Comorbidity increases with age for both populations, but is greater at each age in the Aboriginal and Torres Strait Islander population.

Aboriginal and Torres Strait Islander people already diagnosed with chronic illnesses or with elevated risk factors are likely to be using specialist and hospital services. In the ACT, Aboriginal and Torres Strait Islander peoples had higher rates of potentially preventable hospitalisations for chronic disease (27.8 per 1,000) compared to other ACT residents (7.9 per 1,000) in 2013-14 (Steering Committee for the Review of Government Service Provision, 2016). Chronic diseases are the cause of a large proportion of Aboriginal and Torres Strait Islander hospitalisations in the ACT, with Aboriginal and Torres Strait Islander people hospitalised at 3.6 times the rate of non-Indigenous Australians from diabetes and 1.6 the rate for circulatory diseases in 2008-10, while they were hospitalised at about the same rate for respiratory diseases (Australian Institute of Health and Welfare, 2013a).

Many people with complex needs would benefit from access to care coordination and follow-up supplementary services but no formal pathways or discharge planning arrangements currently exist to connect relevant patients using specialist or hospital services directly to the primary care Closing the Gap program delivered through Winnunga and CHN.

Diversifying the current chronic disease referral pathways to increase access to the Closing the Gap program initiatives and care coordination has been identified as a promising and important direction.

Providing information about Closing the Gap program eligibility and building a formal referral system and pathways with Aboriginal Liaison Officers, discharge planners, chronic disease teams and ED staff could generate additional referrals for two groups of patients:

- People who would benefit from time limited support and encouragement to self-manage their chronic health problems as well as information about PBS co-payments or supplementary services
- People with more complex needs who would also benefit from focussed care coordination.

When a patient presents to an ED, a discharge summary is faxed to the patient's GP, but there are currently no discharge planning arrangements for patients who require assistance (with, for example, transport, health literacy) to visit a GP or other primary health care provider post ED presentation (see Section 1 on discharge planning processes).

Access issues and pathways for people in Queanbeyan and Yass who use primary health care and hospital services in the ACT but live within the boundaries of the Southern NSW Primary Health Network also need to be clarified.

Strategy

CHN will work with the ACT Aboriginal and Torres Strait Islander community to deliver the Integrated Team Care (ITC) program. The ITC program will work across the Aboriginal and Torres Strait Islander and mainstream primary care sectors in the ACT and aims to contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions. This will be achieved through better access to coordinated and multidisciplinary care and provision of supplementary services. This will include promotion of the use of the annual health check (MBS 715) available to all Aboriginal and Torres Strait Islander peoples, provided by GP's and to encourage the early detection, diagnosis and intervention for common and treatable conditions.

5. Vulnerable populations

Overview

Vulnerable populations can be defined as those at greater risk for poor physical, psychological and/or social health status and health care access. Vulnerable populations include older people, children, those living with mental illness, people from refugee backgrounds and those from culturally and linguistically diverse (CALD) backgrounds, those living with chronic disease, those experiencing domestic violence, those who are homeless or at risk of homelessness, those affected by the harms caused by alcohol, tobacco and other drugs and those who are Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI). The vulnerability that these groups experience usually can be attributed to one or some combination of three factors: economic status or geographic location; health, functional, or developmental status; or ability to communicate, however, not all sources of vulnerability can be explained by these factors.

The vulnerable populations we will be focussing on in this section of the report include:

- people from a CALD background
- people from refugee backgrounds
- those who are homeless or at risk of being homeless
- people experiencing domestic violence
- those who are LGBTI

Older people, children, those living with mental illness, those living with a chronic condition and those affected by the harms caused by alcohol, tobacco and other drugs will be covered in the other sections of this report.

There is a clear need to increase the level of attention paid to vulnerable populations, including both those who, because of their chronic illness or disability, have many interactions with the health system, and those who have difficulty accessing the system and may be most likely to fall through the cracks.

People from culturally and linguistically diverse (CALD) backgrounds

The ACT has a large number of culturally and linguistically diverse (CALD) communities, with people coming from over 200 different countries.

According to the 2011 Census, 24.2% (86,324 people) of ACT usual residents were born overseas. Gungahlin-Hall had the highest proportion of overseas born residents (29% of all residents) and Tuggeranong had the lowest proportion (19%). Over half (58.7%) of these people have lived in Australia for at least 15 years. The majority of these longer term residents were born in European countries (54.4%) with only 25.8% born in Asian countries (ACT Government, 2012). As shown in Table 5.1, the main countries of birth for overseas born residents are England, China, India, New Zealand and Vietnam (ACT Government, 2012).

Table 5.1: Main countries of birth in the ACT, 2011

Country	%
England	15.1
China	7.6
India	6.8
New Zealand	5.1
Vietnam	3.4

Source: (ACT Government, 2012)

Based on the 2011 Census, 64,673 (18%) people in the ACT spoke a language other than English at home. Of the 64,673 people who spoke a language other than English at home, 87% spoke English ‘very well’ or ‘well’. However, English proficiency for 11.9% (7667) of people was rated as ‘not well’ or ‘not at all’ (ACT Government, 2012). Gungahlin-Hall had the highest proportion of residents who spoke a language other than English at home (28% of all residents) and Weston Creek-Stromlo had the lowest proportion (12%). The main languages spoken by this group of people were Mandarin (915 people), Vietnamese (802 people) and Cantonese (609 people) (Table 5.2). Mandarin was also the most common language spoken by all people speaking a language other than English at home, closely followed by Cantonese, which means that there were nearly 11,000 Chinese language speakers resident in the ACT. Other popular languages were Vietnamese (3,787 people), Italian (3,312 people), Spanish (2,924 people), Greek (2,777 people), Arabic (2,420 people), Croatian (2,402 people) and Hindi (2,314 people).

Table 5.2: Most common and fastest growing languages other than English spoken at home, ACT, 2011

Rank	Most common languages	Fastest growing languages
1	Mandarin	Karen
2	Vietnamese	Malayalam
3	Cantonese	Nepali
4	Italian	Gujarati
5	Spanish	Punjabi
6	Greek	Telugu
7	Arabic	Afrikaans
8	Croatian	Dinka
9	Hindi	Shona
10	German	Urdu

Source: (ACT Government, 2012)

Over the decade to 2011, the fastest increase in overseas born people counted in the ACT was people born in Iraq (up 300 percent). The next fastest growth was people born in India and people born in China. The number of people born in South Korea also increased rapidly, from 647 people in 2001 to 1,556 people in 2011.

As well as increases in the numbers of people from South Korea, China and India, there has been an increase of people born in the Philippines, Sri Lanka, Vietnam, South Africa, the United States of America and Malaysia (ACT Government, 2014).

Key Issues

Barriers to interpreter use

Not using interpreting services, or working with unskilled interpreters, can seriously compromise patient health outcomes. Non-English speaking patients are found to spend more time in hospital, be more likely to suffer adverse clinical reactions and have higher readmission and diagnostic testing rates. This strain on patients and services can be alleviated through access to professional interpreting services, as this enhances health outcomes for patients whose first language is not English.

Health services can face challenges in responding to the needs of people from new and emerging communities. There is a shortage of appropriately qualified interpreters from new and emerging communities due to small population size, lower average level of English and earlier stage of

interpreter training. In small communities, there is an increased likelihood that the client will know the interpreter, complicating and compromising the professional relationship. There is an ongoing need to address these issues for new and emerging communities.

Cultural competence/awareness training for health professionals

A culturally competent health care system is one which is aware of and responsive to differing cultural values and beliefs in relation to health and illness, the responsibilities of the individual and the health care provider and to the health system overall (National Center for Cultural Competence). This also involves ensuring CALD communities have ready access to health information in their preferred language. A culturally competent health care system is essential to improved health literacy in the CALD communities. Cultural competency training and education is the best way to support health care workers and to facilitate improved understandings and positive interactions between diverse health models.

Education for health care providers that incorporates cultural perspectives and experiences can improve provider preparedness for working with CALD populations and their future commitment to working for change. This can lead to more open attitudes, increased awareness, more effective advocacy, a preparedness to engage with people from a CALD background, and a better understanding of CALD health issues.

Access to translated culturally appropriate materials

It is important that health information is culturally appropriate. Information based on Western cultural perceptions may have little meaning to some community groups and may be disregarded. Terminology can also be problematic in a cross-cultural context, as certain words are not used in some cultures. Difficulties defining terms can be related to varying cultural perceptions of health. Many issues with translated materials can result from a lack of consultation with target communities before, during and checking after the translation process.

Many older people with limited English proficiency speak a dialect and may not understand standard translations. Also, there are significant levels of limited literacy in the first language amongst communities of people with limited English proficiency.

Health literacy/language barriers

Language barriers impede access to health care, can compromise quality of care, and may increase the risk of adverse health outcomes among patients with limited English proficiency. People with inadequate health literacy have limited ability to search for and use health information, make

informed decisions or maintain their basic health. Research demonstrates that there are strong correlations between low health literacy and less healthy behaviours, poorer self-management of chronic conditions, higher rates of hospitalisation, difficulty communicating with providers and poorer health status in general (Ethnic Communities' Council of Victoria Inc., 2012).

The impact of low health literacy on people from non-English speaking backgrounds means they are:

- Less likely to access the services that they need
- Less likely to understand issues related to their health
- More likely to experience social isolation, which can lead to damaging behaviours and negatively impact physical and mental health
- At risk of mismanaging their medication
- Less likely to have an adequate understanding of health issues

Priority Issue

Health practitioner use of interpreters

It is well documented that the use of interpreters and bilingual workers is essential in facilitating access to care and delivering quality care for people from a CALD background and refugees (Joshi et al., 2013). Interpreter services can either be onsite or via a telephone service, particularly for more routine care (Crossman et al., 2010). Use of informal interpreters such as friends or family members can undermine the quality of care (Flores, 2005). It is therefore important to make interpreter services more available to assist in primary health care for those from a CALD or refugee background.

Language and communication barriers to access and optimal care include not only the lack of interpreters and bilingual staff but the need for their appropriate use. Refugees' and the CALD population's low levels of English language proficiency and access to qualified interpreters is a systemic problem compounded by providers' reluctance to use interpreter services and or insufficient interpreters for certain language groups.

It is important to understand the factors that encourage health practitioners to use qualified interpreters as a way of disseminating successful strategies others can adopt and to encourage the routine use of qualified interpreters in day to day practice. Increasing health practitioners' awareness of interpreter services and how to access them makes it more likely they will use the services (Foundation House, 2012). The RACGP accreditation standards for general practices require

that GPs and staff are aware of TIS for clients not proficient in English. Practices are obliged to provide sufficient information to enable patients to make informed decisions regarding their care, which includes providing for the communication needs of patients who are not proficient in the primary language of the clinical team and/or who have a communication impairment (The Royal Australian College of General Practitioners, 2013). Criterion 1.2.3 of the RACGP Standards states that 'our practice provides for the communication needs of patients who are not proficient in the primary language of our clinical team and/or who have a communication impairment' (The Royal Australian College of General Practitioners, 2013). It is the responsibility of the treating doctor (not the patient) to arrange an interpreter when required.

To facilitate this, GPs, specialists and pharmacists in Australia have free access to professional interpreters for Medicare-rebateable consultations via the Translating and Interpreting Service (TIS) (Department of Social Services, 2015). TIS operates a telephone service available 24 hours a day, seven days a week, with ninety percent of calls providing access to an interpreter within three minutes (Department of Social Services, 2015). TIS has priority processing for medical practitioners, who have free access to the service (DIAC, 2003). Evidence suggests, however, that professional interpreters are under-utilised in general practice (Huang and Phillips, 2009, Phillips and Travaglia, 2011, Attard et al., 2015). The findings from a sub-study of the Bettering the Evaluation and Care of Health (BEACH) program, which sought to determine the need for, and use of, professional interpreters in general practice, confirm that the use of professional interpreters at language other than English (LOTE) consultations is rare in Australian general practice (Bayram et al., 2016). Anecdotal evidence in the ACT suggests that this is also the case.

The use of family members as interpreters does not meet best practice. There is no way to determine their level of English proficiency, nor if their interpretation is accurate and reflective. The use of family members has been shown to result in longer, poorer quality consultations (Phillips, 2010).

There are many barriers to interpreter use, including time required to engage interpreters, length of consultation, lack of awareness of interpreter services by health professionals, inaccurate assessment of English language proficiency, lack of understanding of the importance of professional interpreting, interpreters unavailable and client reticence (Foundation House, 2012). A common misconception is that using an interpreter lengthens consultation times. In fact, the literature indicates that because interpreted consultations utilise a pared back communication style, they can usually be conducted without extending the consultation time (Phillips, 2010). A wide variety of factors have been identified as facilitators to the use of qualified interpreters by health practitioners,

including awareness of interpreter services, efficient interpreter booking systems, policy and procedure documentation and review, and ensuring staff are aware of and trained to access and use interpreters (DIAC, 2003).

A key issue identified during consultation was access to timely interpreter services for people from refugee backgrounds, new arrivals and migrants, and a perceived reluctance by some health providers to use this service. Another key issue identified during consultation was the need for more Arabic translators and interpreters for the Iraqi and Syrian communities. Problems arising from lack of access to interpreters in ACT services are raised by patients in about 1 in every 20 consultations, indicating a very high level of concern among patients (Companion House, March 2013). Many hospital outpatient clinics and some community clinics for instance prefer a model of on-site interpreting (twice the usage rate than TIS overall), which involves significant delays and more complicated logistics over what would be available through TIS. The efficacy of this approach needs to be reconsidered.

Strategy

There is a need to promote health professional training in relation to interpreter use in the ACT. (see following section re Refugees – provision of training on qualified interpreter use).

People from Refugee Backgrounds

ACT is a significant placement site for people from a refugee background and is regarded as a good place to settle. It has a relatively large refugee population per head of population and as a result is a linguistically diverse jurisdiction.

A person from a refugee background is a person who has had to leave his or her home country because they were being targeted for persecution due to reasons of race, religion, nationality, political opinion or membership of a particular social group, and who is unwilling or unable to return to his or her country of origin (UNHCR, 1951). In Australia, this includes refugees and humanitarian entrants with permanent resident visas.

Most refugees and asylum seekers have experienced traumatic events such as physical and psychological trauma or torture, deprivation and prolonged poverty, periods in immigration detention and poor access to health care prior to arrival. As a result, many people from a refugee

background have multiple and complex physical and psychological health problems on arrival, including high levels of avoidable illness and associated mortality.

Due to their experiences and in some cases their region of origin, people from refugee backgrounds may be at increased risk of the following health problems: psychological disorders (related to past trauma, immigration detention and the challenges of settlement); physical consequences of torture and armed conflict, (e.g. musculo-skeletal pain or hearing loss); infectious diseases (e.g. intestinal parasites or malaria); under-immunisation; poor nutrition; undetected or poorly managed chronic diseases (e.g. high blood pressure or diabetes); poor dental health, as a result of poor diet and nutrition, lack of fluoridated water, poor dental hygiene, limited dental care and sometimes torture to the mouth; growth and development issues in children as a consequence of malnutrition or previous illness (NSW Health, 2012).

The majority of people from refugee backgrounds in the ACT settle in the Inner North and Belconnen areas, with significant numbers in the Gungahlin area. There are smaller concentrations of people in Tuggeranong and Weston Creek, but very few in the Inner South (Companion House, March 2013).

The medical and social needs for many people from refugee backgrounds differ depending on country of origin and are attended to by Companion House, which is a community based organisation with in excess of 1,200 clients on its books. Companion House is part of the FASSTT (Forum of Australian Services for Survivors of Torture and Trauma) network. Companion House provides medical services, counselling, complementary therapy, community development, training and professional development, advocacy and immigration advice. Medical services provided by Companion House have increased over recent years to include additional GP sessions and a full-time practice nurse.

The immediate health care issues for people from refugee backgrounds and new arrivals in the ACT, as is the case globally, are in relation to catch up primary health care (dental issues, catch-up immunisation), mental health needs (related to past trauma, immigration detention and the challenges of settlement) and nutrient deficiency (including Vitamin D deficiency, particularly for dark-skinned people and those who wear hijab, iron deficiency and Vitamin B12 deficiency) (Benson et al., 2013, Royal Australasian College of Physicians, 2007, NHMRC Centre for Research Excellence in Population Health, 2013). In the longer term, needs relate to childhood nutrition (over and undernutrition post settlement), safe and affordable housing, safe motherhood and chronic diseases (including diabetes, renal disease and smoking) (Phillips, Dec 2013).

The ACT is widely regarded as a refugee service model for other jurisdictions. Companion

House provides longer term care for refugees in the ACT rather than being an 'on arrival' assessment service. It is a nationally unique service, with nurses leading the Medical Service. The Medical Service responds to surge by increasing nurses and doctors and by using networks to increase the numbers of GPs. Companion House is a specialist screening service and has an onsite paediatric registrar and very experienced GPs. All newly arrived people from refugee backgrounds are linked in to Companion House by the Migrant and Refugee Settlement Service (MARSS) and offered screening. Companion House deals with nearly 100% of newly arrived refugees (Phillips, Dec 2013).

People from refugee backgrounds can face a number of barriers to health care when trying to address their health needs, which include:

- Financial constraints.
- Limited trust of health service providers.
- Unfamiliarity with Australian health care services and systems (due to low levels of health literacy and health system literacy).
- Unfamiliarity of health professionals with the detection and management of certain diseases.
- Risk of re-traumatisation if procedures are reminiscent of past abuse (NSW Health, 2012).

Interventions that orientate people from refugee backgrounds to the health care system are likely to improve accessibility, e.g. raising awareness of what they are entitled to, support making and attending appointments.

Key Issues

Transition to mainstream services

People from refugee backgrounds need to be able to access the same primary care services as the local population. Navigation out of Companion House into mainstream general practice after about a year is a big issue. Referral from Companion House to a GP can be difficult as it requires extensive handover. Companion House is a transitional general practice which is designed to carry about 600 patients. The service currently has a patient to GP ratio of 1,500:1, far in excess of the ACT average. There is a clear need for a safe, evidence-based transition process to ensure that suitable patients can be moved to mainstream practices and are supported to do so.

Lack of familiarity with the health system due to low levels of health literacy and health system literacy is a barrier to mainstream service access for refugees, particularly those disconnected from settlement support. Limited affordability and access to low or no cost services as well as financial

disincentives for service providers have also been identified as having a significantly negative impact on the access to and coordination of primary health care services for people from refugee backgrounds (Russell et al., 2013a).

The recent development of an evidence-based best practice framework for coordinated primary health care for people from refugee backgrounds has recommended that effective transition to mainstream services requires:

- Case management and advice from refugee focussed health services
- Providers skilled in the use of interpreters
- Providers with access to knowledge concerning some of the challenges faced by refugees and access to resources to assist with the management of individual refugees.

Further case management was strongly endorsed by the evidence as being associated with improving communication and coordination between service providers, particularly for those refugees with complex health or multiple health service needs. The development of clear protocols for the transition of clients from refugee specialist to mainstream services was also recommended (Russell et al., 2013a). In the medium to longer term these could provide the ability for refugees to navigate the health system more effectively.

Syrian Community

In 2015, the government announced Australia will accept 12,000 Syrian and Iraqi refugees as part of the Humanitarian Program, in addition to Australia's annual humanitarian intake (which will also include people from Syria). The ACT will accept at least 250 of these 12,000 Syrian and Iraqi refugees. The Australian government is targeting those assessed to be most vulnerable - women, children, and families with the least prospect of ever returning safely.

Syrian and Iraqi children are at risk for poor nutrition, with high risk of both macronutrient (energy intake/protein) and micronutrient (vitamins and trace elements) deficiencies (Kiang and Paxton, 2015). High rates of post-traumatic stress disorder (PTSD), depression, and anxiety are reported in Syrian and Iraqi refugees arising from mass displacement, exposure to conflict and violence, including sexual violence, and with many people experiencing death or loss of family members. This conflict has produced a significant proportion of female-headed households – the loss of fathers and of family integrity creates acute and ongoing stress for mothers and children. Many children have also lost the physically, mentally, and socially protective environment that is provided by schools and education. In terms of disability related to conflict, injuries may result in physical disability and sensory impairment, in addition to psychological trauma (Kiang and Paxton, 2015).

It is very difficult to predict what the issues will be as the Syrian and Iraqi refugees start to arrive in the ACT, as the gaps will emerge over time. In terms of primary health care, one issue that has been highlighted is the lack of access to NDIS for people on temporary visas.

Priority Issues

Interpreters/translators

See previous section (Health practitioner use of interpreters, p5).

Strategy

The provision of training on qualified interpreter use is considered to be best practice (Foundation House, 2012). Training should include issues such as (Foundation House, 2012):

- Understanding the importance of using qualified interpreters
- Practical advice on how to work effectively with interpreters
- Assessing whether clients are adequately proficient in English for the clinical situation
- When to engage an interpreter
- Practical advice on how to work effectively with interpreters
- Cultural competence
- Particular considerations for use of interpreters when working with people from refugee backgrounds and asylum seekers, taking into account the impact of refugee trauma and torture

There is a need to develop new resources to build the capacity of mainstream primary health care providers to work with refugees and asylum seekers and to improve the use of interpreters. This can be undertaken by developing web-based training resources on the use of telephone and on-site interpreters, using vignettes of consultations on the key safety aspects of using interpreters, including the risks of using minors or family members, evaluating patient's language competence, and identifying consultation-specific circumstances where interpreters are likely to be needed (consent, crisis, assessing competence, and complex instructions).

People who are homeless or who are at risk of being homeless

Homelessness

There are three main categories of homelessness in Australia, according to the Australian Bureau of Statistics definition:

- primary homelessness (those who are 'sleeping rough', living without a roof over their heads)
- secondary homelessness (those staying with family or friends or 'couch surfing')
- tertiary homelessness (those living in insecure accommodation, such as boarding houses, on a medium to long term basis for over 12 weeks) (ACT Auditor-General's Office, 2013).

It is difficult to measure the actual number of people experiencing homelessness in the ACT due to the transient nature of homelessness and the difficulty of counting people who are sleeping rough or living with relatives and friends. For this reason the figures are probably an under-representation of the actual number of homeless people.

Homelessness is a key determinant of health, and is associated with many poor health outcomes. It is a demographic that often has very complex health, social and psychological needs.

According to the 2011 Census, 1,785 people were counted as homeless in the ACT, which is the second highest rate of homelessness (50 persons homeless per 10,000 persons) in Australia, after Northern Territory. The number of people at risk of homelessness has also grown from 251 in 2006 to 484 people in 2011. Almost 300 children under the age of 12 were classified as homeless in the ACT in 2011. 30% of the ACT's homeless people were aged 18 or under, with half of the homeless people between the ages of 19 and 44 years. Table 5.3 shows the numbers of people in the ACT in the various ABS homelessness categories.

Table 5.3: Homelessness categories in the ACT in 2011

Homelessness category	2011
Persons who are in impoverished dwellings, tents or sleeping out	29
Persons in supported accommodation for the homeless	1,105
Persons staying temporarily with other households	316
Persons staying in boarding houses	50
Persons in other temporary lodging	5
Persons living in 'severely' crowded dwellings	280
Total	1,785

Source: Australian Bureau of Statistics, Catalogue Number 2049.0 – Census of Population and Housing: Estimating homelessness, 2011

Due to the broad scope of the Australian Bureau of Statistics definition of homelessness, there have been difficulties in accurately reflecting homelessness in the community. The Australian Bureau of Statistics definition and method of counting homelessness was revised in the 2011 census to include overcrowding, which had the effect of significantly increasing the number of homeless people recorded in the ACT. The Australian Bureau of Statistics and the Australian Institute of Health and Welfare use different definitions in collecting data on homelessness, which makes it difficult to monitor homelessness and to determine whether or not progress is being achieved (ACT Auditor-General's Office, 2013).

In 2014-15, 4,987 people (1 in 77 people; 129.2 per 10,000) living in the ACT were supported by specialist homelessness services, which is higher than the national rate of 256,000 people (1 in 92 people; 108.8/10,000) (Australian Institute of Health and Welfare, 2015f). The ACT had the fourth highest rate of use of specialist homelessness services in 2014-15 behind Northern Territory, Victoria and Tasmania. The number of people supported by specialist homelessness services has decreased by 6.5% since 2013-14, where the ACT had the third highest rate (Australian Institute of Health and Welfare, 2015f).

Of those people who received support from specialist homelessness services in the ACT in 2014-15, more than half were female (54%) which is consistent with 2013-14 data. This is lower than the national figure of 60%. The largest group supported were those aged 18-34 years (42%), which is also consistent with 2013-14 data. Of this group (18-34 years), 46% were female and 37% male, compared with the national figure of 55% female (Australian Institute of Health and Welfare, 2015f).

Children continue to be overrepresented in the specialist homeless services data, with 1 in 7 people supported in the ACT being children aged 1-10 years in 2014-15 (children aged 0-10 years comprise just over 12% of the ACT population (Australian Bureau of Statistics, 2016a)). This is a slight increase from 2013-14 data but lower than the national figure of 1 in 5 people (Australian Institute of Health and Welfare, 2015f).

Males are more likely to present alone to specialist homelessness services whereas females are more likely to present single with children. Females presenting as one parent with child(ren) accounted for the largest group (43%), while females presenting alone accounted for 29% of the total number of female clients (Australian Institute of Health and Welfare, 2015f). The most likely explanation for this is the high proportion of women presenting to services having escaped domestic and family violence.

In terms of the reasons for seeking assistance from specialist homelessness services in the ACT, just over half of all people who received support (51.6%) sought assistance because of financial difficulties. Females were more likely than males to nominate financial difficulties as a reason for seeking assistance. The proportion of people who nominated housing affordability stress as a reason for seeking assistance increased from 27% in 2013-14 to 31% in 2014-15. The proportion of people seeking assistance for housing crises also increased from 31% in 2013-14 to 43% in 2014-15 (Australian Institute of Health and Welfare, 2015f).

In terms of health-related reasons for presenting to Specialist Homelessness Services in the ACT, mental health issues were the most common health reason (21.9%) (Australian Institute of Health and Welfare, 2015f). In total, 1,361 people reported one or more health related reasons, which represents 29% of all people who presented. Other health related issues included medical issues (12.5%), problematic drug or substance use (10.7%) and problematic alcohol use (6.6%) (O'Donnell, 2014).

Family/relationship breakdown continues to be the main interpersonal relationships issue for which people sought assistance from homelessness services. The proportion (41%) was the same in 2014-15 as it was in 2013-14. Escaping domestic and family violence was the other leading reason for seeking assistance for interpersonal relationships. There was a small increase in the proportion of people who sought assistance for domestic and family violence (27%) in 2014-15 compared with 25% in 2013-14 (Australian Institute of Health and Welfare, 2015f).

The average number of unassisted requests for services was 2.4 per day in 2014-15 compared to 2.6 per day in 2013-14. A disproportionate number of females had unassisted requests for support than males (females accounted for 59% of unmet requests compared with 54% of overall clients).

Housing stress

A household is considered to be experiencing housing stress if it is among the lowest 40% of income earners but is spending more than 30% of household income on recurrent housing costs (rent or mortgage payments) (Yates and Gabriel, 2006). This measure, however, does not take into account housing related costs such as electricity, water and transport so may underestimate the extent of housing stress.

The ACT has been particularly affected by the rapidly increasing housing costs in Australia over the past decade. In the six years from 2006-2012, housing costs in the ACT increased 63%, making Canberra's housing market one of the country's least affordable for low and moderate income

earners (Australians for Affordable Housing, 2012). The ACT private rental market is among the most expensive in the country and vacancy rates are among the lowest. According to the most recently available figures (2007-08) from the 2009 Council of Australian Governments (COAG) Reform Council, more than 40% of low to moderate income earners in the private rental market experience housing stress (National Housing Supply Council, 2011).

Key Issues

Aboriginal and Torres Strait Islander homeless people

Homelessness has been identified as a significant issue for Aboriginal and Torres Strait Islander people in the ACT, with Aboriginal and Torres Strait Islander people over-represented in the homeless population in the ACT. Housing circumstances have potential impacts on health, with homelessness strongly associated with poor health outcomes (Ford et al., 2014). Homelessness can have profound and ongoing effects on people, including on their mental and physical health, on schooling and employment experiences, and more broadly on their inclusion in social and civic opportunities.

The Aboriginal and Torres Strait Islander population in the ACT is highly overrepresented in the number of people accessing homelessness services. In 2012-13, 772 Aboriginal and Torres Strait Islander people accessed homelessness services in the ACT (Australian Institute of Health and Welfare, 2013c). This is equivalent to 14% of all people who accessed services, despite the fact that the Aboriginal and Torres Strait Islander population in the ACT is about 2% of the total population.

The reasons for Aboriginal and Torres Strait Islander homelessness in Canberra are complex, including finding big enough homes to accommodate large families, and anecdotal feedback suggesting that racial discrimination is also a factor.

Priority Issues

Access to health services

Homeless people experience poor access to health care, leading to delayed clinical presentation, increased reliance on emergency departments and higher rates of hospitalisation, often for preventable conditions (Kushel et al., 2001, Kushel et al., 2002, Salit et al., 1998). Data from the Specialist Homelessness Services data collection suggests that poor health is a significant contributing factor causing homelessness (Australian Institute of Health and Welfare, 2016b), while

the World Health Organisation's Social Determinants of Health research agenda highlights socioeconomic deprivation, including homelessness, as a cause of poor health (World Health Organization, 2014). Appropriate access to GP services, including GP outreach, is critical in delivering health services to people experiencing homelessness, as well as providing an entry point to the broader health system (O'Donnell, 2014).

During consultation it was emphasised that health service providers need to understand the difficulties faced by people who are homeless and that standard health services do not meet the needs of this population. Services that only operate in business hours or where a set appointment is required are often unsuitable or unfeasible for the homeless. While health care is a need for this population, they have other competing needs such as obtaining food, clothing, shelter and keeping safe, so they may assign lower priority to health care in favour of fulfilling basic needs.

Homeless people encounter substantial barriers to accessing mainstream primary health care services. These include long waiting times, inflexible scheduling and inadequate service options. There is a perception that a lack of bulk billing GPs in the ACT is also a barrier. It has been identified that there is a need to address issues regarding GP willingness to work with homeless people.

Transport continues to be highlighted as a big unmet need, particularly for getting to a doctor's appointment or hospital and in the after hours period for those dependent on public transport. Consultation undertaken by the Health Care Consumers' Association in 2013 found that transport was listed as one of the main issues preventing homeless people from accessing health care. Distance from health services often meant that these people would delay accessing care or would try to treat themselves (McGowan, 2014).

There are many services/organisations in the ACT providing free meals to the homeless and it was suggested that it would be good to provide outreach primary health care services at these locations (St John's Care, the Roadhouse, Ainslie Village, Boomerang Centre etc) as this population can be quite distrustful of health professionals and will often not turn up for appointments. Assertive outreach (actively seeking out and engaging with clients in their own environment) or 'in reach' was identified as a model of care that has been shown to be effective with the homeless population, such as free health checks in the community.

Consumer consultation has found that residents in an accommodation facility for the homeless or those at risk of homelessness wanted to have a GP or nurse available to come to the facility for regular appointments. Residents felt that there would be a good uptake of this type of outreach

service, even though in the past, specialists have come to the facility to provide testing, workshops and immunisations, but residents were not always willing to access these services (McGowan, 2014).

There is an ongoing need for outreach services for the homeless population in the ACT, based on the evidence that homeless people encounter poor access to mainstream health care services. CHN is involved in two initiatives to provide outreach primary health care services to the homeless population in the ACT:

Early Morning Centre

ACTML was funded by the ACT Government in 2014 to support a 12 month demonstration/pilot project to establish 'in-reach' primary health care services for disadvantaged ACT residents attending the Early Morning Centre (EMC). The EMC is run by UnitingCare Canberra City and is a free service which provides breakfast, shower facilities, laundry and a range of services to homeless people (predominantly older men). Two GP services run a simple primary health care clinic at the EMC once a week. The purpose of the pilot was to provide accessible, affordable and connected health care to vulnerable and disadvantaged ACT residents who are homeless or at risk of homelessness and who are generally disconnected from mainstream primary health care services due to financial, physical or psychological barriers.

Strategy

Consultants were engaged by ACTML in 2015 to undertake a review of the first 10 months of the 12 month pilot of the primary health care service. The review found that the service appears to provide a welcoming, affordable and accessible primary health care service for a vulnerable group of homeless people in the ACT. Clients receive high quality primary health care in a familiar and trusted setting. While some of the clients do access other primary health care services, very few have a regular GP or relate to a 'health care home'.

The establishment of the service demonstrates to mainstream general practice that a simple primary health care service of this nature can make a difference to vulnerable clients and enhance engagement by mainstream primary health care services with hard to reach groups in the ACT population. The service provides a safe first access point to primary health care for a vulnerable group (generally homeless or transient) and in turn, links the client group back into mainstream primary health care services in the ACT (Schultz, 2015). The service also provides a type of 'in-reach' model which could be expanded to other locations that have concentrations of homeless/vulnerable people.

Further evaluation of the EMC will be completed in 2016. A scoping project is currently being undertaken to outline possible options for expansion of the EMC model of primary health care service provision to other locations and for other vulnerable population groups in the ACT.

Common Ground

Common Ground Canberra is a not-for-profit organisation working in partnership with government, business and the not-for-profit sector to develop permanent, high quality, supportive and safe housing for Canberra's homeless people and low income individuals and families. The Common Ground model is a proven evidence-based supported housing model which has been successfully implemented across Australia and internationally. The ACT Government, in partnership with Common Ground, committed to the development of a 40 unit facility in Gungahlin. The facility opened in July 2015.

Strategy

CHN is represented on the Advisory Committee for Common Ground, which provides a monitoring/evaluation role and advice to the Community Services Directorate (CSD) on the process to support the provision of primary health care services for residents of the Common Ground facility. Northside Community Services, a partner in ACT Common Ground, are responsible for linking residents of Common Ground in with primary care services. CHN provides assistance to Northside Community Services in relation to linking people into GPs or mental health services if needed.

People experiencing domestic and family violence (DFV)

Definition of domestic and family violence

Domestic, family or intimate partner violence is a pattern of abusive behaviour through which a person seeks to control and dominate another person with whom they are or were in a relationship. Partners may be married or not married; heterosexual, gay, or lesbian; living together, separated or dating.

Examples of abuse include:

- verbal abuse (including name-calling, yelling, shouting and swearing)

- social abuse (keeping a partner from contacting their family or friends and other contacts in the community)
- financial abuse (taking control of / restricting access to money and how it is spent, not giving a partner enough money to survive on or forcing them to hand over their money)
- stopping a partner from getting or keeping a job
- actual or threatened physical harm (including punching, hitting, kicking, pushing, slapping, choking, or the use of weapons)
- sexual assault (being forced to have sex or participate in sexual activities, either by watching or participating)
- stalking
- emotional abuse (making a partner feel worthless, criticising their personality, their looks, the way they dress, constantly putting them down, threatening to hurt them, their children or their pets)
- damaging property such as furniture, the house or pets in order to threaten or intimidate

Violence can be criminal and includes physical assault (hitting, pushing, shoving, etc.), sexual abuse (unwanted or forced sexual activity) and stalking. Although emotional, psychological and financial abuse are not criminal behaviours, they are forms of abuse and can lead to criminal violence.

Victims of domestic violence can be of any age, sex, race, culture, religion, education, employment or marital status. Although both men and women can be abused, most victims are women. Children in homes where there is domestic violence are more likely to be abused and/or neglected. Even if a child is not physically harmed, they may have emotional and behavioural problems.

The extent of violence against women is notoriously difficult to determine. Because most people who experience it do not report it to the police, recorded crime statistics underestimate exactly how many people in the ACT have experienced domestic violence. The most comprehensive data comes from the ABS Personal Safety Survey, which collects data about the nature and extent of violence experienced by both men and women nationally.

According to data from the Personal Safety Survey, undertaken in 2012 (Australian Bureau of Statistics, 2013e):

- in the 12 months prior to the survey, around 8,900 ACT women had experienced some form of violence;

- 6,900 had experienced physical violence, and 3,200 had experienced sexual violence (note: where a woman experienced both physical and sexual violence they were counted separately for each type of violence but were counted only once in the total);
- younger ACT women reported higher levels of violence than older women during the 12 months preceding the study with 15.3% of 18 to 24 year olds and 10.1% of 25-34 year olds reporting violence in the preceding 12 months; and
- ACT women experiencing violence in the last 12 months were more likely to experience violence from a current or former intimate partner or other known person than a stranger:

According to ABS data collected in 2013 (Australian Bureau of Statistics, 2014b):

- there was a 4.4% increase in the number of sexual assault victims in the ACT from 2012;
- the majority of sexual assault victims were female – 92%; and
- persons aged 19 years or under accounted for 56% of all ACT sexual assault victims; and
- nearly two in three victims of sexual assault knew the offender, with one in four identifying the offender as a family member.

In the ACT, the Domestic Violence Crisis Service (DVCS) collects data on their service users, which helps to provide an understanding of the size of the issue in the ACT. The DVCS is providing support to an ever-increasing number of people affected by domestic/family violence in the ACT community – in 2013-14, 94.4% of DVCS clients were female. DVCS works with ACT Policing to provide direct crisis intervention responses at the time of the incident, and also provides 24/7 telephone support. Of particular note has been the marked increase of calls to their crisis line each year. DVCS statistics from 2013-14 indicate the following:

- The number of people provided with face-to-face direct crisis intervention was 1,408 (up from 1,096 in 2012-13);
- The number of calls to the 24/7 crisis line was 15,644 (up from 13,959 calls in 2012-13);
- The number of people supported through court processes/matters (civil criminal) was 670;
- The number of people assisted with emergency motel accommodation was 67; and
- The number of sessions provided to children and young people who have been impacted by having lived with domestic/family violence was 363.

Statistics from the Canberra Rape Crisis Centre (CRCC) also show that they are experiencing increases in the reporting of sexual violence in the ACT. Over 2012–13:

- A total of 10,859 calls were received on the CRCC crisis line (a 21% increase on the previous year). This equates to 30 calls every day of the year, or almost 2 calls an hour, responding to someone in the ACT community affected by sexual assault.
- CRCC attended the highest number of callouts ever attended by the agency (an increase of 40% on the previous year). The majority of callouts continue to occur during business hours and can range from 2–12 hours in length.
- CRCC also supported record numbers of clients in counselling sessions. Almost half were adult survivors of child sexual assault. A total of 7,202 sessions were provided to women aged 26 and over, and 5,685 sessions (37%) were provided to young people between 12 and 25 years.

While domestic violence can happen to anyone, some people in the ACT are more at risk than others, and it can be harder for people who are marginalised in some way to get help.

- Studies show that for young women, the risk of violence by a male intimate partner can be three to four times higher than the risk for women across all age groups (Young et al., 2000).
- Aboriginal and Torres Strait Islander women are nearly 10 times more likely to die as a result of assault than other Australian women, and are 35 times more likely to be admitted to hospital for family violence related injuries.
- Women from culturally and linguistically diverse (CALD) communities who experience domestic and family violence can face significant difficulties, including a lack of support networks, language barriers, socioeconomic disadvantage and lack of knowledge of their rights and Australia's laws.
- Women with disabilities are more likely to experience violence than other women, and the violence can be more severe and last longer. A recent survey of 367 women and girls with disability found that more than 1 in 5 had been affected by violence in the previous year.
- More than a third of women identifying as lesbian, bisexual, transgender or intersex have been in a relationship where their partner abused them.

The ACT Report on Domestic and Family Violence outlines issues and recommendations arising from an extraordinary meeting which was convened by the ACT Government and the Domestic Violence Prevention Council (DVPC) in April 2015 (Domestic Violence Prevention Council, 2015). The purpose of this meeting was to assist the DVPC to identify the key issues in the ACT relating to domestic and family violence in order to provide advice to the Attorney-General on how best to address these issues. A broad range of stakeholders attended, including community experts, frontline workers, first

responders and people with lived experience of domestic violence. The key recommendations arising from this meeting were (Domestic Violence Prevention Council, 2015):

- the ACT should establish an integrated whole-of-government service delivery system to ensure that all ACT Government Directorates work together to deliver connected and well-targeted services and responses
- the ACT needs to focus on challenging and changing cultures and attitudes towards domestic and family violence, including sexual assault, through primary prevention methods such as education in schools, and discussion in the community and workplaces
- it is vital to ensure that existing services are maintained and available to meet demand, including services for perpetrator intervention and specialist domestic, family and sexual violence services.

In relation to health, some of the views expressed at the extraordinary meeting of the DVPC included (Domestic Violence Prevention Council, 2015):

- The need to know how to ask the question about domestic violence and respond to disclosures.
- Need for a whole of life approach to avoid the risk of focusing on a particular cohort and missing others e.g. elder abuse and children against parents
- Use of National Health and Medical Research Council (NHMRC) 5 questions each visit
- Focus on emotional wellbeing of pregnant women
- Need to work with clinicians in ED, dental clinics, walk in clinics re recognition of domestic violence and response to disclosure
- Need to use common assessment pathway for women and children e.g. ARACY Common Approach to Assessment, Referral and Support (CAARS) – this has been shown through independent evaluation to be an appropriate strategy to help reduce child abuse and neglect, through:
 - Assisting in identifying and verifying early signs that a child or family needs support
 - Increasing practitioners' awareness of their role in the prevention of abuse and neglect
 - Assisting practitioners to think holistically about the strengths and needs of the child and family
 - Assist in provision of support to children and families, before problems escalate into crises (Australian Research Alliance for Children and Youth, 2013)

Also included in the DVPC Report were findings from consultations with diverse stakeholders (Justice and Community Safety Directorate and community sector staff, police, courts etc.) to inform the Review into Domestic and Family Violence Deaths in the ACT (DVPC Death Review). The following key themes were highlighted (Domestic Violence Prevention Council, 2015):

- Clinicians can miss domestic violence as they tend to be very focused on symptoms and interventions
- There is a variance in how clinicians deal with domestic violence and it depends on their competence and experience
- Some clinicians are hesitant about asking questions as they are unsure about what they can do and to whom they can refer
- Referrals vary across clinicians and depends on relationships they have with other agencies such as DVCS, Inanna etc.
- There is no domestic violence training and concern that there is a lack of understanding of what constitutes domestic violence
- A need for information on domestic violence and skills development on how to talk to clients, how far to go to elicit more information, what to do with disclosures, when to refer, who to refer to, how far to go with the client
- Domestic violence and CALD is challenging – there is a need for an understanding of domestic violence in different cultural contexts. People from a CALD background often lack support and are isolated
- No developed referral pathway for domestic violence – a one stop shop of relevant information online and continually updated would be useful
- Little awareness of domestic violence in the ED – there is a need to build capacity and awareness of domestic violence in EDs
- In relation to HealthPathways, there are some pages on sexual assault but nothing as yet on domestic violence

Key issues

Physical and mental health impacts of domestic and family violence

Domestic violence has a significant impact on the health and well-being of women. Exposure to domestic violence leads to poorer physical health overall compared with women who have not experienced violence, and it increases the risk of women developing a range of health problems.

Some of these health problems include stress, anxiety, depression, back pain, headaches, eating disorders and sleep disturbances (World Health Organization, 2000). An Australian study found intimate partner violence was the leading contributor to death, disability and illness in Victorian women aged 15 to 44 (VicHealth, 2008). Recent research shows that children who live in abusive families experience negative effects on their health, wellbeing and ongoing relationships (Kitzmann et al., 2003). A study undertaken by the Domestic Violence Crisis Service in 2014 found that of 35 people who had remained in their homes after domestic violence, all had developed post-traumatic stress disorder and more than half were homeless within 12 months (Watson, 2014).

Economic impacts of domestic and family violence

It has been projected that domestic violence will cost the Australian economy \$9.9 billion in 2021-22 if appropriate action is not taken to address it (The National Council to Reduce Violence against Women and their Children, 2009). This includes costs associated with homelessness, loss of employment and costs to the health care system (The National Council to Reduce Violence against Women and their Children, 2009). The largest contributor of cost is pain, suffering and premature mortality. However, survivors are the group that bear the largest proportion of the costs of domestic violence (Access Economics, 2004).

Social impacts of domestic and family violence

The social costs of domestic violence include insecure housing and homelessness, as women are often forced to escape from violence in their home. In addition to this, women can experience disruption to their social connections and their children's schooling.

Leading cause of homelessness for women in the ACT

Domestic and family violence related homelessness is a widespread and growing problem in the ACT as it is in Australia. Every year, an unacceptable number of Australian women and children have their lives and housing circumstances disrupted because of domestic and family violence. Domestic violence is the most often cited reason given by women presenting to specialist homelessness services seeking assistance. Data from the Australian Institute of Health and Welfare (AIHW) shows that in 2012-13, 5,367 ACT people are reported to have sought support from Specialist Homelessness Services in the ACT and more than half (55%) were female (Australian Institute of Health and Welfare, 2013c). In most cases, females presenting to homelessness services due to domestic and family violence are accompanied by children.

This situation has significant impacts on all involved, especially children. There is an increasing number of women and children who because of domestic and family violence find themselves

unintentionally homeless or living in inappropriate accommodation – couch surfing, living in a car, sub-standard accommodation, in caravan parks or boarding houses. Many women who end up homeless because of violence actively avoid identifying as homeless, instead pretending that their circumstances are ‘normal’ so as to avoid being labelled by society as either homeless or someone who has been a ‘victim’ of violence (Johnson et al., 2008).

The experience of LGBTIQ communities

There is limited research in relation to the prevalence of domestic and family violence experienced by LGBTIQ populations and under reporting is a significant issue. An online survey conducted with 5,476 Australians who identified as LGBTI found that of those participants who had experienced abuse, only one in 10 had reported the abuse to the police and this rose to 18 and 19 per cent respectively for those who reported being hit or forced to have sex (Pitts et al., 2006). Research demonstrates that LGBTIQ people can be reluctant to turn to mainstream services when they have experienced domestic violence because of fears of homophobia or of being ‘outed’ or of an inappropriate response (Jeraj, 2013).

Women’s Centre for Health Matters (WCHM) undertook a community survey in 2014-15 to identify barriers, gaps and opportunities for improvement in domestic violence support services for LGBTIQ people in the ACT. The findings showed that LGBTIQ people felt that they did not belong within mainstream or DFV services and there was a lack of understanding about the service delivery system and whether they would be accepted or able to access support within that system for DFV. Respondents reported that unhelpful service responses involved judgement and assumptions of heterosexuality (Greenhalgh and Roberts, 2015). Women who participated in the survey reported that when they made contact with services there was a presumption that the violence was committed by a male partner and there was little to no recognition that they could have been in a same sex relationship or experiencing violence from someone within the family unit (Greenhalgh and Roberts, 2015). One of the key findings was the need for a wider visibility and understanding that DFV is an issue within the LGBTIQ community. It was considered important that mainstream DFV services are supported to build capacity to respond adequately and to broaden service options for LGBTIQ people to access (Greenhalgh and Roberts, 2015).

Culturally and Linguistically Diverse (CALD) women

The research on the prevalence of DFV against women from CALD backgrounds is unclear, but it does indicate that cultural values and immigration status enhance the complexities normally involved in DFV cases and women from CALD backgrounds are generally less likely than other groups

of women to report cases of DFV (Pease and Rees, 2007). There are a number of reasons for the uncertainty in relation to exact figures on the number of CALD women affected by DFV, including the lack of quantitative evidence available generally to illustrate the prevalence of issues impacting on culturally and linguistically diverse Australians and the reluctance or inability to talk about or report DFV due to stigma and shame they may face from their own communities. Factors which may influence their inability to talk about or report DFV include the limited availability of appropriate translator/interpreter services for at risk women and access to support services; limited support networks and reluctance to confide in others; isolation; lack of awareness about the law; continued abuse from the immediate family; cultural and/or religious shame; and religious beliefs about divorce (Pease and Rees, 2007, Morgan and Chadwick, 2009). Anecdotal evidence suggests that poor English is the biggest barrier faced by women in the ACT.

CALD women face many challenges in addressing domestic violence and can be presented with several barriers when seeking help. Other challenges include socio-economic disadvantage, community pressure and lack of knowledge about their rights. CALD women may have difficulties accessing the paid workforce or higher education and this can contribute to gender inequality. These factors need to be addressed to achieve better outcomes for CALD women who experience domestic violence.

Priority Issues

GPs and their role in screening, risk assessment and referral

GPs are the major professional group to whom women experiencing family violence turn (Hegarty and Taft, 2001). It has been estimated that full time GPs are seeing up to five women per week who have experienced some form of intimate partner violence (Roberts et al., 2006). GPs have a key role to play in early detection, intervention and provision of specialised treatment of those who suffer the consequences of domestic and family violence, whether it be physical, sexual or emotional. Responding effectively to domestic and family violence requires knowledge of the physical and emotional consequences of the violence, an understanding of appropriate and inappropriate responses, and having good networks with local family violence services. After family and friends, victims are most likely to tell a health professional about violence (Young, 1998). GPs are in a unique position to help women affected by sexual assault and domestic and family violence, which is why it's important that they have the appropriate tools, information and guidance to know how to respond. Whether it's noticing the signs and knowing how to start difficult conversations, or dealing with disclosure, how GPs respond can have a huge impact.

The role of GPs includes all the following to address domestic violence across the lifecycle:

- Identifying predisposing risk factors
- Noting early signs and symptoms
- Assessing for violence and safety within families
- Managing consequences of abuse to minimise morbidity and mortality
- Knowing and using referral and community resources
- Advocating for changes that promote a violence-free society (The Royal Australian College of General Practitioners, 2014a)

Strategy

GPs have the opportunity to identify and support people who have experienced domestic and family violence. Lifeline provides online and face to face training for health professionals called DV-Alert. The face to face training:

- Provides opportunities to ask questions and learn from other's experience
- Builds on and increases the participant's local resources and supports
- Provides opportunities to learn about self-care and debrief if necessary
- Builds on and increases the participant's broader networks
- Promotes positive communication and opens up new communication channels

There is also a DV-Alert online course. DV-Alert E-Learning is for health professionals who are unable to attend a two day face-to-face workshop. The online course runs for 18 hours over a period of 6 to 8 weeks, and GPs can work at their own pace to learn how to recognise the signs of domestic and family violence, respond to someone experiencing domestic and family violence, and know about the best practice methods that should be used to refer people on to the most appropriate support service.

CHN could potentially convene one or more of the DV-Alert face to face courses for GPs and other health professionals.

Another useful resource for GPs is the manual, *Abuse and violence: working with our patients in general practice*, 4th edition (the White Book) (The Royal Australian College of General Practitioners, 2014a). This manual, based on the best available evidence in February 2014, has been developed by GPs and experts which ensures that the content is the most valuable and useful for health practitioners. The manual offers health practitioners evidence-based guidance on

appropriate identification and response in clinical practice to patients experiencing abuse and violence, with a particular focus on intimate partner and sexual violence and children experiencing abuse, as these are often the main victims of abuse.

A domestic violence HealthPathway is being developed in 2016 which will provide GPs with information on how to assess, manage and refer patients who are experiencing domestic/family violence.

Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) population

Definitions

Lesbian and *gay* people are sexually attracted to and/ or have romantic relationships with people of the same gender as themselves. People who identify as *bisexual* are sexually attracted to and/or have romantic relationships with both men and women. Bisexual people may also be attracted to people with non-binary gender identities. Nine percent of adult men and 15% of women in Australia report same-sex attraction or having had sexual contact with someone of the same sex, although only approximately 2% actually identify as lesbian, gay or bisexual (Smith et al., 2003).

Transgender people have an internal sense of gender (their gender identity) that differs from their birth sex. The term *transgender* is sometimes shortened to 'trans', which is an umbrella term that includes transsexual, genderqueer, sistergirl, cross-dressers and other identities. People who are transgender also have varying sexual orientations.

Intersex people are born with a physical variation that differs from cultural/societal expectations of male or female sex, e.g. they have a variation in their genitals, XXY chromosomes or hormone production levels (Diamond, 2004). Approximately 2% of the population have intersex variations. These are biological variations and intersex status is not to be confused with gender identity or sexual orientation. As with the general population, people with intersex variations have a broad range of gender identities and sexual orientations.

'LGBTI' is a commonly used acronym that encompasses all people whose sexual orientation, gender identity or biological sex differ from heterosexual or male/female sex and gender norms, regardless of the identity labels people use. Sometimes the term 'sexuality, sex and gender diversity' is used to be inclusive of all these groups (Rosenstreich, 2013). The United Nations (United Nations Human Rights Office of the High Commissioner, 2015) and the Australian Human Rights Commission (Australian Human Rights Commission, 2013) refer to 'sexual orientation' and 'gender identity'.

Background

The LGBTI population is known to have significantly poorer health and wellbeing outcomes than the general population across a number of areas (Beyond Blue, 2012). Several studies have revealed important differences in health between LGB adults and their heterosexual counterparts, including higher risks of poor mental health, smoking and limitations in activities (Dilley et al., 2010, Conron et al., 2010). Barriers in accessing appropriate health care and discrimination on the basis of sexual orientation, gender identity or intersex status can directly contribute to higher rates of depression and anxiety and these poorer health and wellbeing outcomes.

It's important to note that the LGBTI community is not a homogenous group, although similarities may exist between constituent groups on sexual orientation (lesbian, gay, bisexual), biological sex (intersex) or gender identity (transgender). Each of these individual constituent groups have specific social, cultural, psychological, medical and nursing care needs. There is, however, the shared experience of being part of a minority population likely to have been subjected to lack of inclusion or acceptance and discrimination and stigma throughout most of their lives.

Key Issues

Access to services

For LGBTI people, inconsistent service experiences can be a barrier to seeking support and can have a lasting impression. It is important to ensure that GPs are well educated and equipped to connect LGBTI people to supportive services, as they are often the first health professional with whom people discuss issues of depression and anxiety, sexual health issues, requests for safe sex information, issues about reproductive health that require a non-judgemental and informed response from GPs and knowledge of appropriate referral pathways.

Access to services and supports for transgender people

Research undertaken for Beyond Blue found that transgender participants reported negative experiences with health care providers even more frequently than LGB participants (Beyond Blue, 2012). Participants reported that referral of transgender people to gay, lesbian and bisexual friendly health care providers is inappropriate as providers are not necessarily well informed about or sensitive to transgender specific issues or concerns.

The lack of understanding and sometimes explicit discrimination from health care professionals can result in additional barriers to asking for help (Beyond Blue, 2012). Research conducted by La Trobe University found that a large number (34%) of LGBTI people hide their sexuality or gender identity when accessing services (Leonard et al., 2012). A national survey found that almost 50% of trans and gender diverse people reported feeling discomfort disclosing their gender identity in a clinical health care setting (Leonard et al., 2012).

Access to services and supports for intersex people

In a recent survey of people born with atypical sex characteristics, 60% reported having had medical treatment interventions related to their intersex variation, with most participants having been given no information on the option of declining or deferring treatments and 20% given no information at all about any of the treatments they received (Jones et al., 2016). Over half of the reported interventions occurred when the participants were under 18 years of age and were most commonly genital surgeries and hormone treatments. The majority of participants reported at least one negative impact from these experiences and for some these were life-threatening (Jones et al., 2016).

It should be noted that there is an absence of health-related information about intersex people in Australia, however, it should not be assumed that this issue does not also exist for intersex people (Irlam, 2012).

Mental health

The mental health of LGBTI people is among the poorest in Australia (Leonard et al., 2012). Gay, lesbian, bisexual and transgender people are three times more likely to experience depression compared to the broader population (Beyond Blue, 2012). In 2005, at least 36.2% of transgender people and 24.4% of gay, lesbian and bisexual people met the criteria for experiencing a major depressive episode, compared with 6.8% of the general population (Pitts et al., 2006). Lesbian, gay and bisexual Australians are twice as likely to have a high/very high level of psychological distress as their heterosexual peers (18.2% v. 9.2%) (Australian Bureau of Statistics, 2010), which makes them particularly vulnerable to mental health problems.

More than twice as many homosexual/bisexual Australians experience anxiety disorders as heterosexual people (31% vs 14%) and over three times as many experience affective disorders (19% vs 6%) (Australian Bureau of Statistics, 2007). Same-sex attracted Australians have up to 14 times higher rates of suicide attempts than their heterosexual peers. 20% of transgender Australians and

15.7% of lesbian, gay and bisexual Australians report current suicidal ideation (Pitts et al., 2006). Transgender attempted suicide rates have been estimated to be as high as 50% (Ceglie, 2000). Aboriginal and Torres Strait Islander LGBTI Australians, LGBTI people from a CALD background and refugees, LGBTI young people and older LGBTI Australians are likely to be at particularly high risk of suicide (National LGBT Health Alliance, 2009). The elevated risk of mental ill-health and suicidality among LGBTI people is due to discrimination and exclusion as key determinants of health (sometimes referred to as minority stress) (Meyer, 2007). Exposure to and fear of discrimination and isolation can directly impact on a person's mental health, causing stress, psychological distress and suicidality (Hillier et al., 2010). Again it should be noted that there is a lack of data in relation to intersex people and mental health.

Intersex infants and children have often been subjected to medical interventions (including genital surgery) to align their bodies to cultural expectations, which can seriously impact their long-term physical and mental health in various ways. This use of medical intervention has been criticised as it does not address actual health issues (National LGBTI Health Alliance, 2012a).

Older people

Until comparatively recently, there has been minimal examination and inclusion of the diverse genders, bodies, sexualities, and relationships of older Australian's. A few studies have examined health disparities among LGB adults aged 50 years and older and have reported higher rates of mental distress, physical limitations and poor general health compared with their heterosexual counterparts (Valanis et al., 2000, Wallace et al., 2011). To better address the needs of an increasingly diverse older adult population, health disparities research is needed for this at-risk group.

Concerns facing ageing LGBTI people when accessing health services include:

- The fear that health care services will not understand their experiences, issues and needs
- The fear that because they have lived through a time when prejudice and discrimination against LGBTI people was common, that they will experience this type of treatment from health care services today (National LGBTI Health Alliance, 2012b)

These experiences can cause LGBTI older people to be reluctant to reveal their sexual orientation and/or gender identity and/or intersex status to service providers and be reluctant to make complaints when they experience prejudice or discrimination (National LGBTI Health Alliance, 2012b). A report released in 2014 by the ACT LGBTIQ Ministerial Advisory Council based on findings

from a public forum and survey recommended better advocacy for LGBTIQ and HIV-positive people in aged care. Participants identified a fear of discrimination by aged care organisations, staff and residents, concerns about a lack of control in the disclosure of their personal identity and health status and social isolation (ACT LGBTIQ Ministerial Advisory Council, 2014). Service providers need to be aware that many older LGBTI people have experienced prejudice and discrimination at different points in their life and this can have a negative impact on their expectations, fear and mistrust of providers now. There is a need for service providers to provide training to all staff on working with and being inclusive of LGBTI people.

Diverse Families

Diverse families are families who can be lesbian mothers, gay fathers, one or more bisexual parents, who may have children from previous relationships or increasingly having children using Assisted Reproductive Technology (ART) by artificial insemination by known or unknown donors using clinics or private arrangements. Both local and international surrogacy can also be used. Diverse families may also be formed by families with a transgender parent who may identify with other diverse families or may choose not to. Diverse families can also be formed by short and long term foster care and adoption arrangements.

Diverse families have existed in the ACT and have successfully raised children for many years. The number of diverse families is growing in the ACT. Anecdotally, five diverse families were at the first day of kindergarten at one inner city school. There are many other diverse families with children in other grades at the same school. Access to non-judgemental and informed GPs will be a growing issue for diverse families.

Men who have sex with men (MSM)

The term MSM acknowledges some men who have sex with men and may not choose to self-identify as gay or bisexual. MSM can be isolated and have few places to get accurate non-judgemental advice and support about their sexual health, safe sex and have limited access to appropriate regular comprehensive sexual health testing. Access to a well informed and non-judgemental GP is essential, where they can discuss their sexual health and access appropriate testing and safe sex support and advice.

The Aids Action Council has had recent anecdotal experiences with well over a dozen men over forty years of age who engaged in sex with other men and did not identify as gay or bisexual (Aids Action Council, July 2016). A direct question was asked of the group in relation to being able to obtain

advice and support from their GP about the type of sex they were currently engaging in. All men said they had not discussed their current sexual behaviours or sexual health with their current GP (or anyone else) and all did not feel comfortable raising it in the future.

Young people

Young lesbian, gay, bisexual, gender queer, non-binary young people require access to non-judgemental primary health care. GPs need to allow young people over 15 years to access care without the requirement for parental involvement, if requested by the young person. Young people can obtain their own Medicare card at the age of 15 and consent to their own treatment. In some cases, young people may not be ready to 'come out' to their families. GPs who are prepared to maintain confidentiality for a young person can be an essential source of information and support for young people. Young LGBTIQ people may be in the process of discovering their sexual orientation and gender identity. Access to GPs who will respect the process of self-discovery without problematizing sexuality and gender identity is essential to prevent mental health issues and suicidal ideation. A well supported young person allowed to make their own decisions at their own pace is less likely to need mental health treatment and exhibit suicidal ideation.

Key Issues for Intersex and Transgender people

Lack of knowledge and skills

There is a need to improve the knowledge and skills among GPs about how to treat transgender patients (Peterkin and Risdon, 2003). GP knowledge seems to be limited by the lack of available population-based data (McNair and Hegarty, 2010) and by a lack of education, either initially or as ongoing professional development, resulting in low knowledge of the issues.

A survey undertaken in 2013 in the UK to collect information about transgender patients' experiences of accessing health care services from their GP found that most GP practices were not only totally unaware of the special health needs of transgender people, but also misunderstood when dealing with other non-trans health issues that it is unnecessary to raise or involve the patient's transgender status, or history and that doing this can cause much distress to the patient. It was also found that the majority of GPs were ignorant of how to treat and refer transgender patients to the gender identity services (Bishop, 2014). Those who conducted the survey concluded that these issues could be easily addressed through support, training and guidance for both GPs and other practice staff (Bishop, 2014). Many respondents to the survey felt that much more work on the training of GPs and their practice staff was the principal key to improving service provision to

transgender people (Bishop, 2014). This aligns with the findings of the *Gender Diversity in the ACT* report which was released by A Gender Agenda in 2011 (David et al., 2011).

Unnecessary medical interventions for intersex people

Anecdotal evidence during consultation suggests that unnecessary medical interventions are being undertaken on intersex people. These interventions include surgical, hormonal, investigatory and invasive 'monitoring'. The justification of surgical alterations on the basis of 'psycho-social' reasons is also problematic. Surgical interventions should only be undertaken if and when an intersex person requests them, and then only after she or he has been fully informed of the risks and likely outcomes. These surgeries carry substantial risks to life, fertility, continence, and sensation. Despite the fact that there is a growing body of literature (statements, reports) highlighting that such interventions should not occur in the manner that they do, there are currently no agreed professional best practice guidelines on the issue (Dreger, 2005).

Reparative therapy/treatment in the ACT

Reparative therapy is a range of practices that claim to change a person's sexual orientation or gender identity or expression (Human Rights Campaign, 2016). Young people are especially vulnerable to requests for therapy or treatment and this type of therapy can lead to depression, anxiety, drug use, homelessness and suicide. Some parents, churches and schools still hold beliefs that types of reparative therapy can work and request it from Health Care Professionals. This can be subtle and could be advice to parents such as suggesting it is just a phase and ensuring a young person does sex role appropriate activities such as rugby or cooking and childcare and that dressing in sex role appropriate ways and/or sending them to a single sex school for appropriate role modelling will help the young person work through this phase. According to feedback from the Canberra LGBTIQ Community Consortium, this advice has been heard by parents and young people in the ACT from Health Professionals, including GPs, and is a subtle form of discredited reparative therapy/treatment (ACT LGBTIQ Community Consortium, July 2016). It is important to ensure that any type of 'reparative therapy' is not being conducted in the ACT.

Access to services for transgender and gender nonconforming people

In terms of transgender people and services, those who will/want to undergo hormonal and surgical intervention will require the input of a GP, psychologist, psychiatrist, endocrinologist and legal representation (if under the age of 18). They may also need community support through support groups and/or other organisations. They may also find the input of a speech pathologist useful in

voice re-training. The financial barrier to transition can be significant, particularly for adolescents. As an adolescent they may still be at school, not yet in paid employment or have become unemployed. It is most important that services are client focussed, open and responsive to the particular individual needs of each person.

The World Professional Association for Transgender Health (WPATH) promotes the highest standards of health care for individuals through the Standards of Care (SOC) for the Health of Transsexual, Transgender and Gender Nonconforming People (World Professional Association for Transgender Health, 2016). These standards of care are based on the best available evidence and expert professional consensus. The SOC state that transgender health care is multidisciplinary in nature and that it includes ensuring social support services. This document advises that anyone identifying as transgender should be assessed by a suitably qualified mental health professional (psychiatrist or psychologist with sufficient experience in the area or a health professional who is appropriately trained in behavioural health and competent in the assessment of gender dysphoria) before commencing hormonal treatments. The WPATH SOC also state that the SOC are intended to be flexible and that individual health professionals can modify them.

During consultation it was identified that GPs are a first point of contact for people wanting to obtain more information and support around transitioning. In particular, many transgender people are seeing a GP in an effort to gain access to gender affirming hormonal medications. GPs also provide referral for other modes of transition. For example, they may seek referral to surgeons for various surgeries such as gender affirmation surgery. Before undertaking any surgical intervention, most surgeons will mandate psychiatric assessment endorsing the surgery is undertaken. Feedback from stakeholders suggests that accessing a private psychiatrist with an interest in this area or a willingness to undertake an assessment is difficult in the ACT, even in private practice.

These issues can be more complicated for those under 18 years of age as they require a family court approval before commencing gender affirming Stage 2 Hormone Treatment. Feedback during consultation suggests that it is difficult to access a child and adolescent psychologist and psychiatrist in Canberra who feels confident to confirm the appropriateness of gender transition for a patient under 18 years of age.

Lack of reliable information in relation to best practice

Feedback from consultation has suggested that there is a lack of reliable and evidence-based information in relation to best practice for GP management of LGBTI people, including a lack of referral information and pathways. In consultation with A Gender Agenda (a community

organisation in the ACT engaged in increasing public awareness and understanding of sex and gender diversity issues) it was revealed that a significant percentage of calls that are received by the organisation are from health professionals seeking information (Phillips, April 2016). There is a need for evidence-based LGBTI guidelines that are more rigorously developed, disseminated and evaluated specifically for the primary care setting and there is a pressing need for mainstream services to become culturally competent in this area (McNair and Hegarty, 2010).

LGBTI individuals have a diversity of sexual health information needs, require advice and information about safe sex and access to appropriate sexual health testing that require a non-judgemental and informed response from GPs. The communities can also require information about a wide range of reproductive health issues.

Strategy

There is a need to ensure that GPs are well educated and equipped to connect LGBTI people to supportive services. CHN will coordinate some education/training sessions for GPs and other providers with the aim of supporting the primary health care workforce in the ACT to deliver more inclusive, accessible and appropriate care to all residents of the ACT, regardless of their sexuality or gender identity. CHN will also investigate the development of Health Pathways in consultation with relevant community organisations and health professionals.

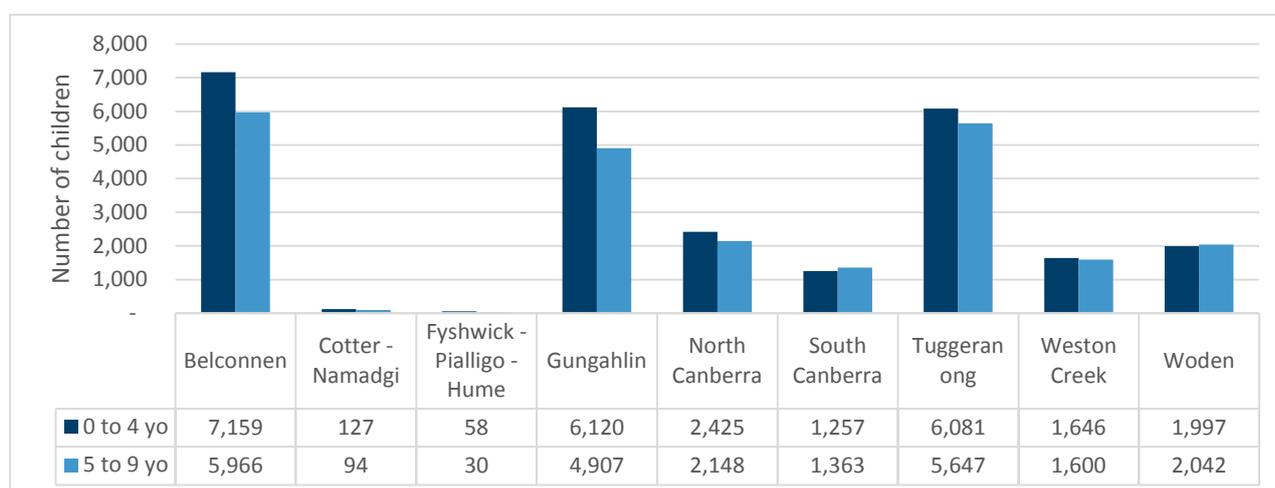
6. Early Childhood

Overview

Early childhood is defined as the period from birth to eight years of age. There is clear evidence from Australia and overseas that the early years of a child’s life have a profound impact on their future health, development, learning and wellbeing (McKenzie et al., 2014).

In the ACT in 2014, it was estimated that there were 50,667 residents aged 0-9 years, equating to 13% of the population (Australian Bureau of Statistics, 2015a). Belconnen, Tuggeranong and Gungahlin had the highest number of children aged 0-9 years (Figure 6.1).

Figure 6.1: Estimated number of ACT children (0-4 and 5-9 years) in 2014, by Statistical Area 3



Source: (Australian Bureau of Statistics, 2015a)

The foundations for future health, development, learning and wellbeing are laid down during the prenatal and early childhood years, a time of rapid brain growth and development. The benefits of exposure to high quality early years learning and development opportunities has lasting impacts both for the community as a whole and to the individual child across their lifetime (Moore and McDonald, 2013).

There is growing evidence for the importance of both the prenatal and postnatal period in children’s development and that children’s long term outcomes can be compromised directly by adverse experiences during both of these periods. Promoting children’s development and learning requires ensuring that the environments in which they spend their time are optimal (Murdoch Childrens Research Institute, 2014). In the case of young children, family and other caregivers are the main providers of the relationships and experiences that make up the child’s learning environments.

The environmental factor that has the greatest positive impact on child development and family functioning is social support and social connectedness, while the environmental factor that has the greatest adverse influence on child development and family functioning is poverty (Murdoch Childrens Research Institute, 2014). The consequences of poverty for children are wide-ranging and long-lasting with children from socioeconomically disadvantaged families beginning their lives with a poorer foundation for health (The Marmot Review, 2010).

Discrepancies between children from advantaged and disadvantaged backgrounds are evident from less than one year of age (Nicholson et al., 2012). Development discrepancies are evident across cognitive, social, behavioural and health outcomes with advantages and disadvantages accumulating throughout life and across generations (Najman et al., 2004).

Poorly-resourced families can find the heightened demands of contemporary living and parenting overwhelming and as a result, there has been an increase in the number of families with complex needs, and more pockets of intergenerational disadvantage, underachievement and poor health and developmental outcomes (McLachlan et al., 2013). Although they represent only a small minority, these families and their children subsequently account for a highly disproportionate percentage of the costs and resources for mental health, education services and welfare services.

Children from families who have poor social supports and make limited or no use of early childhood and family services are at increased risk of poor health and developmental outcomes (Murdoch Childrens Research Institute, 2014). The parents in most need tend to be the ones who are least likely to access support. These include families with limited income, lack of social support, lack of private transport, unstable housing or homelessness, low literacy levels, large family size, personal preferences and beliefs about the necessity and value of services, physical or mental health issues or disability and day-to-day stress (Carbone et al., 2004).

This is further exacerbated by structural barriers, including: lack of publicity about services; cost of services; limited availability; failure to provide services that meet parent's felt needs; inability to respond promptly to requests for help; rigid eligibility criteria; inaccessible locations; lack of public transport; limited hours of operation; inflexible appointment systems; and not having an outreach capacity (Carbone et al., 2004).

The Council of Australian Governments outlined a National Early Childhood Development Strategy in 2009; the Strategy acknowledges the importance of minimising the impact of risk factors in the first years of life before problems become entrenched and reducing the inequalities in outcomes between children (Council of Australian Governments, 2009). This is particularly important for some

Aboriginal and Torres Strait Islander children who, on average, have significantly poorer health outcomes than non-Indigenous Australian children, and also for children with a disability with higher rates of abuse and neglect than children and young people without disability.

Key Issues

“Most children in the ACT are continuing to achieve positive health, wellbeing, learning and development outcomes, but there are still challenges and areas for improvement. A strong evidence base, solid public policy, high quality services and monitoring of the collective effort remains crucial in maximising outcomes for Canberra’s children and young people” (ACT Government, 2013b).

Vulnerable children

The ACT has a high standard of living when compared to other Australian states and territories, however, there are ACT residents who experience significant levels of disadvantage, including exposure to (or experience of) poverty, social isolation, homelessness, violence, disability, drug and alcohol use, mental health issues, family breakdown, and illness (Shaddock et al., 2015). A nationwide survey of marginalised young people found that while “most children report high life satisfaction”, a quarter of children “have a family member who has a disability, chronic illness, mental illness or drug or alcohol addiction” (Flinders University, 2015). These children experience significantly more health complaints than other children (Flinders University, 2015).

Children with complex and challenging behaviours

In 2015 an expert panel reviewed policy and practice in all ACT schools in regards to students with complex needs and challenging behaviours (Shaddock et al., 2015). The report found school populations are becoming more complex because of school retention policies, the preference of many parents/carers for mainstream placement for their child with a disability, and an increased prevalence of developmental conditions and other issues that affect learning and behaviour.

Many of the challenging behaviours exhibited by students at school have a much longer history, often developing in early childhood, before starting school (Shaddock et al., 2015). The experiences that children have during their lives before school enrolment have significant impact, and sometimes determine, a child’s future development and behaviour. To minimise the negative impact of these issues on children’s behaviour and development, appropriate interventions must start as early as possible (e.g. at the time of their recognition or diagnosis) (Shaddock et al., 2015). Supports offered should be tailored to meet the individual needs of children and should be available early, when help is most likely to be beneficial, and before challenging behaviours become entrenched. The report

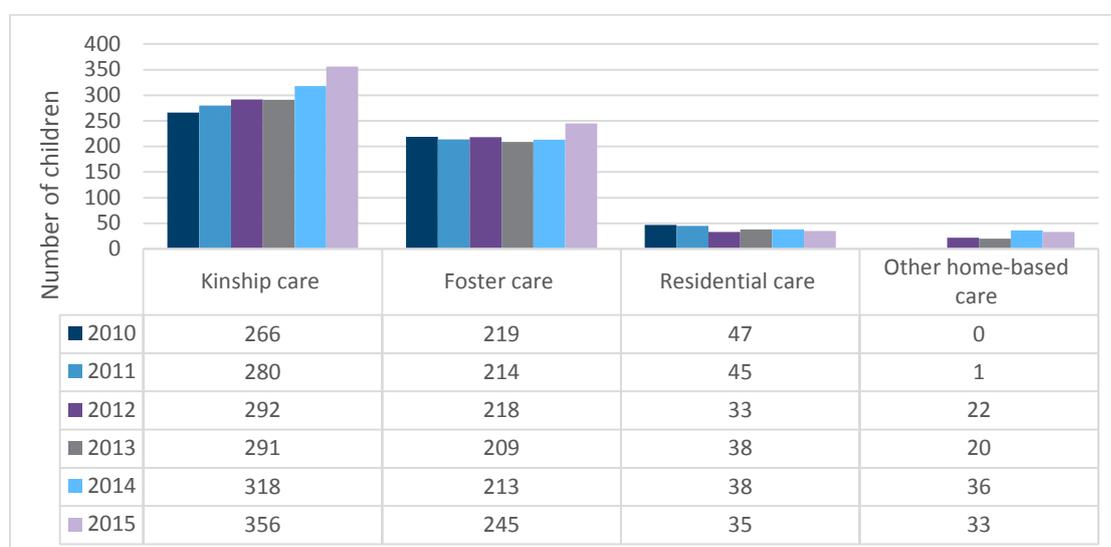
suggests there's a lack of knowledge about the use of referral and diagnostic services for potentially vulnerable children attending various child care facilities across the ACT, and therefore children with complex needs and challenging behaviour may not have their needs recognised or acknowledged (Shaddock et al., 2015).

Out-of-home care

Children in out-of-home care are a vulnerable and at-risk group in the population, and although existing data is limited, they are likely to have poorer physical, mental and developmental health than their peers (Royal Australasian College of Physicians, 2006). All children who enter care have suffered trauma as a consequence of both the circumstances that led them to enter care and the loss of familiar relationships and environments (ACT Community Services, 2014). They may have already been exposed to multiple traumatic experiences including abuse; neglect; domestic violence; a family history of mental health issues; drug and alcohol abuse and family involvement with the criminal justice system. Negative outcomes for the children can include anxiety; depression; post-traumatic stress; attachment problems; sexual behaviour problems; hyperactivity; anger and aggression; suicidal behaviour and other serious mental health issues (ACT Community Services, 2014).

As seen in Figure 6.2, the majority of children in out-of-home care in the ACT are in home-based care (e.g. relative/kinship care and foster care). The number of children in out-of-home care has continued to rise in the ACT, with a total of 671 children in out-of-home care at June 2015 (Australian Institute of Health and Welfare, 2016a).

Figure 6.2: Number of ACT children in out-of-home care, by type of placement, as at June 2010, June 2011, June 2012, June 2013, June 2014 and June 2015



Source: (Australian Institute of Health and Welfare, 2016a)

Of the 671 children in out-of-home care in the ACT at June 2015, 407 (61%) were aged under 10 years (Table 6.1), with 55% of children overall being boys and 45% girls (Australian Institute of Health and Welfare, 2016a). At 30 June 2015, 4 in 5 children (80%) had been continuously in out-of-home care for 1 year or more, with about 2 in 5 children (43%) in out-of-home care for 5 years or more (Australian Institute of Health and Welfare, 2016a). During 2014-15, 219 ACT children were admitted to out-of-home care, while 146 were discharged.

Table 6.1: Age of ACT children in out-of-home care, as at June 2013, June 2014 and June 2015

	Years of age					Total
	< 1	1-4	5-9	10-14	15-17	
2013	15	118	184	155	86	558
2014	30	124	188	181	83	606
2015	27	151	229	183	81	671

Source: (Australian Institute of Health and Welfare, 2016a)

Nationally the rate of Aboriginal and Torres Strait Islander children in out-of-home care was 9.5 times the rate of non-Indigenous Australian children (Australian Institute of Health and Welfare, 2016a). In the ACT this rate is higher, at 13.1 times (i.e. 74.8 per 1,000 Aboriginal and Torres Strait Islander children compared to 5.7 per 1,000 non-Indigenous children). As at June 2015, the ACT had the highest rate per 1,000 Aboriginal and Torres Strait Islander children in out-of-home care nationally.

The ACT Government (Community Services Directorate) has developed the Out of Home Care Strategy 2015-2020 to guide the delivery of services for children and young people who cannot safely live with their parents (ACT Community Services, 2014). A number of new services and initiatives, including ACT Together, a consortium of Australia's leading organisations in child protection, began in 2016. ACT Together brings together all the services designed to support children and young people in care and will mean children will have just one organisation responsible for their care over the course of their time in care.

The ACT appears to have had limited success in identifying a child development system of care that provides a streamlined, accessible, affordable and well-connected pathway of care for families and their young children and has been unsuccessful in ensuring that the most vulnerable children are able to participate fully or achieve equitable health, social and educational outcomes (ACT Medicare Local, 2014a). A consultation workshop between ACTML, ACT Health and the ACT Local Hospital Network Council, in 2013, raised system of care issues around early childhood. These issues included (ACT Medicare Local, 2014a);

- GPs not sufficiently aware of services available and/or access issues for these services, e.g. 9 month waiting list for community paediatrician appointments.
- Disconnect between primary/GP care and services in the community which are required for effective intervention and follow up over time.
- Equity issues between families – those who cannot afford private follow up face access issues to hospital clinics.
- Coordinating within community across campaigns/interventions.

As recognised, there is a need for GPs to identify vulnerable children in the ACT and promote the free services offered at ACT's Child and Family Centres. The Child and Family Centres located in Gungahlin, Tuggeranong and West Belconnen aim to positively influence the development pathways and life trajectory of children, build capacity and resiliency of families to support their children and strengthen the linkages and connections of families to supportive communities (ACT Community Services, 2016b). They achieve this by providing free professional services to all children and families, including, early intervention and mental health assistance, structured group sessions for vulnerable groups of the community, as well as tailored support and health services (ACT Community Services, 2016a).

Strategy

- CHN is planning a Paediatric Symposium in the first half of 2017. With the symposium including a session focusing on vulnerable children and the ways in which GPs can support families and identify and refer children to appropriate services (e.g. Child and Family Centres).
- There will also be continued development and promotion of paediatric HealthPathways to assist GPs with assessment, management and referrals. Priority paediatric pathways include; Child or Young Person at Risk, Behavioural Concerns in Children, Developmental Concerns in Children and Child Development Milestones.

Access to early mental health intervention services

It has been recognised by the ACT government that identification and access to early intervention services around developmental delay and mental health is complex and difficult to navigate for consumers. The introduction of the NDIS and the reduction of services provided by the Child Development Service (formerly Therapy ACT) has contributed to this complexity.

Difficulties with child behaviour such as tantrums, aggression and frequent night waking are common in the first few years of life. For some children, these behaviours are transient and part of normal development, but for others they persist and lead to significant behavioural problems. It has been reported that up to 50% of preschool behaviour problems evolve into childhood mental health problems (Prior et al., 2001, Campbell, 1995).

Distinguishing between transient behaviours and early mental health problems can be difficult (Campbell, 2006). Behaviours that are frequent and transient in most young children can also indicate more serious problems that may merit mental health intervention. Therefore primary/universal service providers (e.g. GPs, community nurses, child care providers, early childhood educators/teachers) should always explore any concerns that parents raise about their child's behaviour or emotional development. Referral for specialist intervention may be necessary when there is a cluster of persistent symptoms across settings or relationships, when symptom severity is likely to impede the child's ability to achieve developmental tasks, and where it affects day-to-day functioning (Campbell, 2006).

Behavioural (externalising) problems affect around 14% of Australian children, this includes aggression, hyperactivity and oppositional defiance disorder. Emotional (internalising) problems affect up to 15% of Australian children, which include anxiety, fears and phobias in younger children, and depression and anxiety in school-aged children (The Royal Children's Hospital Melbourne, 2012). The incidence of mental health problems is even higher for those from disadvantaged backgrounds, including Aboriginal and Torres Strait Islander children (24%) (Zubrick et al., 2005), children residing in 'out of home care' (55-60%) (Tarren-Sweeney and Hazell, 2006) and children with a learning disability, who are up to four times more likely to have mental health problems than children with no disability (Witt et al., 2003).

The younger the child, the more vulnerable their brain is to environmental influences. Experiences in the early years shape the development of young children's brains in ways that have long lasting effects. Mental health problems can develop at any stage of life, including infancy and pre-school age. Children's mental health problems are the result of interactions between genetic-biological vulnerabilities (e.g. temperament in infancy) and environmental stress (Beardslee et al., 1997, Beidel and Turner, 1997). There are a number of family environmental factors that contribute to children developing externalising and internalising problems, which are potentially modifiable. These include (Royal Children's Hospital, 2006):

- parenting practices (e.g. low warmth, harsh discipline, over-protective parenting)

- insecure parent-child attachment relationship
- parents' mental health problems (e.g. depression)
- family stress and trauma.

Many parents respond to their young children's challenging behaviours in ways that reinforce and entrench the very behaviours that cause them concern in the first place (e.g. harsh physical punishment in response to aggressive child behaviour) (Sanders et al., 2000). Cultural context should also be carefully understood, since culture may influence parents' help-seeking strategies, care-giving practices and perceptions of child behaviour as problematic (Royal Children's Hospital, 2006).

Good mental health is essential for children's learning, social development, self-esteem and resilience to stress (Royal Children's Hospital, 2006). The best chance of preventing mental disorders or providing early intervention to minimise the impact of mental illness across the lifetime is during childhood. Untreated conduct disorders in childhood significantly increase the social and economic costs to the individual and the community later in life. Childhood mental health problems often continue into adolescence and then adulthood, adding further costs related to areas such as school dropout, substance abuse, poor employment outcomes, family violence and suicide, along with sick leave, unemployment and crime (Royal Children's Hospital, 2006). This can then affect the next generation of children.

The effectiveness of early intervention is poorly recognised in the current system and schools and early childhood services are generally ill-equipped to identify problems early and intervene effectively. Additionally, the child mental health services in Australia that do exist can struggle to bridge the gaps between health and the settings where children spend much of their time – education or child care (Department of Health, 2011a).

Only twenty-five per cent of young people with mental illness access services, and for most there is a long delay between the start of symptoms and when they receive help (Department of Health, 2011a). Young people are hard to reach, as they don't necessarily make regular visits to health services.

Government funding for initiatives such as Better Access, headspace and suicide prevention has had some success, but young Australians still need better access to more services to minimise the toll of mental illness on their lives and their families.

Please refer to the mental health section for more information about access to early mental health intervention services.

Priority Issues

Healthy growth and development

Childhood overweight and obesity impacts around 26% of ACT children in the 5–17 year age range and this figure has remained relatively stable between 2007 and 2014 (ACT Health, 2016f), which is comparable with other Australian states and territories. Younger children (5-6 years) represent a smaller proportion of children in the ACT who are overweight or obese, with this figure remaining stable at around 15-16% (ACT Health, 2016f). 15.7% of kindergarten children in the ACT in 2012 were measured as overweight or obese (ACT Kindergarten Screening Program) compared to 17.3% in 2011 and 15.7% in 2010. While rates of overweight and obesity in children have remained reasonably stable, significant numbers of children will continue to be at risk of developing serious disease and chronic health conditions in adulthood if action is not taken early in life to prevent childhood overweight and obesity.

A physically active childhood is important for healthy growth and development and sets up healthy behaviour patterns which are likely to continue on into adulthood. It also improves the child's social and emotional development and wellbeing and increases mental awareness and boosts confidence and self-esteem. In the ACT, 19% of primary school aged children are meeting the National Physical Activity Guidelines of 60 minutes or more of physical activity each day (ACT Health, 2016f). Boys were more likely to meet the national guidelines than girls. Less than a third of ACT parents were aware of the recommendation made by the National Guidelines (ACT Health, 2013c). In addition to this, around 35% of children aged 5–15 years spend more than 2 hours a day engaging with electronic media, with boys more likely than girls to exceed the guidelines of 2 hours or less a day (ACT Health, 2016f). The relatively low numbers of children who meet the physical activity guidelines is in line with the Australian average, however, it is concerning that the number of parents aware of the Department of Health guidelines is also quite low. These low results are significant in the sense of long-term chronic disease prevention as it is well documented that good nutrition and a solid grounding in physical activity in the early years (amongst other things) are considered to be protective factors that play a role in long-term health, development and wellbeing (Center on the Developing Child at Harvard University, 2010).

Encouraging children to eat vegetables on a daily basis is a task seen as difficult by many caregivers. In the ACT only around 5% of children aged between 2 and 17 years are meeting the minimum National Health and Medical Research Council (NHMRC) dietary guidelines for vegetable consumption (National Health and Medical Research Council, 2013). However, fruit consumption

among children in the age range sits at around 68% indicating that about two thirds of children were eating 1–2 serves of fruit each day (ACT Health, 2016f, National Health and Medical Research Council, 2013). It is encouraging to see that sugary drink consumption by children aged 5-15 years in the ACT is on a downward trend, reducing from around 50% in 2007 to around 30% in 2014 (based on children who consume more than 2 sugary drinks per week) (ACT Health, 2013c).

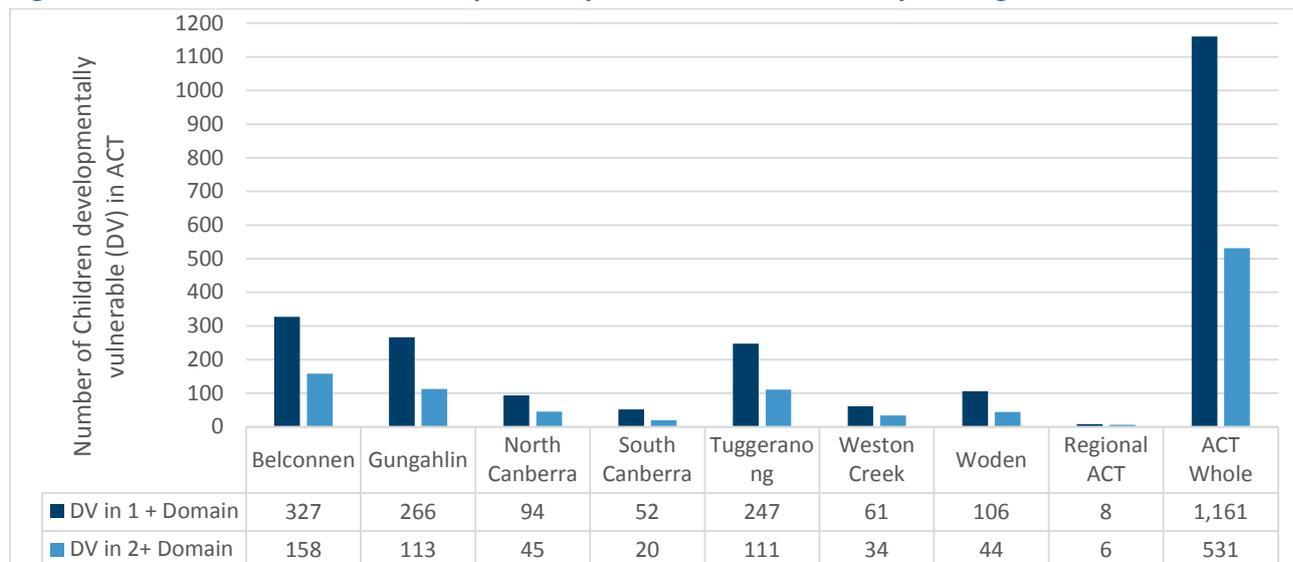
Physical inactivity, poor fruit, vegetable and sugary drink consumption are considered to be risk factors for the development of cardiovascular disease, cancer, diabetes, obesity as well as mental health conditions (specifically depression and anxiety).

Australian Early Development Census

Successful transition to school is greatly shaped by children’s attainment of the basic skills for life and learning in the early years. Children’s development in the years before school has an impact on both their ability to be ready to learn at school entry and their social and economic outcomes over the course of a lifetime. The quality of the relationships, environments and experiences in the early stages of development are crucial in shaping a child’s health, wellbeing and developmental outcomes. The Australian Early Development Census (AEDC) provides a population measure of children’s development as they enter school. The AEDC questionnaire is completed by teachers for children in their first formal year of schooling every three years (2009, 2012, and 2015), results are presented based on the postcode in which the child resides. The ACT has a smaller population size than all of the other states and territories, therefore it is important to consider the AEDC data for the ACT in terms of the numbers behind the percentages.

The latest year of data for the AEDC (2015) indicates that overall, the majority of children in the ACT are developmentally ‘on track’ (in the top 75% of the national AEDC population) and doing well. The proportion of ACT children developmentally vulnerable (children whose domain score is below the 10th percentile of the AEDC national population) on one or more domains (22.5%) is similar to their Australian peers (22.0%) and the proportion developmentally vulnerable on two or more domains (10.3%) is slightly less than their Australian peers (11.3%) (Australian Early Development Census, 2015). Results in the ACT from 2009, 2012 and 2015 have remained relatively stable with little change in vulnerability on one or more domain(s) (22.2%, 22.0% and 22.5% respectively) as well as vulnerability on two or more domains (10.9%, 9.8% and 10.3% over time) (Australian Early Development Census, 2015).

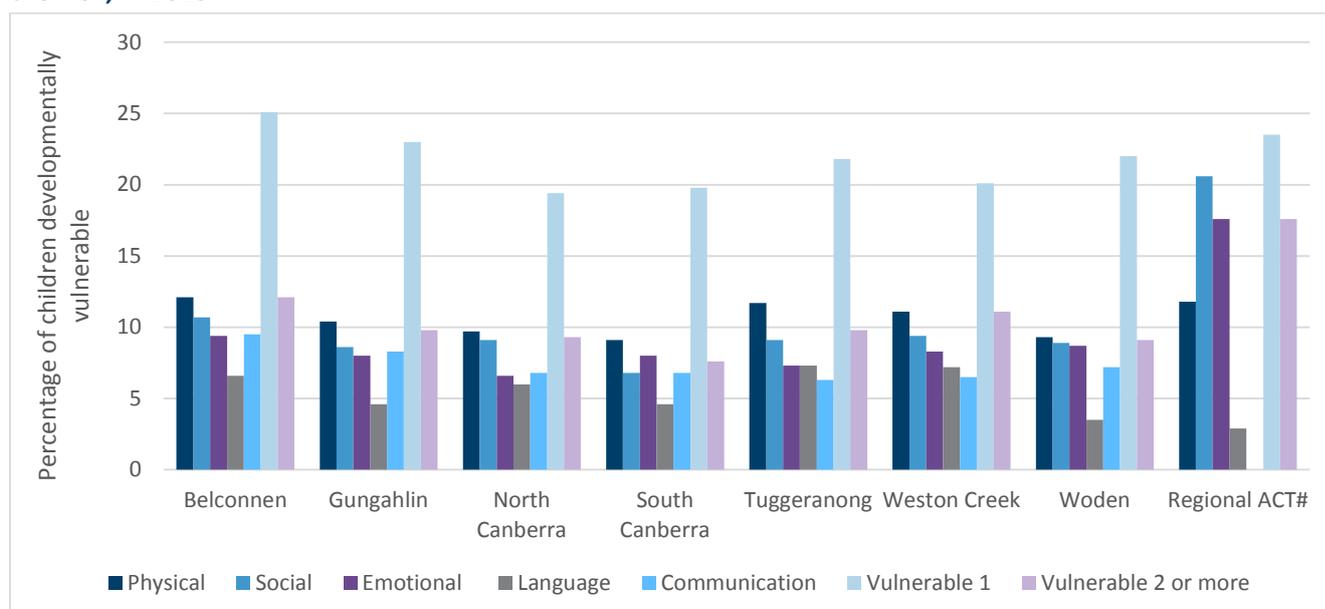
Figure 6.3: Number of children developmentally vulnerable in the ACT, by sub-region, AEDC 2015



Source: (Australian Early Development Census, 2015)

The Belconnen region has seen the greatest rise in developmental vulnerability in each of the domains between 2012 and 2015 with an increase in developmental vulnerability in all domains except physical health (Australian Early Development Census, 2015). Physical health remains the domain where children demonstrate the highest proportion of developmental vulnerability across all sub-regions of Canberra. Figure 6.4 demonstrates the proportion of children developmentally vulnerable by domain in the sub-regions of the ACT in 2015.

Figure 6.4: The proportion of children developmentally vulnerable, by domain, in sub-regions of the ACT, in 2015



#Only a very small number of Children reside in Regional ACT therefore percentages may not be comparable to other Canberra regions. Source: (Australian Early Development Census, 2015)

When comparing the proportion of ACT children to Australian children in 2015, results are quite similar for those children developmentally on track, at risk and vulnerable on each domain (Table 6.2). The biggest discrepancy was seen in the Physical health domain, with 5% less children developmentally on track in the ACT (72.7%) when compared to Australia (77.3%) (Australian Early Development Census, 2015).

Table 6.2: The proportion of ACT and Australian children developmentally on track, at risk and vulnerable on each domain of the AEDC, 2015

Domain	Developmentally on track (%)		Developmentally at risk (%)		Developmentally vulnerable (%)	
	ACT	Australia	ACT	Australia	ACT	Australia
Physical health	72.7	77.3	16.4	13.0	10.9	9.7
Social competence	74.5	75.2	16.2	15.0	9.4	9.9
Emotional maturity	75.9	76.4	15.9	15.3	8.2	8.4
Language and cognitive skills	83.5	84.6	10.6	8.9	5.9	6.5
Communication	75.5	76.3	16.8	15.1	7.7	8.5

Source: (Australian Early Development Census, 2015)

Strategy

The ACT Government recognises the importance of early intervention around childhood overweight and obesity prevention, and seeks to gain momentum in this area through initiatives that form part of the Towards Zero Growth Healthy Weight Strategy (ACT Health, 2013e).

CHN coordinates the 'Connect Up 4 Kids' Initiative which provides support to primary care and community sector professionals focussed on optimising healthy growth and development to families with children aged 3-7 years to both general practice and the community sector.

The program provides education and resources for health professionals and community sector organisations to empower them to work more effectively with families around understanding healthy growth in young children and promoting healthy lifestyle choices.

The goal is to encourage general practitioners and practice nurses to have more frequent conversations with families around healthy growth in children and making healthy lifestyle choices as a family, in order to prevent childhood overweight and obesity.

The program promotes seven key messages: Move Your Body, Switch off Screens, Good Night Sleep Tight, Be Healthy Together, Munch on Veg, Enjoy Some Fruit and Choose to Drink Water.

Resources surrounding these key messages have been developed to assist health professionals in encouraging behaviour change.

ACT Health and CHN continue to work together to strengthen the Kindergarten Health Check by providing education and support to general practice in secondary screening tools and referral pathways to local services associated with kindergarten health screening outcomes. This aims to build the capacity of general practice-based clinicians to recall families and provide a timely, pro-active and coordinated response. Healthy weight issues will be a significant component of this work.

CHN will continue to support the work of “place-based” West Belconnen Local Services Network 0–8 working group in increasing awareness in, and access to, services for parents with young children. This includes improving physical health and wellbeing, increasing opportunities for preparing children and parents for school entry and create opportunities for a sustainable and community driven approach by leveraging existing resources.

CHN is represented on this working group and a number of projects were identified to work towards achieving better outcomes for children aged 0-8 years in West Belconnen. These include holding a ‘Kids Carnival’ to demonstrate local services with a focus on opportunities for child development, social participation and school readiness, establishing a sustainable home visiting program for the region allowing for home visiting for families with children over the age of 18 months, establishing an in-service program for education providers in West Belconnen to assist educators in identification of programs and services in the area that may assist the referral of families to local services and create more opportunities for West Belconnen families to encourage early literacy.

CHN will also determine the feasibility and acceptability of commissioning an ‘out-reach’ model of primary health care services for those families who have been identified as vulnerable and are participating in a parenting support program (such as NEWPin, HIPPY etc) and are not connected with mainstream primary health care services. *(Subject to outcome of current feasibility assessment)*

7. Older people (aged 65 and over)

Overview

There is great diversity in the health and wellbeing of older people. Ageing involves physical and mental changes which may impact on sight, hearing, memory, mobility and balance. Ageing also brings an increased risk of developing chronic diseases and other age related diseases such as cancer. Table 7.1 demonstrates the prevalence of disease for those 65 years and over is much higher than the proportion for the population across all age groups, in the ACT and Australia (Australian Bureau of Statistics, 2015c).

Table 7.1: Comparison of prevalence of disease by age

Condition	Australia total population (%)	ACT total population (%)	Australia 65+ years (%)	ACT 65+ years (%)
Diseases of the eye and adnexa	54.9	57.3	93.4	97.3
Short sightedness/myopia	25.6	31.5	39.2	45.8
Long sighted/hyperopia	28.9	27.1	60	59.1
Cataract	1.8	0.9	9.1	4.3
Glaucoma	0.8	0.3	4.1	1.5
Diseases of the musculoskeletal system and connective tissue	29.9	29.4	66.8	64.1
Arthritis	15.3	13.7	50.5	49.6
Rheumatoid arthritis	1.8	0.4	5.5	1.5
Back problems	16.2	15.9	25.9	23.6
Osteoporosis	3.5	3.9	14.2	15.2
Diseases of the circulatory system	18.3	19.8	58.5	59.5
Angina	1.2	1.4	5.7	8.1
Total heart, stroke, vascular diseases	5.2	3.7	23.1	17.3
Hypertension	11.3	12.1	40.7	46.7
Endocrine, nutritional and metabolic diseases	13.8	14.8	40.1	41.6
Diabetes	5.1	4.3	17.4	13.7
High cholesterol	7.1	8.6	23.9	23.6
Diseases of the respiratory system	30.8	36.3	34.9	34.5
Chronic obstructive pulmonary disorder (COPD)	2.6	2.1	7.8	6.7
Asthma	10.8	11.5	10.4	9.2
Hay fever and allergic rhinitis	19.4	25.9	17	22
Mental and behavioral problems	17.5	18.4	17.7	13.6
Mood affective problems	9.3	10.1	10.5	8.8
Malignant neoplasms (cancer)	1.6	1.8	6.6	7.8

Source: (Australian Bureau of Statistics, 2015c)

As people age, they are more likely to access health care. People aged between 65-75 years are twice as likely to be admitted to hospitals as the rest of the population and those aged over 85 years are more than five times likely to be admitted to hospitals (Government of South Australia, 2007). Older people with complex health needs tend to have more visits to GPs and allied health professionals, use hospitals more frequently and for longer periods and are prescribed more medication.

In line with the national general population the number and proportion of older people in the ACT region is increasing. The proportion of the population aged over 65 is expected to increase from 11.2% to 21.9% by 2059 (ACT Health, 2014a). This trend towards an ageing population is inevitably accompanied by increased prevalence of chronic disease and disability. The number of older people with dementia is also increasing. It has been estimated that there are 4,400 people in the ACT living with dementia, with 3 new cases being diagnosed in the ACT each week, most of whom are aged 65 years or more (Alzheimer's Australia ACT, 2016). Dementia is a key driver of increased demand in aged care services and beds, and there are already shortages in both community and residential places (ACT Health, 2014a).

If we can get health and care systems and services right for our older population – those with the highest complexity, activity, spend, variability, and use of multiple services – we should help get it right for other service users (Oliver et al., 2014).

While aspirational, the above quote underscores the significance of transforming health and social care for older people. There are both social and economic imperatives driving the need to address the improvement of services across the whole health and aged care system. This requires consideration of each component of care as the quality, capacity and responsiveness of any one component will affect others. Transforming care for older people requires a fundamental shift towards care that is coordinated around the full range of an individual's needs and care that prioritises prevention and support for maintaining independence (Oliver et al., 2014).

From a health service impact perspective the evidence is very clear. Older people constitute a high percentage of hospitalisations for chronic diseases; chronic obstructive pulmonary disease (COPD, 81.5%), cerebrovascular disease (78.9%), osteoporosis (72.3%), colorectal cancer (66.0%), lung cancer (64.2%), coronary heart disease (62.9%) and chronic kidney disease (58.3%) (ACT Health, 2016d).

In the ACT older people now constitute around 36% of hospital separations. Emergency Department (ED) presentations and per capita hospitalisation rates have increased by 23% and ED presentation

rates by 14% over a decade. Significant increases in these figures are being driven by people over the age of 85. The costs to the health system are significant particularly in the last year of life (Kardamanidis et al., 2007) and increasing above health inflation (McGowan, 2015).

It is recommended that this section be read in combination with the ACT Health, Population Health Division report; *Health and Wellbeing of Older Persons in the Australian Capital Territory 2016 (Health Series Number 64)*.

Key Issues

Consultations raised many key and priority issues associated with improving our health care systems for older people. Key among these were:

Dementia

It is well established that cognitive impairment is not well recognised or managed in the acute hospital setting generally within Australia and internationally (Alzheimer's Australia, 2014). Patients with cognitive impairment are at greater risk of adverse incidents, poorer outcomes and longer lengths of stay, and they and their families/carers have a more negative experience of hospital (Alzheimer's Australia, 2014).

With the number of older people with dementia increasing, consultation feedback confirms that ACT Residential Aged Care Facilities (RACFs) are not adequately funded to meet the level of care and support needs required by these residents. This is often a reason why transport to ED is initiated and adverse outcomes for the older person can be experienced.

Falls prevention

Falls are one of the adverse incidents that are known to be more prevalent in older people with cognitive impairment. Causes of falls are varied and can include chronic health conditions, such as low blood pressure (which can affect dizziness), impairments such as muscle weakness or poor vision, or even slippery/wet floors and trip hazard such as rugs or furniture.

In the ACT more than one in five (21.8%) older persons reported falling within the 12 months to January 2016 (ACT Health, 2016d). Of this group, almost half (49.3%) fell more than once, and 22.4% were hospitalised as a result. Falls-related hospitalisations for older persons have increased over time, and are higher for women than men (ACT Health, 2016d). Between 2003–04 and 2012–13, fall-related injuries were the seventh most common reason for hospitalisation of older persons in the ACT, with the average length of stay being 6.8 days (ACT Health, 2016d).

In relation to falls occurring in ACT RACFs hospitalisation rates are markedly higher than the national average (5.7 per 10,000 bed days, compared with 3.4 per 10,000 respectively) (ACT Health, 2016d).

Feedback has indicated that there is a lack of health care professional awareness regarding availability of falls awareness and prevention programs in the ACT (Council on the Ageing, 2016, Health Care Consumers Association, 2016b).

Implementation of My Aged Care and integration with National Disability Insurance Scheme (NDIS)

My Aged Care is a website established by the Australian Government to help consumers, service providers and health professionals navigate the aged care system online (Australian Government, 2016). It is designed to give more choice, control and entry point access to a range of aged care services.

The Productivity Commission's Caring for Older Australians report (June 2011) identified the need for an improved entry point to the aged care system, to help older Australians to retain control over their lives (Productivity Commission, 2011). My Aged Care was launched in mid-2015 with feedback so far indicating that the system is complex and confusing for clients, carers and providers, with the initial screening assessment process being time consuming and repetitive. Consultation feedback included client assessment details not being passed on to local Regional Assessment Service (RAS) or Aged Care Assessment Teams (ACAT) for action, therefore requiring clients to be reassessed with repeated questioning.

In addition the need for clear processes and protocols for transition between the NDIS and the aged care system was highlighted during consultation. Clear pathways for collaborating with My Aged Care and NDIS-funded services were identified as a gap for hospitals, general practitioners, and other health professionals. Specifically highlighted was the potential for many older people to 'fall through the cracks' if clear provider roles and pathways were not established or communicated.

Nutrition and hydration in hospital, residential and home care

It is well recognised that good nutrition is important for maintaining health and wellbeing. Nutrition and hydration (particularly for those with dementia, are cognitively impaired, or obese) was highlighted as an issue in hospitals with examples given of patients forgetting to eat, not recognising or being disinterested in food, or becoming insensitive to thirst (Care Search, 2015).

Chronic illness and disability can also cause difficulty with eating, and the effects of medication can reduce appetite or sensory awareness, as certain drugs can interact with the absorption and

metabolism of nutrients. Frailty and an inability to nourish themselves can be another reason for malnutrition in older people.

Feedback has suggested that the issues surrounding inadequate nutrition and hydration in aged care occurs, in hospital and residential care settings, as a result of insufficient staffing levels at mealtimes, missed meals - or staff not having enough time to feed people, quality of food and budget restrictions (Council on the Ageing, 2016, Health Care Consumers Association, 2016b).

Chronic pain management by GPs

Chronic pain is associated with increased hospitalisation, GP visits and ED presentations. It is generally more common with increasing age, with prevalence peaking in the 65-69 year age group for males and in the 80-84 year age group for females (ACT Medicare Local, 2014a).

Nationally chronic pain affects 1 in 5 patients attending general practice. Increasing with patient age, 1 in 3 patients aged from 65 years are estimated to have chronic pain, with the majority being musculoskeletal in nature (Britt et al., 2015). Obesity has a strong influence on the cause and progression of osteoarthritis, and osteoarthritis is the leading cause of chronic pain. The fact that 93.4% of patients with chronic pain use one or more medications for pain management also adds to their risk of polypharmacy-related adverse events, such as falls (Britt et al., 2015).

Feedback has suggested a need to raise awareness among GPs in the ACT, as limited knowledge about multidisciplinary approaches to the assessment, treatment and management of persistent pain was highlighted (Council on the Ageing, 2016, Health Care Consumers Association, 2016b).

Elder abuse: financial, emotional and physical

Elder abuse is a human rights issue that is underappreciated and a serious problem. Every person has the right to make their own (supported) decisions, live self-determined lives, live with dignity and free from exploitation, violence and abuse. Those rights do not diminish with age (Aged Care Insite, 2016).

Elder abuse takes many forms and can involve intimidation, threats, neglect, and financial deception. As older people become more physically frail, they are less able to stand up to mistreatment, or fight back if attacked, which can lead to more adverse mental and physical health outcomes. A recent NSW Nurses and Midwives' Association survey found most people who suffer abuse in RACFs are staff and residents, caused by acts perpetrated not only by people who yield power over them, but those who lack power and are most at risk of abuse themselves (NSW Nurses and Midwives' Association, 2016).

It is recognised that seniors in the ACT are being abused or harmed in some way, often by people who are directly responsible for their care, although the true incidence is unknown. An Australian National University (ANU) Baseline Survey on Canberra as an Age-Friendly City (2011) indicated that 6% of respondents experienced some kind of elder abuse, however it is assumed that this is a conservative figure (Cotterell et al., 2015).

Feedback suggests that elder abuse is an issue in the ACT that needs to be addressed, with greater awareness about elder abuse, responsibilities for reporting, support services and access for older people, carers and health professional staff.

Carer Support

In a population of 393,013 (Dec 2015) (ACT Government, 2016a) there are around 45,000 unpaid, family and friend carers in the ACT (equating to 11.5% of population) this is in line with the National 2012 figure, of 2.7 million carers, representing 12% of population (Australian Bureau of Statistics, 2013c). Carers are an integral part of our health system and are the foundation of our aged, disability and community care system (Carers ACT, 2015).

Feedback suggests that the lack of access to carer supports is likely to increase as the population ages as the current service system for carers is complex, fragmented and difficult to navigate. In addition to financial support, carers need to access support for aged care, disability and mental health services, and find referral pathways and information for the person they care for.

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) older people

People of diverse sexual orientation, sex or gender identity are a group requiring particular attention when accessing aged care services due to their experience of discrimination and the limited recognition of their needs by service providers. The growing numbers of lesbian, gay, bisexual, transgender and intersex (LGBTI) people accessing aged care services represents an emerging and potentially challenging area for aged care service providers (Department of Health and Ageing, 2012).

Older LGBTI Australians have lived through a time in the nation's history when they suffered stigma, discrimination, criminalisation, family rejection and social isolation. It is important for people working in aged care to consider the impact of historical discrimination faced by older LGBTI people and its effect on LGBTI people accessing and using aged care services (Department of Health and Ageing, 2012).

In the ACT the AIDS Action Council, in conjunction with Council on the Ageing ACT (COTA) and the LGBTIQ Ministerial Advisory Council, are delivering workshops for people interested in gaining a better understanding of the needs of the older LGBTI community members and working in the aged care sector. Feedback suggests that these workshops are well received and support should continue.

Mental Health for older people

Older people who are lonely and don't have strong social networks and support can be at risk of developing mental health conditions such as depression.

Approximately 45% of older people when first admitted to residential care have mild symptoms of anxiety and/or depression (Australian Institute of Health and Welfare, 2013b). The odds of newly-admitted residents with symptoms of depression having behaviours that impact on care needs are more than double (139% higher) the odds for those without symptoms of depression. As residents settle more permanently in their new home, there is an increase in the rate of depression with over half of permanent residents showing symptoms (women 53% and men 51%) (Australian Institute of Health and Welfare, 2013b).

Feedback suggests that low intervention activities, programs and counsellors or psychologists who specialise in mental health and wellbeing for older people within aged care settings (such as residential aged care facilities and independent retirement communities) are needed in the ACT (Nurse Practitioner, 2016).

Medication management

Medicines can cause harm if used incorrectly or inappropriately and older people are more at risk of experiencing side effects from their medicines. Older people may also experience difficulties with vision, hearing, memory or cognitive functions which can make managing medicines safely a lot harder.

According to The Pharmacy Guild approximately 50% of patients don't take their medication as prescribed by their health care professional (Pharmacy Guild of Australia, 2010). This medication non-compliance compromises the effectiveness of treatments, increases the risk of medication incidents and reduces quality of life. Limited knowledge and understanding about the ongoing interface and interaction between medications and nutrition was highlighted, for both health professionals and older people.

For Home Medicines Review (HMR MBS item 900) and Residential Medication Management Review (RMMR MSB item 903), for 2014-15, reviews for people in the ACT community were below national

averages, see Table 7.2 below (Department of Human Services, 2016). These rankings are ordered to include all eight States and Territories, with ACT sitting second last behind the Northern Territory.

Table 7.2: Medication Management 2014-15 (MBS items: 900 & 903)

Medication Management		Services per 100,000 population			
MBS Item	Name	ACT	National	ACT % of National	Ranking
900	Home Medicines Review (HMR)	158	266	59%	7
903	Residential Medication Management Review (RMMR)	113	228	50%	7

Source: (Department of Human Services, 2016)

Pharmacists could play a significant role in medication review for the ACT community and provide advice with regard to medication management (Department of Health, 2014).

Feedback suggests that community pharmacies often don't deliver new medication to residential aged care (i.e. antibiotics after 2pm weekdays and 12pm Fridays) resulting in difficulty treating infections in facilities in a timely fashion.

Consultation has also advised that the unavailability of geriatric rehabilitation service at Calvary hospital prevents patients from receiving management before they deteriorate with polypharmacy and many chronic health problems.

CHN is undertaking a 12 month pilot program (General Practice and Pharmacy Integration pilot) to examine the feasibility and viability of establishing a model to utilise pharmacists within general practice - at the point-of-prescribing.

Chronic disease management and education

Chronic diseases can take years to develop and tend to be progressive. Diabetes, cardiovascular disease, cancer, respiratory disease, musculoskeletal disease and dementia are significant contributors to the chronic disease burden in older people (ACT Health, 2016d).

Older persons are more likely than younger persons to be hospitalised for chronic diseases. It is widely accepted that some lifestyle behaviours can increase the risk of developing many chronic diseases, some of which are a leading cause of hospitalisation and death (ACT Health, 2016d).

Almost all (95.8%) older persons in the ACT reported having a disease of the eye and adnexa, with 83.8% being either short or long sighted (ACT Health, 2016d). Other common conditions were

diseases of the musculoskeletal system and connective tissue (67.0%), and diseases of the circulatory system (62.1%). More than half of older persons in the ACT (54.6%) reported having arthritis, while just under half (43.3%) reported having hypertension (ACT Health, 2016d).

A key issue for older patients with chronic disease is a requirement for early attention and focus on advance care planning. While there has been an increased uptake with advanced care plans being carried out with hospital patients, this is often too near the end of life. Focus on advanced care planning within community prior to entering hospital has been raised as an issue. Increasing the capacity and capability of the health care system to deliver coordinated care to patients with complex chronic conditions and support advanced care planning (including health literacy and skill), to manage their own health and end of life is highlighted as a need.

Increasing the use of digital technology in care for older people

Price Waterhouse Coopers (PWC) 2014 Health Research Institute Report found that digitally enabled care had moved from a "nice-to-have" to a "fundamental of delivering high quality care" (Health Research Institute, 2014). The access to telehealth and home monitoring devices and services, designed specifically for clinical care, is becoming more widely available in the ACT (Integrated Living, 2016, KinCare, 2016).

Despite availability the lack of telehealth and home monitoring digital technology uptake, awareness and acceptance in the ACT by GPs has been identified as an issue.

Medicare funding limitations

Feedback has suggested that when patients are admitted for specific conditions to community based hospital services such as hospital in the home (HITH) and GPs are unable to access Medicare funding, the result can be the deterioration of other clinical issues. These clinical issues can become moderate to severe by the time the patient is discharged (from HITH) instead of being prevented in the first place through early GP consultation.

Feedback has suggested that changes to these Medicare funding structures are required to enable early intervention for preventable conditions.

Priority Issues

Rapid access to GPs for homebound patients

A fundamental part of any comprehensive primary health care system is every individual's right to have reasonable access to a GP. This is also the key principle that underpins the concept of a health

care home and the continuity of care which is critical for those with multiple comorbidities in particular.

The health care home, as defined by the Royal Australian College of General Practitioners (RACGP), is an approach to providing quality patient care whereby each patient has a stable and ongoing relationship with a general practice that provides continuous and comprehensive care to people at all life stages. The health care home facilitates a partnership between individual patients, and their personal GP and extended health care team, allowing for a better-targeted and effective coordination of clinical resources to meet patient needs (The Royal Australian College of General Practitioners, 2015).

There are 2247 operational RACF beds available in 26 age care facilities in the ACT, with 85% (22 of the 26) operating as not-for-profit (Aged & Community Services NSW & ACT, 2016).

Ready access to a GP once a person enters residential aged care was identified as a priority area for action by the GP Taskforce in 2009 and still remains a significant issue (ACT GP Taskforce, 2009). Only a small number of the ACT's residential aged care facilities have adequate GP coverage, and this is usually the result of an in-house GP arrangement or an arrangement with a local multiple GP practice. Feedback has suggested that currently if a GP expresses an interest in RACF work, they end up seeing a huge number of patients and it can "become an all or nothing arrangement", and as a result significant GP coverage issues arise if a GP retires or changes practice.

Lack of timely access has knock-on consequences for not only the older person, their family and RACF staff but also for the ED and hospital system. Many RACF residents, and those with mobility difficulties, are effectively alienated from mainstream primary care and "primary care practitioners they know and trust".

When the health or independence of an older person deteriorates rapidly they should have access to rapid urgent care, including effective alternatives to hospital. The lack of an accessible GP is often the cause of referral to ED as an alternative, and many cases an inappropriate one. It is a common view among ACT health professionals and aged care advocates and indeed in other national and international jurisdictions, that EDs are not geared to fully addressing the complex underlying physical, social, cognitive, and situational needs of older people (Hwang et al., 2013).

There have been some responses to this issue in recent years, such as the establishment in 2011 of the General Practice Aged Day Service (GPADS) program to provide short term, episodic GP in-hours support to RACF residents and for the homebound in the community. This service was reviewed in

2014 (Edwards, 2014) and ceased operation in June 2015, due to ACT Health funding ceasing and its high per unit cost.

Another initiative was the Extended Care Paramedics (ECP) program piloted in the ACT until completion in June 2015. As part of a Health Workforce Australia (HWA) initiative the ACT Ambulance Service recruited highly experienced Intensive Care Paramedics who treated patients in their usual place of residence utilising advanced skills and pharmacology and referral to other health professionals as appropriate. Impressive results were achieved, such as 70% of patients being treated in the community and therefore avoiding transport to ED as compared to the regular ambulance service which had only a 20% non-transport rate (Thompson et al., 2014).

The Canberra After Hours Locum Medical Service (CALMS), is a Canberra after hours locum medical service, contracted to provide after hours home visits to RACFs in the ACT. Feedback from RACF has indicated that CALMS provides an excellent service with most occasions being bulk billed, although this is dependent on the doctor on call, and in some cases a significant fee is payable. More recently RACFs will often contact and refer to the relatively new National Home Doctors Service (NHDS) which bulk bills.

The NHDS is a network of general practitioners who provide bulk billed after hours medical care to homes and aged care facilities in the ACT. They have reported that the NSW Ambulance paramedics now often refer callers with non-emergency symptoms to this team therefore avoiding transfer to ED (National Home Doctor Service, 2016).

Feedback through consultation has indicated that RACF staff, residents and families are happy with and complimentary about both the CALMS and NHDS services.

Addressing GP access issues requires understanding the barriers. While the GP shortage has eased in the last few years, the underpinning reasons why many GPs do not do home or RACF visits and do not take on new patients in RACFs have not changed (Edwards, 2014). The current business model for many ACT GP practices works against home visits to RACFs and private dwellings, particularly as MBS remuneration for RACFs or home visits is lower than for in-practice services and does not adequately recognise the time away from the practice involved in a RACF visit.

Medicare Benefits Schedule (MBS) data indicate that older persons in the ACT have consistently had lower rates of Medicare services per capita than the national average. Over time, this gap has widened. In 2011–12, there were an average of 31.7 services per older person in Australia, compared with 25.6 services per older person in the ACT (ACT Health, 2016d).

While this is a national issue, there are ACT specific factors at play including the ACT's lower than average bulk billing rates, which may discourage some from utilising GP care. ACT's relatively healthy population may require fewer health services, and the higher proportion of people in the ACT with private health insurance may also contribute (ACT Health, 2016d).

Several informants believe that general practice will need to be re-engaged to provide primary medical care for homebound/RACF patients and adopt new multidisciplinary models of care involving specialised nurses and allied health professionals to do so effectively and efficiently (Cranny, 2014).

Strategy

While some responses to this issue in recent years provided a short term solution to fill a gap in hours of GP support in RACFs there is a need to explore longer term solutions that may be more cost effective, sustainable and integrated into the patient centred health care home.

An option is to support GPs to build a sustainable aged care practice, for example practices having responsibility for a small number of RACF beds. This initiative would involve CHN working with ACT Health to develop a strategy to support a small network of general practices to build sustainable aged care practices that support RACFs. Over time these practices could become the preferred providers for RACFs in a geographic area.

Capacity building could occur through:

- Short term subsidisation of home visits while economically feasible models of RACF and home visiting practice are being established.
- Provision of education in geriatric and end of life care for GPs, practice nurses and RACF staff.
- Competency levels and qualifications of RACF staff being recognised.
- Development, support and promotion of care pathways (Calvary, 2015) that support integrated models of care (with ACT Health geriatric and palliative care teams, RACF and pharmacists).
- Review and implementation of an Extended Care Paramedics (ECP) program model.

Essential elements of such a model would be:

- A time limited clearly defined strategy for capacity building including a longer term maintenance strategy.

- Buy-in, commitment to change and some level of investment from the key players – RACFs, general practices, ACT Health, ACT Ambulance Service, National Home Doctor Service and CALMS.
- Engagement of general practices who have the capacity to lead and change models of practice; and ensure there are enough GPs to provide cover.
- May require RACF to undertake a procurement and contracting role with general practices.
- Implementation of an in-hours back-up measure while this strategy is being implemented and the development of an implementable transition plan.

This initiative could assist in achieving a long-term strategy to address the issue of access to primary care in RACF, including quality end of life care. There is a significant change management component in this with heavy reliance on at least a small number of general practices being prepared to change business models and RACFs being prepared to address internal clinical capacity issues.

Another key point highlighted by the ACT based palliative care service is the benefit and value of having a specialist palliative care practitioner (who can prescribe) integrated with RACF and GP's (Calvary, 2015). This is discussed in more detail in the next section.

Based on feedback from the ACT Palliative Care service, benefits have included:

- Reduced hospitalisations
- Increased access to palliative care medicines
- Increased access to prescriptions and medication reviews
- Timely assessment of palliative care needs (e.g. having injectable medicines in place such as morphine has reduced hospital transfer at end of life)
- Increased dying in preferred place of death – which is usually RACF and not hospital.

Prevention of avoidable ED attendances and hospitalisation

Closely related to the issue of access to GPs and primary care support is the issue of avoidable referrals to ED and subsequent hospitalisation. There is a view that there is a strong correlation between inadequate health care in the community and primary care settings and increased hospitalisations (McGowan, 2014). The risks associated with hospitalisation of older people are well documented (Islam et al., 2014). It is also well known that EDs are a challenging environment in which to provide care for the elderly and identifying strategies to reduce the need for ED

presentation while ensuring elderly patients receive the most appropriate care in the most appropriate setting is paramount (Gafforini and Carson, 2013). While a relatively small part of total ED presentations, RACF residents are a particularly vulnerable group (Gruneir, 2013).

Figures from ACT Health's Emergency Department Information System (EDIS) show that, over the 9-year period from 2004–05 to 2012–13, the proportion and rate of ED presentations for older persons in the ACT increased from 28.4% to 35.1% (rate increase from 386.5 to 442.5 presentations per 1,000 population - an increase of 14.4%). This increase was driven by those aged 85 years and over. Almost half (47%) of older persons in the ACT presenting to EDs arrived by ambulance, and this was consistent over the time period 2004–05 to 2012–13 (ACT Health, 2016d).

Whatever the community setting, frail elderly people are believed to benefit greatly from a coordinated chronic health care delivery system that integrates health and social care (Ruikes et al., 2012). The HCCA has reported that "a coordinated approach across a wide range of community services was required to better meet the needs of these people, both in terms of preventing hospitalisation and better supporting older consumers following hospitalisation for an acute illness".

General Practice Aged Day Service (GPADS) received over 3,650 referrals (from 2011 to June 2015) to provide an acute assessment service to homebound or RACF residents when their usual GP was unable to see the patient in a timely manner (ACT Medicare Local, 2015a). This service was reported as being responsible for avoiding unnecessary transfers to ED and therefore providing significant potential savings in ambulance and ED costs (Edwards, 2014).

Ongoing in-hours GP chronic disease management also plays its part although there is a lack of data from GP settings to assess the extent and impact of this. A particular subset of this activity that does have more robust data is the Coordinated Veterans' Care (CVC) Program. This is a program that targets veterans' who have one or more specified conditions (diabetes, COPD, CHF, coronary artery disease and pneumonia) and are at risk of being admitted to hospital for their condition. The program supports the development of coordinated care plans (by practice or community nurses in conjunction with GPs) supported by self-management targets and provides appropriate financial incentives for regular follow up of patients. There were 361 Gold Card holders enrolled in the CVC program in the ACT (as of 31 December 2015) with the potential number being 2707 (CVC Program Manager, Feb 2016).

National feedback indicates that good outcomes have been achieved through CVC, and this is a model of care that should be further examined in terms of applicability to the management of chronic conditions in the elderly.

Similarly studies on functional decline and the impact of preventative screening of the elderly have found that while assessments such as the one-off 75+ Health Assessment doesn't necessarily prolong life, it does however improve quality by minimising falls and admissions to acute hospitals, and maximises opportunities for the elderly to stay in their own homes (The International Centre for Allied Health Evidence, 2015).

There are also other programs in the ACT that have some involvement in supporting older people in community settings, these include:

- RADAR (Rapid Assessment of the Deteriorating Aged at Risk) is an in-hours sub-acute service with typically a 24-48 hour wait for response and therefore not geared to rapid support.
- Hospital in the Home (HITH) programs from both public hospitals provide a relatively untapped set of resources for management of patients in community settings including RACFs, but to date have been sourcing patients once they arrive in ED or on the wards.
- Chronic Disease Management Unit (CDMU), at Canberra Hospital, provides a care coordination service. During the July to September 2015 quarter there has been an increase in hospitalisations of complex multi-morbidity patients, some of whom have required nursing home placement due to deteriorating health requiring 24 hour care (Dugdale and Hopkins, 2015).
- Calvary MOC (integrated model of specialist palliative care) - Clare Holland House partnered with Goodwin Aged Care Services for a 9 month pilot study from November 2014 to August 2015. The trial demonstrated that the model was feasible (it was implemented without extra funding), logical (having built capacity within both services) and effective (supported by initial data and results). The project made the recommendation to roll out this integrated model of specialist palliative care Territory wide and obtain funding and resources to do so (Calvary, 2015). Since completion of the trial this program has continued to provide outreach services to support Goodwin Aged Care Services.
- ACT Ambulance Service piloted Extended Care Paramedics (ECP) program aimed at reducing inappropriate presentations to ED and use of ambulances for transport. As previously stated this program ceased operation in June 2015.
- Private healthy ageing and care consulting organisations operate within the ACT to clinically support in-home care and RACFs.
- Feedback suggests that geriatricians are also often contacted directly by RACFs, patients and families when assistance and help is required.

Derived data from ACT EDs⁵ show that in the year to end of Feb 2014, there were upwards of 820 RACF residents that presented at ED, 92% of whom arrived by ambulance and 74% of whom were admitted to either an ED unit or a ward. Of these presentations, 33% were triage Cat 4 & 5, while 50% were Cat 3. The highest primary diagnosis was “unspecified falls” at 9% (the majority of which are understood to be fractures), while fractured neck of femur only added another 1%.

Strategy

It is widely recognised that the current service model needs to be transformed to meet the needs of older people with complex needs when they deteriorate rapidly in or out of hours and can't be seen by a GP within a reasonable period of time (Oliver et al., 2014). Successful models, such as the Geriatric Rapid Acute Care Evaluation (GRACE) Model (Yazdani, 2012), that are based on collaborative arrangements between hospital staff, GPs and RACFs have been in existence for a number of years.

There is an opportunity to further consider how best to support older people who can't be seen quickly by a GP. It is not likely that the current causes of “market failure” in this area, such as GP availability, attitudes to after hours care and financial disincentives are likely to dissipate in the foreseeable future, so local strategies are required to minimise the negative impacts on the patients, carers and the health care system as a whole.

The spectrum of programs currently operating in the ACT, which have some impact on hospital avoidance strategies for older patients with chronic and complex conditions, have largely developed in isolation to each other. Capital Health Network (CHN) have previously recommended (ACT Medicare Local, 2014a) and have now initiated the development of a ‘whole of system’ overarching analytical framework (Capital Health Network, 2016a) to be used as a basis for future resourcing of a comprehensive and integrated service model.

This framework describes the components of the integrated service model required to minimise preventable hospital admissions, including ED presentations, for older people in the ACT. The analytical framework will present an opportunity to identify gaps in service responses and to consider options for commissioning new services and/or the redesign of existing services. Part of the review consideration could be given to a single whole of territory service that could potentially eliminate the inherent difficulties caused by program/service boundaries and develop

⁵ ED data is derived as Calvary does not code a person's residence as an RACF, but rather their “home”. The data for Calvary is as a result likely to be underestimated.

a highly integrated patient focussed service able to flexibly deploy appropriate resources to meet individual circumstances.

Improving the hospital/community care interface

The need for better hospital admission and discharge planning and communication processes was another key theme during consultation. There is universal concern about the priority that should be given to more effective management of older people in acute ward settings and in particular the pathways associated with these. In 2013, the National Lead Clinicians Network undertook a forum that focused on the transfer of care between sectors and RACFs.

One of the issues identified was the need to strengthen discharge planning and procedures and in particular the importance of the development of a shared understanding of the roles and capabilities of acute care and residential aged care. Strategies in this area would assist clinical teams when making decisions about transfers of care and improve relationships between sectors, leading to better continuity of care and supported decision making with patients.

There are well established reasons why older people are particularly vulnerable to ineffective transition between hospitals and the community. Older people are more likely to:

- Be admitted (with existing health or community services needs) or require step-down to health or social care services on discharge.
- Experience delayed transfers of care.
- Report uncertainty, lack of confidence and lack of support on discharge from hospital.
- Be at high risk of re-admission because of their complex needs and frailty (Oliver et al., 2014).

Strategy

Within ACT Health the Chronic Disease Management Unit (CDMU) manage a chronic care service for people who have had several hospital admissions or visits to the Emergency Department over the previous two years. Upon identification and on discharge the service offers care coordination (from clinical care coordinators), and specialist nursing support (from clinical nurse consultants), available to identified patients enabling them to manage their chronic conditions and remain as well as possible at home. The CDMU also manages the Chronic Disease Management Register (CDMR), which is used to generate patient identification reports (Dugdale and Hopkins, 2015).

System-wide issues as detailed in Section 1 identified issues associated with the discharge planning processes in the ACT. Vulnerable populations and the elderly are particularly prone to adverse outcomes in the transition of care between sectors and we would recommend that the review process (as recommended in Section 1) has as its focus the elderly in the first instance, because *“if we can get health and care systems and services right for our older population....we should help get it right for other service users”* (Oliver et al., 2014).

In 2014 The Kings Fund undertook an extensive review of what is known to work with regard to good discharge planning and post-discharge support for older people and identified:

- Proactive discharge planning (dates and clear clinical criteria for discharge) and first time admission to the right ward and setting.
- Concerted focus on discharge planning throughout hospital stay – with discharge ability, within 24 hours, available 7 days a week.
- Involving older people and their carers in discharge plans - at time of admission.
- Ensuring integrated information and technology systems.
- Strengthening post-discharge assessment and support (including enabling in-reach services from community services) (Oliver et al., 2014).

These general strategies should be incorporated into any review of discharge planning processes and have been included as part of the previously described CHN initiated analytical framework.

End of life care planning

Australia's health system is doing a poor job of managing older people in their final years of life (Binsted, 2016). Older people who are nearing end of life should have access to supported decision making opportunities, timely assistance to plan and discuss their care preferences; and health professionals and carers need to be supported to encourage end of life conversations. It is widely accepted that hospitals remain the last preferred place of death but still remains the most common places to die.

Advances in medical care mean that we can do more to treat illnesses and the majority of people now die in acute care settings with many being actively treated right up to the moment of their death, in some cases involving expensive and futile treatment. Limited community and professional awareness of end of life issues and a societal reluctance to talk about death, combined with the

inability of health professionals to recognise and appropriately treat those who are dying are significant barriers to achieving quality care (Palliative Care Australia, 2010).

Many of the problems associated with the effective provision of end of life care, and indeed the management of complex and chronic cases in general, relate to barriers that occur at the interfaces between settings, between services and between health care professionals. These are further exacerbated in the ACT “as different services interfacing with palliative care being set up in silos and there are difficulties associated with incompatible software and information systems” (National Clinicians Network, 2013).

End of life dementia patients are particularly at risk due to the complex medical, cognitive, emotional, ethical and social considerations that accompany dementia. Often people with dementia are subjected to interventions such as tube feeding or hospitalisation for pneumonia that may be of limited benefit and not consistent with quality end of life care.

Some of the strongest anecdotal evidence about system failure to care appropriately for people with dementia, as they approach the end of life, is found at the transitions between care sectors. Inappropriate transfers into unfamiliar environments such as busy EDs, coupled with invasive procedures may leave patients disoriented, confused and anxious resulting in further complications and behavioural changes that these settings are generally ill-equipped to deal with (Palliative Care Australia, 2010).

*In short, we have an absolute, non-negotiable obligation to get the interfaces ‘right’
(Palliative Care Australia, 2010).*

The ACT is well serviced by a specialist palliative care service offering Palliative Aged Care Consultancy supported by the Calvary Palliative & End-of-Life Care Team. This service operates out of Clare Holland House and provides both hospice and community based in-home support across the Territory and surrounding region.

Guidance and assistance with Advance Care Planning (ACP) requires a fundamental understanding that ACP is a ‘process’, not a one off occurrence. ACP should be a part of routine health care and GPs can play a guiding role in this process.

The ACT also has an active Respecting Patient Choices Program operating from the Canberra Hospital to support ACP. CHN (previously ACT Medicare Local) facilitated training for RACFs and GPs in ACP, and in May 2014 launched a communication campaign involving a TV advertisement and advance care planning support website branded Be My Voice (Be My Voice, 2016).

The Health Care Consumer Association (HCCA) has been funded through the Respecting Patient Choices program (from January 2015 to November 2016), to deliver consumer education workshops focused on initiating and having difficult conversations associated with advanced care planning. Targeting general multicultural and vulnerable consumer groups, these workshops are aimed at ensuring that choice and control is maintained in all aspects of an individual's health care. HCCA also tailor and deliver this education to health care professionals.

HealthPathways provides an online manual for general practice teams to manage and refer their patients to secondary, tertiary, and community services. As part of this program the ACT and Southern NSW HealthPathways team have localised ACP pages to the ACT context in addition to making twelve palliative care focused pathways available to the health professional target audience, enabling a single point of accessing information for these services. Over the next 18 months the HealthPathways team has plans to make aged care focused pathways available with topics and timeframes still being confirmed.

Decision Assist has been funded federally to enhance the provision of palliative care and advance care planning services to the older people. This service is promoted in the ACT, and includes a telephone based advice service and a project focused on enhancing the skills of aged care staff and GPs through specialised education and resources (Palliative Care Australia, 2015). Feedback indicates a very low call volume received from the ACT to the telephone service, although this is not a uniquely ACT issue, as this has been reported nationally (Decision Assist Project Manager, Mar 2016).

With the overall number of older people increasing in the ACT as a percentage of the population, knowledge about advanced health care planning will continue to be an important issue for consumers and the health care system as a whole. Programs such as HCCA's *A Conversation for Everyone* provide a great opportunity for consumers and health professionals alike for raising awareness and learning more about advanced care planning (Health Care Consumers Association, 2016a).

Feedback from consumers suggests that while the quality of palliative care programs is high in the ACT, there is greater demand for services than can currently be met. With an ageing population, the increase in future demands on palliative care services, including those in the community and RACFs, should be considered a high priority (Health Care Consumers Association, 2016a).

Strategy

Improving the integrity and uptake of ACP across care setting interfaces remains a significant issue to be addressed (ACT Health, 2013d). Transitions in and out of acute hospital settings are particularly critical as patients in their last year of life are admitted to hospital an average of 3.5 times. This indicates the need to strengthen cross boundary coordination and discharge planning. The Kings Fund has concluded that a multidisciplinary model of care with good communication between primary and secondary care and with the community sector is essential in end of life care to avoid unnecessary admissions and manage discharge from hospital effectively (Oliver et al., 2014). Community and primary care services that are accessible 24/7 are essential elements.

Low uptake and poor implementation of advance care plans may be addressed by further:

- Increasing community and consumer awareness (Care Search, 2016).
- Encouraging and promoting health professional involvement.
- System-wide implementation of multi-faceted interventions (Rhee et al., 2012).

There are a number of frameworks and guidance documents that can support health professionals to improve their end of life care services. There is evidence that investing in the implementation of structured approaches in RACFs in particular with advance care plans and adequate palliative care support, can significantly improve the quality of care and allow residents to die at home in RACFs (Oliver et al., 2014). In particular, the Gold Standards Framework (GSF), developed as part of the UK National Health Services, has been instrumental in the development of a systems based approach and has been successfully adapted in North West Tasmania for the RACF environment. The GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life, delivered by generalist care providers. GSF includes care for all people in the final year, months and weeks of life, in any setting, with any condition, particularly the frail elderly, those with dementia and other disadvantaged groups.

In the UK, implementation of the GSF has resulted in fewer crises and unplanned events, enabling more people to live and die where they choose and a reduction in hospitalisation.

In recent years the GSF has also developed a Cross Boundary Care Program to improve coordination across various providers as well as a GSF Acute Hospital Program that is showing good results in reducing lengths of stay and rapid discharge as well as improving the quality of patient care on hospital wards (The Gold Standard Framework, 2015). An alternative Australian approach to caring for people dying in acute care has been developed in the Hunter New England Region with the aim of educating and supporting health professionals to understand the issues

important for dying people and supporting the delivery of care based on people's needs rather than their diagnosis (Clark et al., 2014).

Within the ACT a number of complementary strategies are being considered and implemented:

- Calvary Health Care (Bruce) and ACT Medicare Local formed the Capital Health Alliance (CHA) in 2014 to improve health outcomes by identifying issues of importance to patients that can be collectively influenced. In 2014 the CHA facilitated a system change workshop, with interested stakeholders, to discuss enabling a quality of end of life journey. This led to the CHA making a commitment to improving the quality of a patient's end of life journey and the associated experience of their carers and families. An 'Enabling a Quality End of Life Journey' project is currently being scoped and recruited for to develop a detailed Model of Care for endorsement and trial.
- Introducing a systematic approach (such as the Gold Standards Framework) is being investigated for RACFs in the ACT with the view to establishing a comprehensive program of advance care planning. Consultation so far regarding the desirability of introducing a system-wide program with an emphasis on developing best practice models for cross sector boundary patient transfers has been positive. This would involve assessing the interrelationship with investments already made in Respecting Patient Choices and other programs within the ACT. Once finalised the analytical framework (Capital Health Network, 2016a) (as mentioned in the previous section) will present an opportunity to identify gaps in service responses and consider options for commissioning new services and/or the redesign of existing services.
- A program of increasing community and health professional awareness, about end of life care issues and advance care planning, should continue and be integrated into any system-wide models that emerge as part of developing a more systematic approach to RACF and acute/community boundary issues.

8. Mental Health

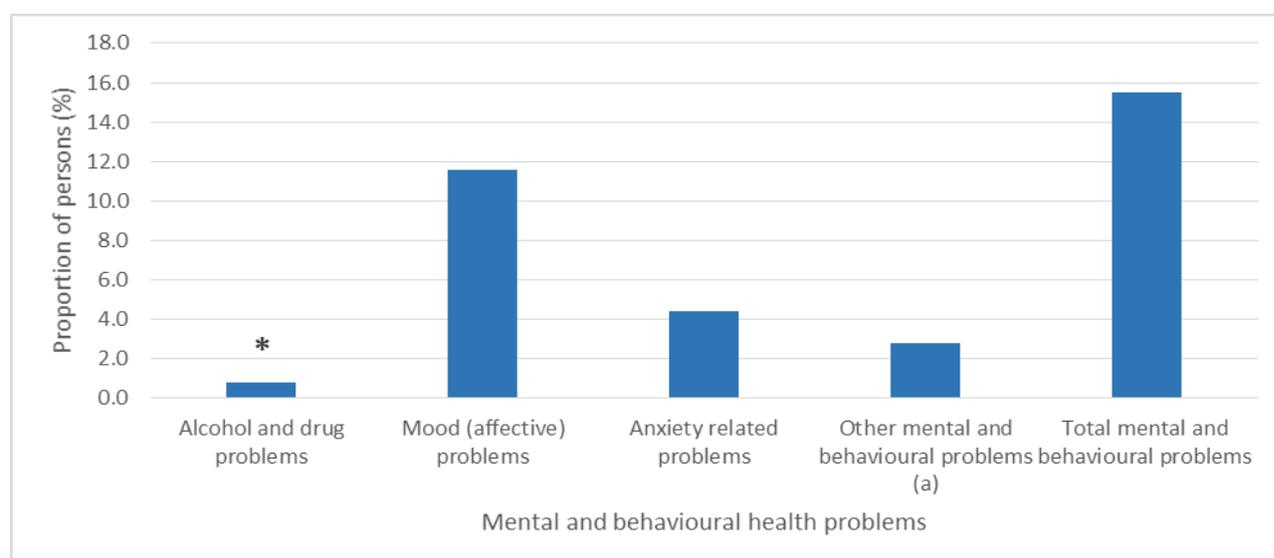
Overview

Mental Health and behavioural disorders include anxiety, depression, substance use disorders, and psychotic disorders. People with mild forms of these disorders often do not receive treatment early and those with moderate to severe presentations often have worse physical health outcomes and worse quality of life than those without a mental health disorder. In the ACT in 2003, mental health disorders were responsible for 15% of the total burden of disease, higher than the national figure of 13.3% (ACT Health, 2014a).

Prevalence

Data from the Australian Health Survey 2011-12 indicates that the prevalence of people with mental and behavioural problems in the ACT was 15.5% (Australian Bureau of Statistics, 2012a). Figure 8.1 outlines prevalence by mental health and behavioural problems. Mood disorders were the most common mental health and behavioural problem, estimated to affect 11.6% of the population. In comparison, anxiety related problems, alcohol and drug problems and other mental and behavioural problems affected less than 5% of the population.

Figure 8.1: Estimated prevalence of mental health and behavioural problems in the ACT

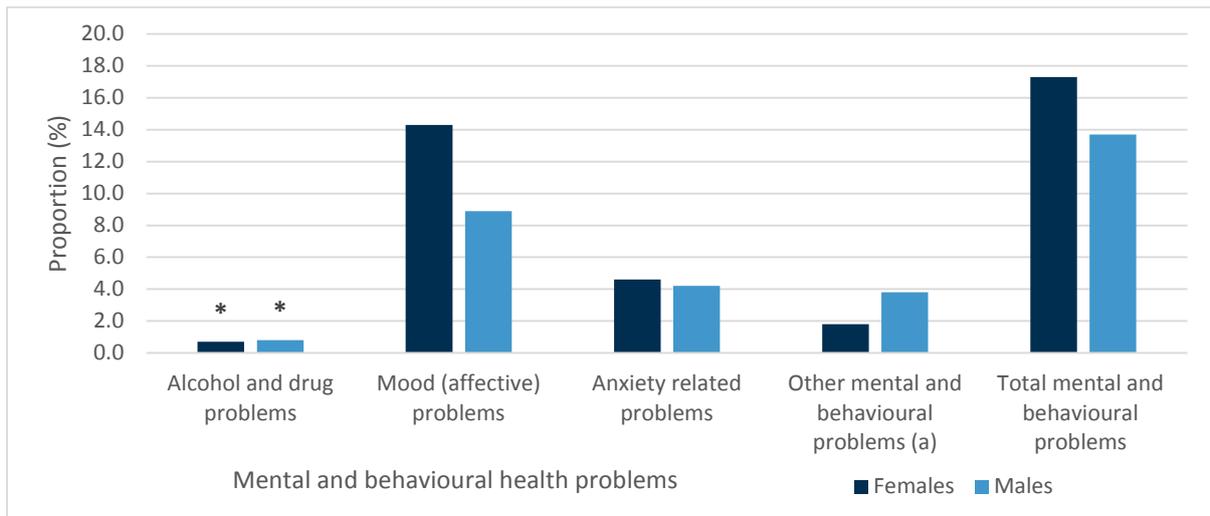


*Estimate has a relative standard error of 25% to 50% and should be used with caution
Source: (Australian Bureau of Statistics, 2012a)

Prevalence of mental health related conditions varied by gender and age group, Figure 8.2 depicts prevalence by gender in the ACT. Overall, the prevalence of mental and behavioural health problems

in females was higher than in males, with 17.3% of females estimated to have a mental or behavioural health problem compared to 13.7% of males. Interestingly, the prevalence of different types of mental health disorders varied with gender. Females were more likely to have mood problems compared to males (14.3% for females versus 8.9% for males). Whereas males were more likely to experience other mental and behavioural problems compared to females (3.8% for males versus 1.8% for females).

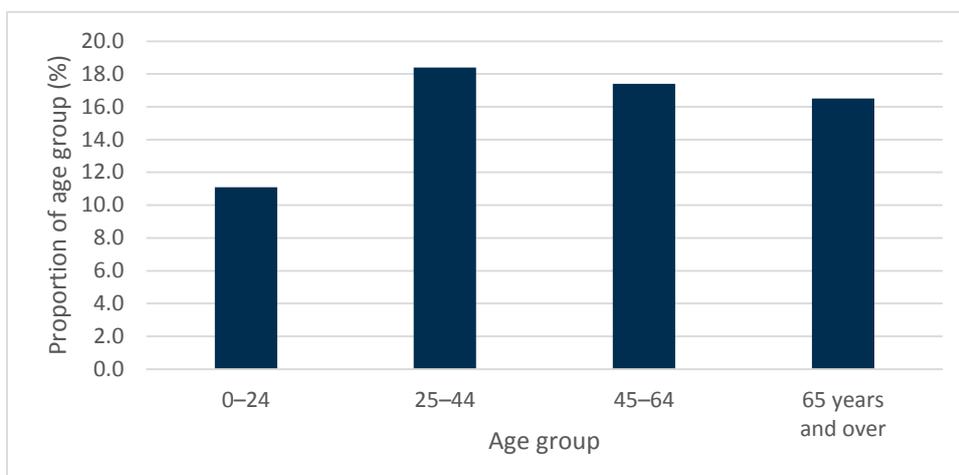
Figure 8.2: Estimated prevalence of mental health and behavioural problems in the ACT by gender



*Estimate has a relative standard error of 25% to 50% and should be used with caution
Source: (Australian Bureau of Statistics, 2012a)

Figure 8.3 outlines prevalence by age, the 25-44 year old age group had the highest prevalence of mental and behavioural health problems (18.4%), followed by 45-64 year olds (17.4%), those over 65 (16.5%) and 0-24 year olds (11.1%).

Figure 8.3: Prevalence of mental health and behavioural problems in the ACT by age group



Source: (Australian Bureau of Statistics, 2012a)

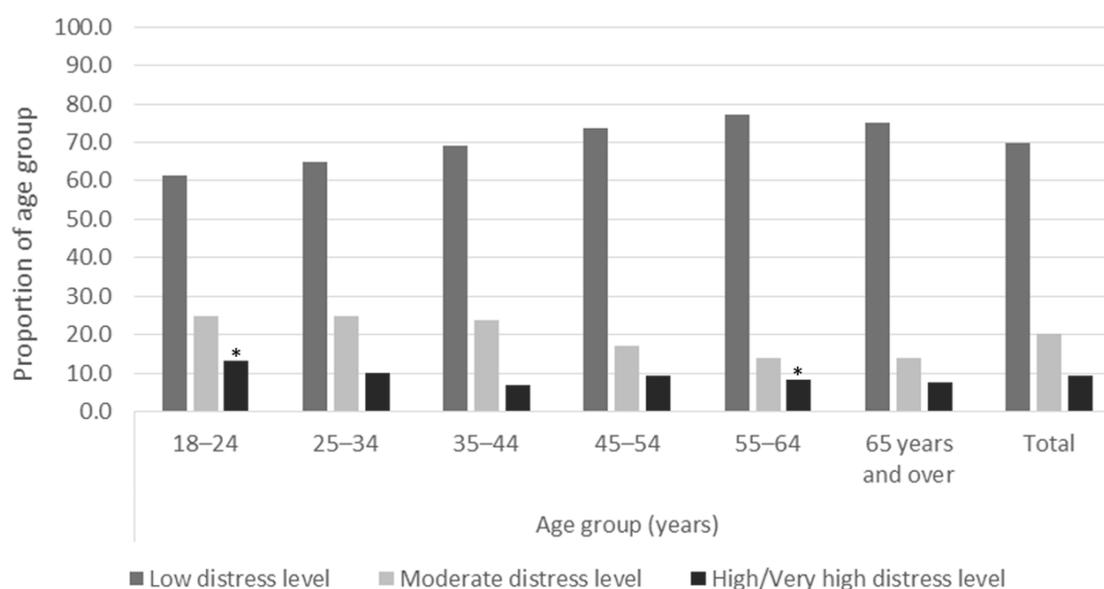
Psychological distress

Data from the Australian Health Survey 2011-12 indicates that the proportion of those with severe psychological distress in the ACT varies by age and gender (Australian Bureau of Statistics, 2012a).

Figure 8.4 outlines levels and rates of psychological distress by age group. Younger adults appeared to have higher levels of psychological distress compared to middle aged and older people.

Specifically, over 10% of individuals in the 18-24 and 25-34 year old age groups were estimated to have high or very high psychological distress, while over 20% of individuals in the 18-24, 25-34 and 35-44 year old age groups experienced moderate levels of distress.

Figure 8.4: Levels of psychological distress by age group in the ACT



*Estimate has a relative standard error of 25% to 50% and should be used with caution

Source: (Australian Bureau of Statistics, 2012a)

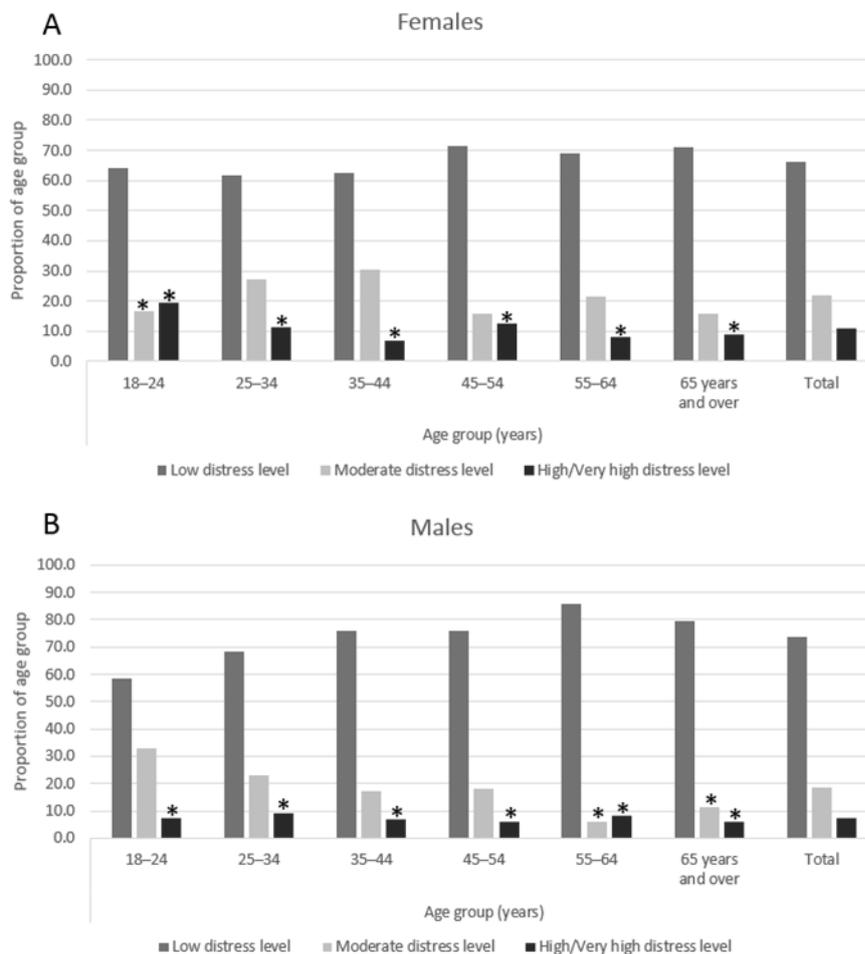
Figure 8.5 outlines levels and rates of psychological distress by gender. Overall, females had a higher level of psychological distress compared to males (Figure 8.5 A and B). High or very high psychological distress was estimated to occur in 11.0% of females compared to 7.2% of males, while moderate distress was estimated to occur in 21.9% of females compared to 18.4% of males.

Females most at risk were those aged 18-24 years, as 19.3% were estimated to experience high or very high psychological distress, and 16.6% were estimated to experience moderate distress (Figure 8.5 A). Additionally, over 10% of females in the 25-34 and 45-54 year old age groups were estimated to experience high or very high psychological distress. Interestingly, the 35-44 year old female age

group had the highest proportion of females experiencing moderate psychological distress, while the lowest proportion of females experiencing high to very high psychological distress.

The proportion of males in each age group experiencing high to very high psychological distress was relatively constant, ranging from 6.0% for 45-54 year olds to 8.9% for 25-34 year olds (Figure 8.5 B). The two most at risk age groups in males were 18-24 year olds and 25-34 year olds, as 40.2% and 31.8% of these age groups respectively experience moderate, high or very high psychological distress.

Figure 8.5: Levels of psychological distress among females (A) and males (B) in the ACT by age



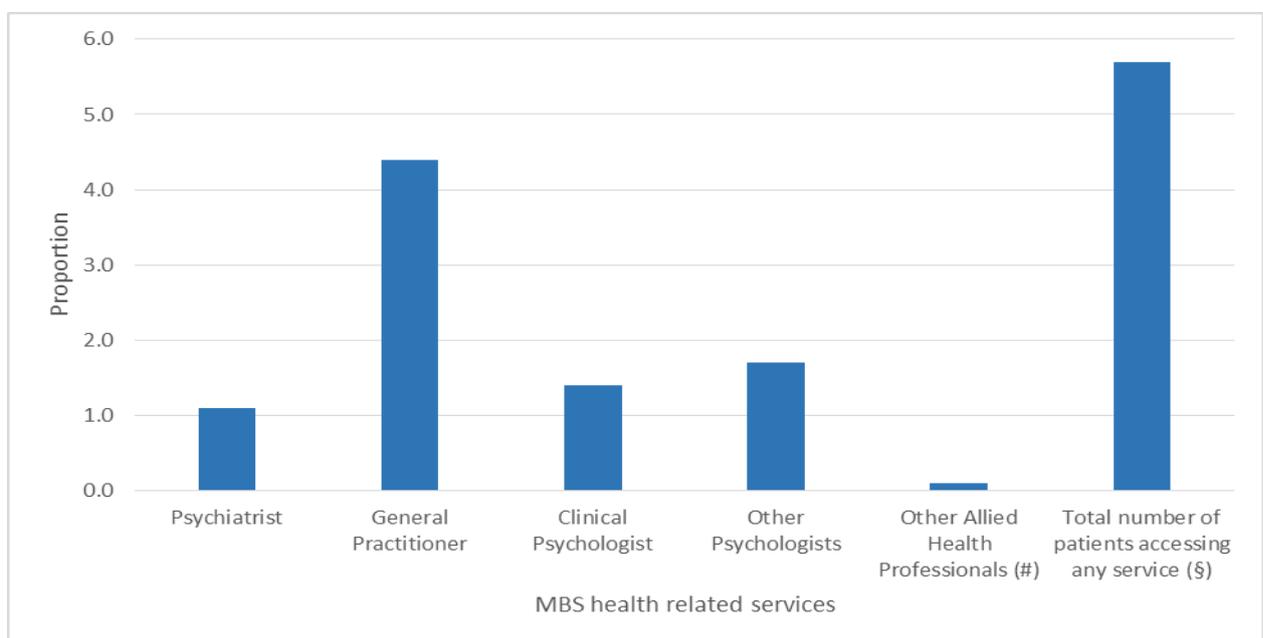
*Estimate has a relative standard error of 25% to 50% and should be used with caution
 Source: (Australian Bureau of Statistics, 2012a)

Rates of contact with primary mental health care

Data available on rates of contact with primary mental health care only provides information about consultations provided through the Medicare Benefits Schedule (Australian Bureau of Statistics,

2014a). The proportion of the ACT population that accessed different forms of mental health related services in 2011 under the MBS subsidy is presented in Figure 8.6. Overall, 5.7% of the ACT population accessed any service subsidised by the MBS. The most common mental health related MBS subsidy was for general practitioner visits, with 4.4% of the population using this service. Following this, 1.7% of the population accessed non-clinical psychologists, 1.4% accessed clinical psychologists, 1.1% accessed psychiatrists and 0.1% accessed other allied health professionals such as mental health nurses, occupational therapists, some social workers, and Aboriginal health workers.

Figure 8.6: Proportion of ACT population accessing MBS subsidised mental health related services, by clinician type



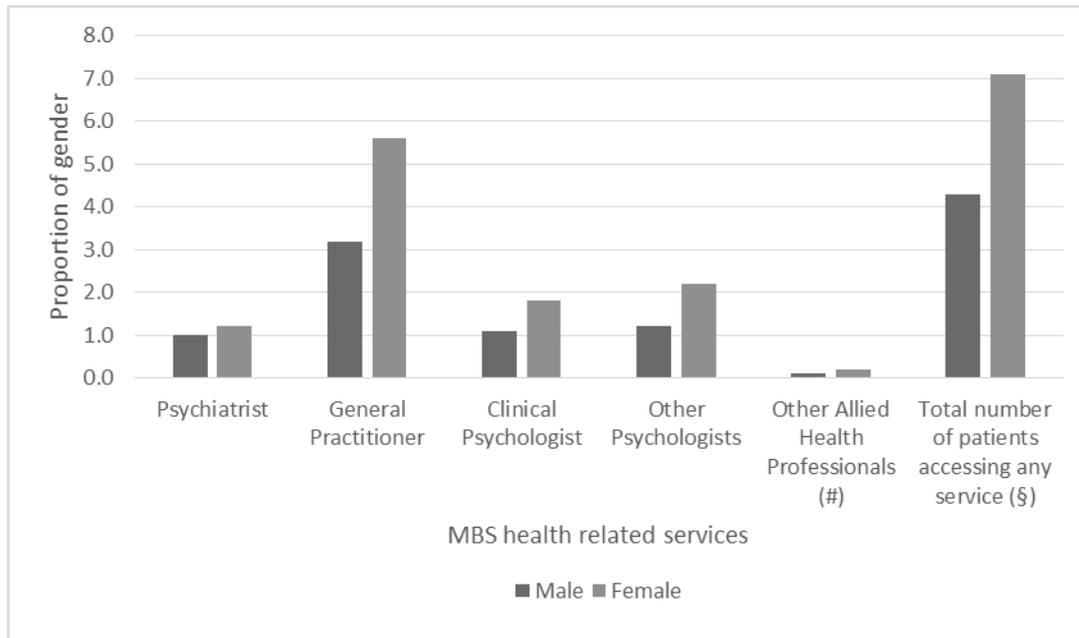
Other Allied Health Professionals include mental health nurses, occupational therapists, social workers and Aboriginal health workers

§ The number of patients accessing each service type may not sum to the total, as a patient may receive more than one type of service. Total includes persons who accessed a single specialist, consultant physician or psychiatrist service over video conference

Source: (Australian Bureau of Statistics, 2014a)

Figure 8.7 breaks down the proportion of MBS subsidised mental health related services in the ACT by gender. Overall, females were 1.65 times more likely to access any MBS subsidised mental health related service compared to males (7.1% of females compared to 4.3% of males). Specifically, females were 1.75 times more likely to visit a general practitioner, 1.63 times as likely to visit a clinical psychologist, and 1.83 times more likely to visit other psychologists compared to males. Females were also 1.2 times more likely to visit psychiatrists and twice as likely to visit other allied health professionals, however the uptake of these services was comparatively small.

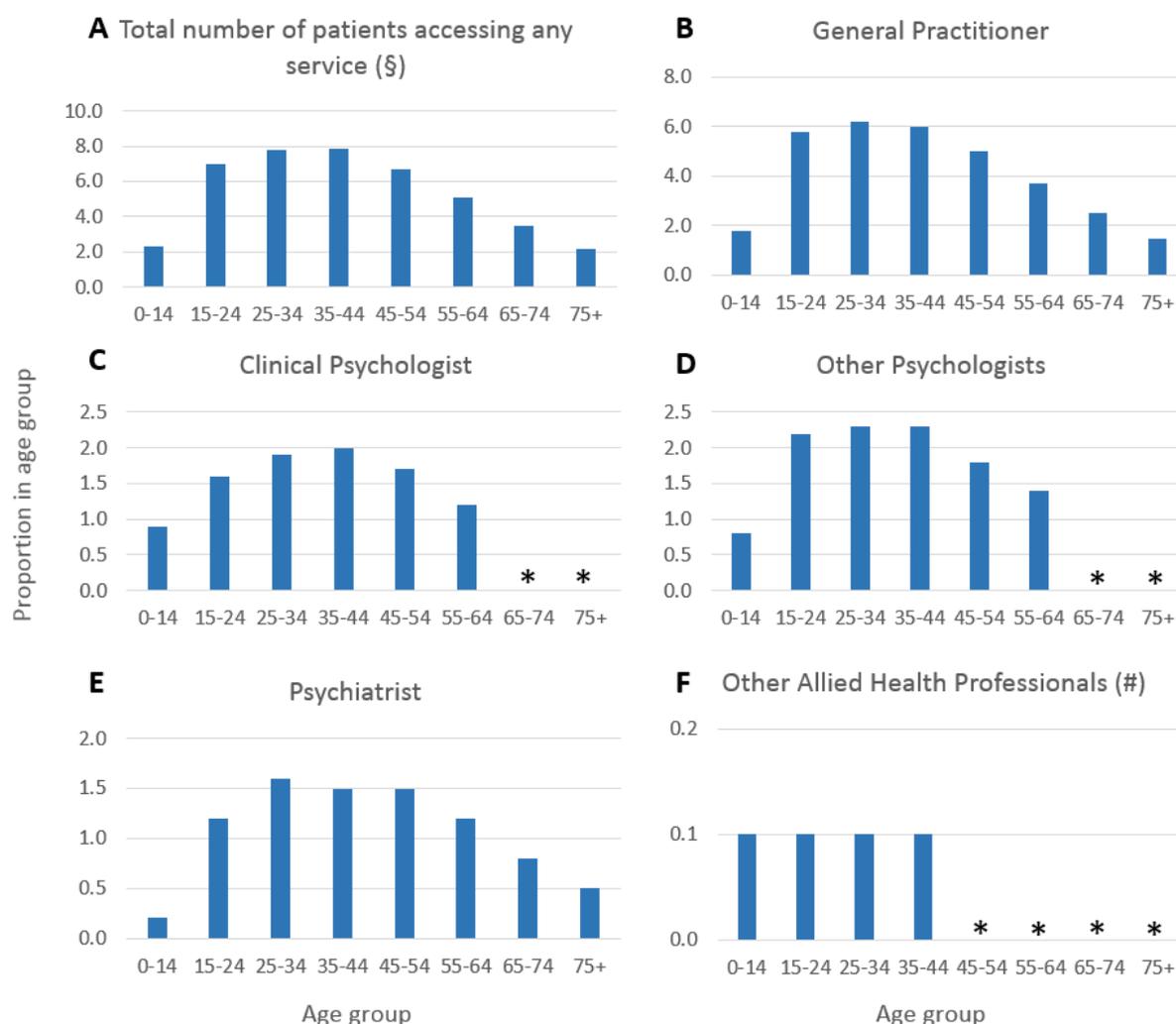
Figure 8.7: Proportion of males and females in the ACT accessing MBS subsidised mental health related services



Source: (Australian Bureau of Statistics, 2014a)

Figure 8.8 A-F depicts the usage of various MBS subsidised mental health-related services in the ACT by age group in 2011. In Figure 8.8 A, the proportion of those in each age group accessing any MBS subsidised mental health service can be seen. Usage of any mental health related service is above 5% in all age groups except those under 14 and above 65. In particular, the 25-34 and 35-44 year old age groups have the highest proportion of people accessing any MBS subsidised mental health related service (7.8% and 7.9% respectively), followed by the 15-24 year old and 45-54 year old age groups (7.0% and 6.7% respectively). Similar trends are evident for usage of general practitioners, clinical psychologists, other psychologists and psychiatrists (Figure 8.8 B-E). The usage of other allied health professionals remains relatively low across the age groups in which data are available (Figure 8.8 F).

Figure 8.8: Usage of MBS subsidised mental health related services in the ACT by age group



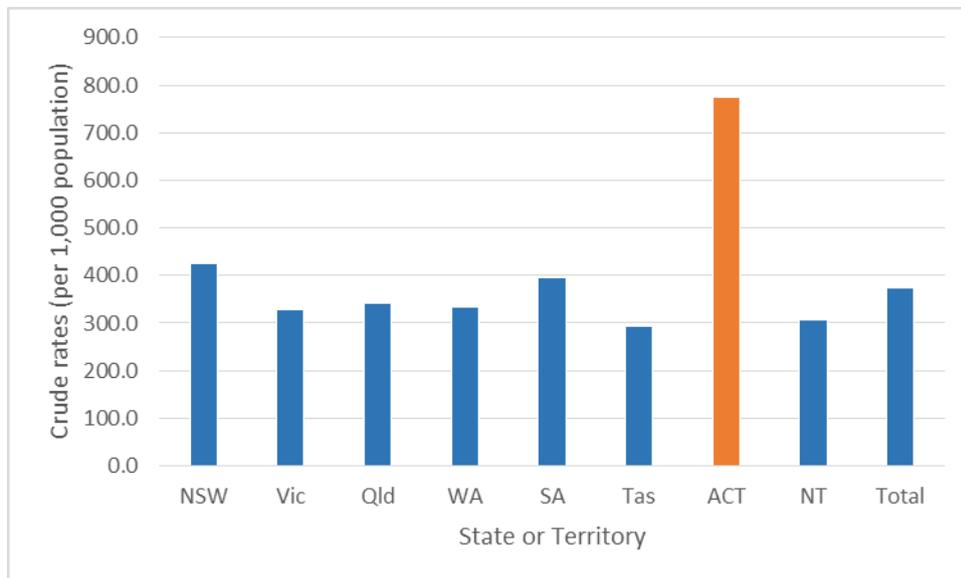
Other allied health professionals such as, mental health nurses, occupational therapists, some social workers, and Aboriginal health workers. § The number of patients accessing each service type may not sum to the total, as a patient may receive more than one type of service. Total includes persons who accessed a single specialist, consultant physician or psychiatrist service over video conference
 Source: (Australian Bureau of Statistics, 2014a)

Contact with community mental health

The ACT has high rates of contact with community mental health services in comparison to other states (Australian Institute of Health and Welfare, 2015e). Figure 8.9 outlines community mental health contact rates by state and territory. In 2013-14, the ACT had the highest crude rate of contacting community mental health care services at 775 persons per 1,000 population. This is almost double every other state and territory. The second highest state, NSW, had a crude rate of 426.1 per 1,000 population, followed by South Australia at a rate of 394.9 per 1,000 population. Importantly, there has been sustained high crude rates of community mental health service contact

in the ACT for several years, with the crude rate in 2009-10 being 719.5 per 1,000 persons compared to 775 per 1,000 persons in 2013-14, an average annual increase of only 1.9% over the time interval.

Figure 8.9: Community mental health care service contacts by state and territory

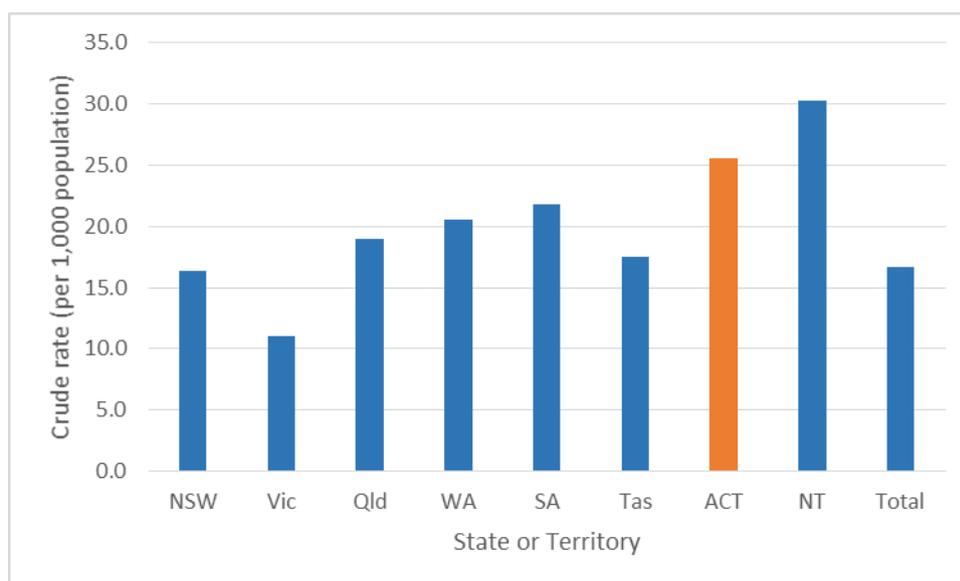


Source: (Australian Institute of Health and Welfare, 2015e)

Further, in 2013-2014 the ACT had a high rate of community mental health care service patients compared to other States and Territories. Figure 8.10 outlines community mental health care service patients by State and Territory. The ACT had the second highest rate of community mental health care service patients in Australia in 2013-2014 (25.6 patients per 1,000 population), only behind the Northern Territory (30.2 patients per 1,000 population). All other states except South Australia (21.8 per 1,000 population) and Western Australia (20.6 per 1,000 population) had a crude rate below 20 patients per 1,000 people. The crude rates of community mental health care service patients in the ACT increased on average by 4.6% per year between 2009-10 and 2013-14.

By dividing the rate of community mental health care service contacts by the rate of patients, the average number of mental health care service contacts per patient was determined for each state or territory in 2013-14. The ACT had the highest average number of community mental health service contact events per patient (30.3), followed by Victoria (29.7) and NSW (26.1). All other states and territories had less than 20 community mental health service contacts per patient. This suggests that the ACT has a reasonably high level of contact with community mental health care patients in their system compared to other states and territories.

Figure 8.10: Community mental health care service patients by state and territory



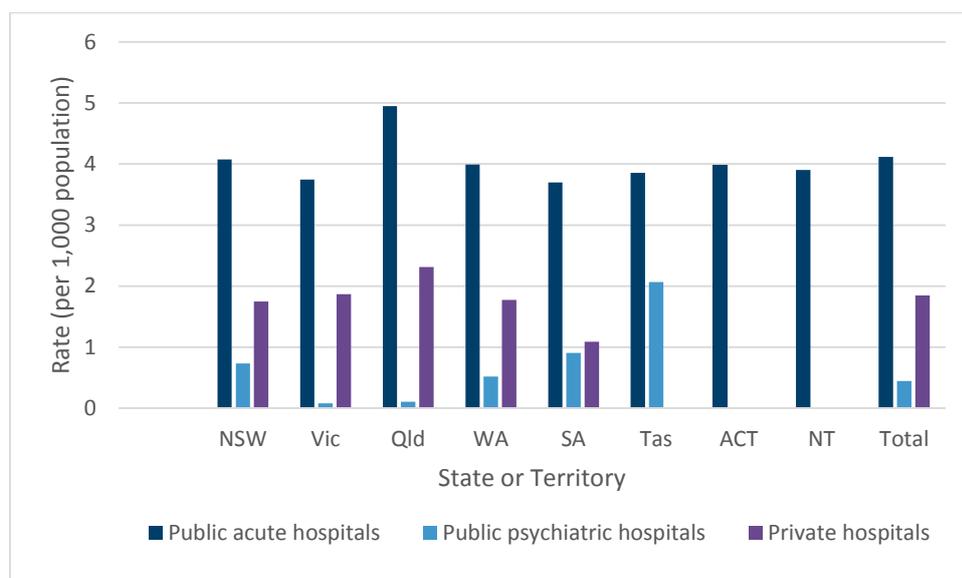
Source: (Australian Institute of Health and Welfare, 2015e)

Contact with tertiary services

In 2012-2013, the rate of admitted mental health-related separations which received specialised psychiatric care in ACT public acute hospitals was 4.0 per 1,000 persons. Figure 8.11 indicates that this rate is similar to all other states and territories except Queensland (4.9 per 1,000 persons). As data were not available for private hospitals in the ACT, it is difficult to ascertain if the rates differ overall. It is worth noting however that all other States and Territories except the Northern Territory and the ACT also have public psychiatric hospitals, which may influence admission to acute public hospitals for mental health events in these states.

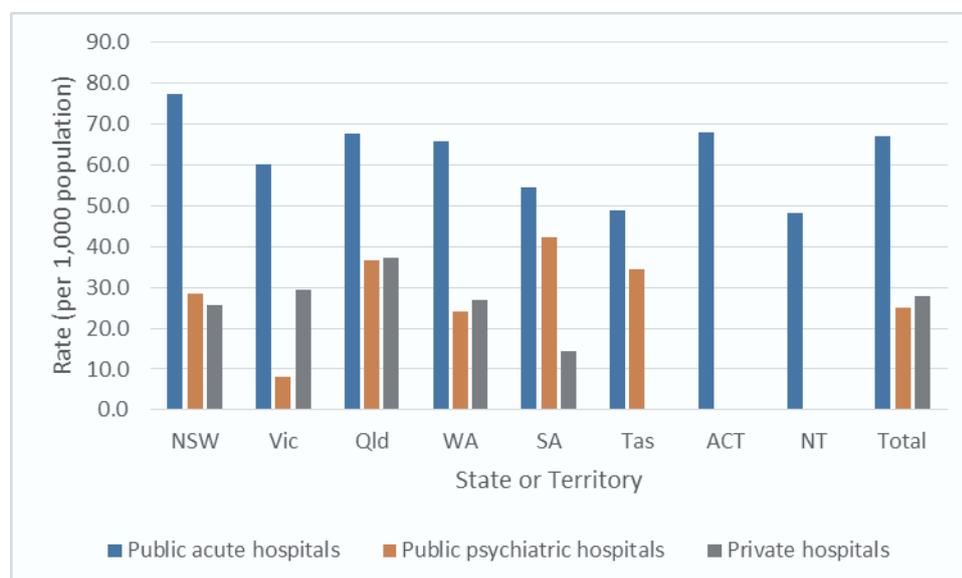
Over the same time interval (2012-2013), the rate of admitted mental health-related patient days for those who received specialised psychiatric care in the ACT public hospital service was 68.2 per 1,000 population, which is reflected in Figure 8.12. When comparing only public hospital patient days, the ACT has a reasonably high rate of patient days compared to other states, with a similar rate to WA (65.8 per 1,000 population) and Queensland (67.7 per 1,000 population). The rate of public hospital patient days in the ACT is below NSW (77.5 per 1,000 population) and above Victoria (60.3 per 1,000 population), South Australia (54.4 per 1,000 population), Tasmania (48.8 per 1,000 population) and the Northern Territory (48.2 per 1,000 population). Importantly, these other States have patients attending public psychiatric hospitals, which may reduce the patient days in acute public hospitals in these States.

Figure 8.11: Age standardised rates of admitted mental health related separations that received specialised psychiatric care by state and territory



Source: (Australian Institute of Health and Welfare, 2015e)

Figure 8.12: Rate of admitted mental health related patient days in patients receiving specialised psychiatric care by state and territory

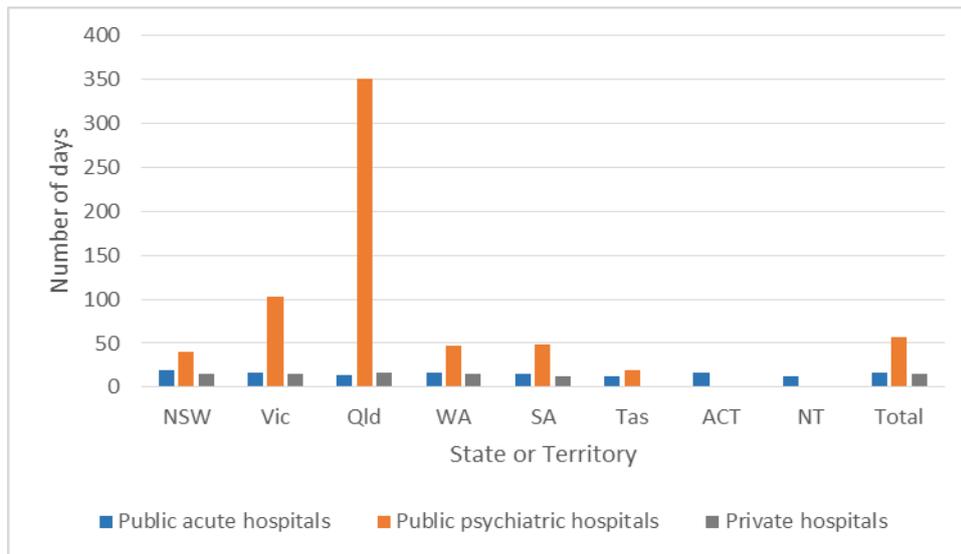


Source: (Australian Institute of Health and Welfare, 2015e)

Average duration of stays are depicted in Figure 8.13. In 2012-2013, the average duration of stay among admitted mental health related separations, which received specialised psychiatric care, in ACT acute public hospitals was 16.9 days. The average length of stay in acute public hospitals in the ACT was similar to Western Australia (16.9 days) and Victoria (16.4 days), and higher than the

average length of stay in acute public hospitals in Queensland (13.7 days), South Australia (15.4 days), Tasmania (12.9 days) and the Northern Territory (12.4 days). Only NSW had a higher average duration of stay in acute public hospitals, at 19.5 days. The average length of stay in acute public hospitals in other States may be lower than in the ACT because these other States have public psychiatric hospitals that are able to provide specialised mental health services.

Figure 8.13: Average length of stay of admitted mental health related separations in those who received specialised psychiatric care by state and territory

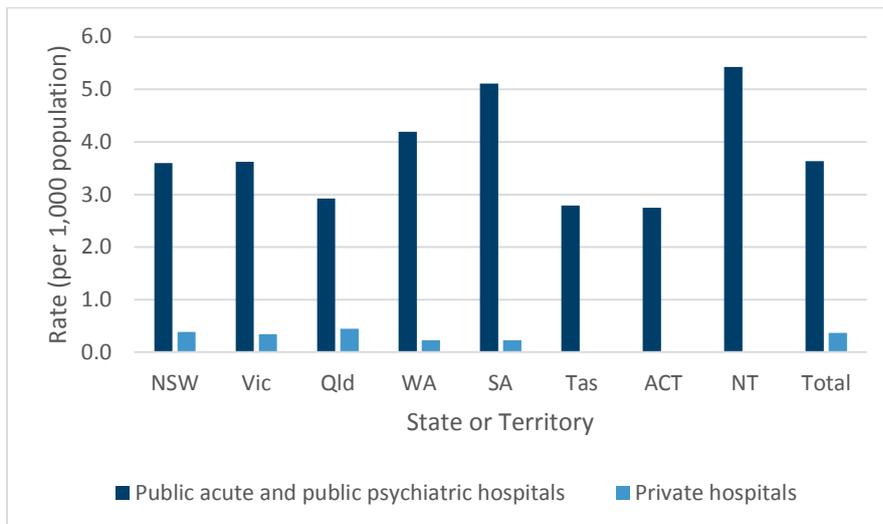


Source: (Australian Institute of Health and Welfare, 2015e)

Rates of patients admitted for mental health related reasons who did not received specialised psychiatric care are detailed in Figure 8.14. In 2012-2013, the rate of admitted mental health-related separations without receiving specialised psychiatric care in the ACT was 2.7 per 1,000 persons. This is below the rate of admitted mental health-related separations that received specialised psychiatric care (4.0 per 1,000 persons). The rate in the ACT is also below any other State or Territory.

In the same year, the rate of admitted mental health related patient days without specialised psychiatric care in the ACT was 17.0 per 1,000 population. This rate is lower than those admitted that received specialised psychiatric care in the ACT (68.2 per 1,000 population). Compared to other states and territories, the rate in the ACT was similar to Western Australia (17.2 per 1,000 population), and below New South Wales (18.2 per 1,000 population), Victoria (18.1 per 1,000 population), South Australia (22.0 per 1,000 population) and the Northern Territory (27.4 per 1,000 population). The rate in the ACT was above Tasmania (12.7 patient days per 1,000 population) and Queensland (12.8 per 1,000 population).

Figure 8.14: Age standardised rate of admitted mental health related separations without specialised psychiatric care by state and territory



Source: (Australian Institute of Health and Welfare, 2015e)

Priority Issues

Through a multi-phased stakeholder engagement process which built off the previous ACT Medicare Local Comprehensive Needs Assessment (ACT Medicare Local, 2014a), key issues were identified in regards to mental health in the ACT. These key issues and potential strategies to address these key issues are explored in detail in this section.

Early intervention in life; in illness; and in episode

Early intervention is the process of providing evidence based intervention and support for a person either early in life, in the development of a mental health condition or in the early stages of an episode. Early intervention promotes more effective recovery, and can reduce the duration of an illness and decrease the negative impact of mental illness on people, families and the community over the course of their life (Western Australian Mental Health Commission, 2012). Prevention and early intervention can also reduce the need for hospitalisation and inpatient facilities.

Stakeholders identified that there were multiple issues in relation to early intervention in life; illness; and episode, including:

- Lack of appropriate, evidence based early intervention and prevention services
- Barriers to accessing early intervention services

Lack of appropriate, evidence based early intervention and prevention services

Stakeholders highlighted the importance of a focus on appropriate, evidence based early intervention and prevention based services for those experiencing mental ill health. In particular, stakeholders highlighted the need for accessible services that focused on providing practical strategies for people early on in their episode of mental ill health. They emphasised the need for services that did not have stigma associated with them, such as online and low intensity self-help services, services not labelled as clinical in nature.

Barriers to accessing early intervention services

Stakeholders identified that there were multiple and often complex issues in relation to access to early intervention and prevention based services. The following issues were most commonly cited in regards to barriers to access:

- Requirement to gain access to a GP for access to mental health services
- Finding a bulk billing GP who is able to focus on and manage the whole needs of the person
- Geographical barriers to accessing services

Access to general practitioners

GPs are ideally placed to identify mental health problems at their early stages, including high prevalence disorders such as anxiety and depression (Rickwood et al., 2007, van Orden et al., 2009). Currently to gain access to a number of mental health services, consumers require a GP referral. However, stakeholders stated that having to gain access to a GP for mental health services can be a significant barrier to gaining treatment early. More specifically, stakeholders cited that people may not be willing to identify or acknowledge their symptoms as a mental health condition and may not feel the need to see a GP. This may result in people seeking help later in an episode, when symptoms worsen, becoming clinically significant. Stakeholders also reported that people with low incomes or other financial barriers to gaining treatment may not be able to afford to see a GP who does not bulk bill.

Geographical barriers to access

For early intervention services to be effective, they need to be easily accessible at the right time (Rickwood et al., 2007). Stakeholders reported that a common barrier to accessing services in the ACT was geographical location. In particular, stakeholders cited that there were a lack early intervention services available in Tuggeranong and Gungahlin, for children, youth and adults.

Stakeholders did acknowledge that there has been an increase in web based early intervention services, however these services are often not accessible for people with financial barriers to gaining treatment.

Strategies

1. *Integration of low intensity psychological interventions model into primary mental health stepped care model*

Primary Health Networks are required to develop a primary mental health stepped care model to better meet regional needs. Through the integration of a low intensity psychological interventions model into the primary mental health stepped care model it is anticipated that low intensity interventions would be more easily accessible, resulting in early intervention and improved clinical outcomes early in an episode.

2. *Integration of new modalities for low intensity psychological interventions*

To ensure that low intensity interventions are as easily accessible as possible to ensure that individuals receive support as early in an episode as possible, the introduction of new modalities of service delivery is recommended. This could include the integration and promotion of free web based low intensity programs, such as MyCompass and the This Way Up Clinic.

3. *Promotion of early intervention services through non-traditional referral pathways*

Early intervention services aim to target people who would not traditionally seek help until their symptoms worsen or become clinically significant. As a result it is proposed that early intervention services, including low intensity interventions, are promoted through non-traditional avenues, including work places, social media, community hubs, and non-mental health related health services, such as allied health based services and medical specialists.

Physical health

There is strong evidence to indicate that people who experience severe mental ill health have poor physical health outcomes (Phelan et al., 2001). This can be attributed to lack of physical care at the right time, as well as psychotropic medication, often leading to chronic diseases such as Type Two Diabetes and Cardiovascular Disease (Phelan et al., 2001).

Stakeholders identified a number of issues in regards to physical health for people experiencing mental ill health:

- Lack of awareness of the physical health outcomes for people experiencing severe mental ill health
- Lack of GPs willing to manage people with mental ill health in the community

Lack of awareness of the physical health outcomes of people with mental health conditions

Stakeholders reported that a high proportion of the workforce working with people with mental ill health have poor awareness of their physical health outcomes, in particular those who experience severe mental ill health. Specifically, stakeholders stated that GPs, mental health clinicians and community workers often focus on the person's mental health condition in isolation of their physical wellbeing. Parks et al. (2006) highlight the importance of physical health, particularly for people with severe mental health conditions who are taking anti-psychotic medications. This can lead to the development of physical health comorbidities such as metabolic disorder, Type 2 Diabetes and other chronic diseases.

Lack of GPs willing to manage people in the community

In addition to the need to improve awareness and understanding about physical health outcomes for people with mental health conditions, stakeholders reported that many GPs are not willing to manage a person with a mental health condition in the community. This could be a result of some GPs feeling that they do not have the confidence or expertise to manage these patients.

Strategies

1. Support for GPs in managing physical comorbidities

GPs see a large range of patients everyday with varied needs, within short consultation time frames. To ensure that mental health consumers' physical health needs are managed, as well as their mental health needs, it is proposed that GPs are supported through education, provision of resources and the integration of clinical care coordination within the primary mental health stepped care model. It is anticipated that this will result in improved management of physical health conditions and in turn, improved physical health outcomes for mental health consumers.

2. Integration of primary mental health care services with multidisciplinary primary health centres

Although research supports the clinical and cost effectiveness of integrating mental health services with primary health care (Durbin et al., 2016), there are currently not many examples of this in the ACT. Through improved integration of mental health services, including clinical

care coordination, it is anticipated that referral pathways between physical and mental health services will be streamlined, consumers will have improved access to GPs and GPs will feel more confident in managing patients with mental health conditions.

Psychological intervention based services for moderate to severe presentations

While there are a range of primary care based mental health services for people with mild to moderate presentations, there are a lack of psychological intervention based services for people with moderate to severe presentations. Stakeholders reported that a large portion of Access to Allied Psychological Services (ATAPS) and Better Access capacity is utilised to work with people with moderate to severe presentations, with this cohort of people often using up to 18 sessions quickly and having no additional service options.

Lack of services focusing on psychological interventions for people with moderate to severe presentations

While there are a number of psychological intervention services targeted at treating people with a diagnosis of a high prevalence, mild to moderate mental health condition, there are a lack of psychological services that are suitable for people with a diagnosis of a low prevalence, moderate to severe mental health condition. Stakeholders highlighted the need for psychological intervention based services to be better targeted at those with moderate to severe presentations. Partners in Recovery (PIR) is a non-clinical care coordination service for people with severe and complex mental illness who are currently not having their needs met. 63% of PIR participants cite uncontrolled symptoms of their mental illness as an unmet need and 57% of PIR participants cite the need for psychological interventions as an unmet need. There is evidence to suggest that focused psychological strategies, including cognitive behavioural interventions, are effective in alleviating symptoms of a moderate to severe mental health condition when delivered in a tailored way (Mueser et al., 2008).

Lack of integration between primary mental health care services and tertiary services

In addition to stakeholders identifying that there is a lack of psychological intervention based services for people with moderate to severe presentations, lack of integration between primary care and tertiary services was highlighted. Stakeholders stated that it is difficult for people with moderate to severe presentations to navigate the mental health system, particularly when they need to be

stepped up from primary care services into tertiary services or conversely when consumers are stepped down from tertiary services or discharged from hospital. The transition from these services is not smooth, with consumers often being left to navigate the system and find services themselves.

Strategies

1. *Development and integration of high intensity psychological interventions into primary mental health stepped care model*

The current primary mental health service system is fragmented in its delivery of psychological interventions along the continuum from mild through to severe mental health conditions. Through the development and integration of a high intensity style model within the primary mental health stepped care model it is anticipated that consumers will be able to better transition between services and the high intensity component will be able to better meet the needs of those with moderate to severe presentations. In the development and integration of a high intensity model there will be improved access to care and a reduction in presentations to secondary and tertiary services.

2. *Integration of primary mental health stepped care model with territory and community services*

Primary mental health services are currently not well integrated with territory and community services in the ACT. This results in difficulties for the consumer in navigating the system and poor client outcomes. Through the integration of primary mental health services with territory and community services it is anticipated that there will improved transition for consumers between services and as a result, improved client outcomes.

3. *Integration of care coordination into stepped care model*

Through the development and integration of clinical and non-clinical care coordination into the primary mental health stepped care model it is anticipated that consumers will experience improved, client centred care from a multidisciplinary team. This will result in improved client outcomes and a reduction in relapse or severity of future episodes.

National Disability Insurance Scheme (Psychosocial Disability)

The commencement of the Psychosocial Disability component of the National Disability Insurance Scheme (NDIS) has resulted in significant changes to the mental health community sector, which provides the majority of psychosocial services in the ACT. Services that have been identified as being in scope for the NDIS have been required to refocus their services to only work with people with

NDIS packages, leaving significant service gaps for those who are NDIS ineligible or who do not wish to transition. Stakeholders identified three areas of concern in regards to the NDIS:

- Uncertainty surrounding system capacity to support people who are not NDIS eligible
- Lack of GP awareness in regards to NDIS and the pre-planning process
- Lack of care coordination of services for people who do not transition to NDIS

Uncertainty surrounding system capacity to support people who are not NDIS eligible

The Psychosocial Disability component of the NDIS does not become a full scheme in the ACT until July 2016. Until this point individuals become eligible in phases, dependent on their date of birth. This means that a significant number of people with severe and complex mental illness who may be eligible for NDIS have not gone through the NDIS eligibility testing process and have not received packages. Stakeholders in the mental health community sector stated that due to this transition period there was a significant amount of uncertainty in regards to sector capacity to support individuals who are not NDIS eligible. Stakeholders specifically stated that housing and accommodation style support services would not be easily accessible for people who are NDIS ineligible and are becoming increasingly inaccessible to those who are NDIS eligible, but have not yet received a package.

Lack of GP awareness in regards to the NDIS and the pre-planning process

Stakeholders in the mental health community sector and mental health consumers stated that there is a lack of GP awareness in regards to the NDIS and the pre-planning process. GPs are often required to provide reports, evidence of a diagnosis or supplementary evidence for patients who are applying for an NDIS package. Stakeholders reported that GPs often do not know what is required of them or do not have the time available to produce a report or supplementary evidence within a short timeframe.

Lack of care coordination services for people who do not transition to the NDIS

As a result of Partners in Recovery and the Personal Helpers and Mentors Scheme being identified as in scope for NDIS, stakeholders cited significant concerns in regards to non-clinical care coordination services for people who do not transition to the NDIS. Stakeholders are concerned that there will be no services for this cohort of people.

Strategies

- 1. Advice for GPs in regards to transition patients to the NDIS, including provision of resources*
GPs require support and advice in regards to transitioning patients to the NDIS, particularly in regards to documentation required to assist individuals in the eligibility testing and planning phases. It is anticipated that this will result in an improved understanding of the NDIS transition process.
- 2. Development and integration of care coordination services into primary mental health stepped care model for consumers who are ineligible for the NDIS*
Through the development and integration of non-clinical care coordination services for consumers who are ineligible for the NDIS, it is anticipated that consumers will have improved access to services they require to aid in their recovery, including community sector services and clinical services. It is anticipated that this will result in improved outcomes for consumers.

Vulnerable populations

Evidence suggests that vulnerable groups experience higher rates of mental ill health (Steel et al., 2002, Fazel et al., 2005, Willging et al., 2006). Stakeholders identified a range of needs for vulnerable populations in the ACT.

Lack of specialist multidisciplinary services for transgender population

Stakeholders stated that there are a lack of specialist services for transgender people. In particular stakeholders cited the need for suitably trained mental health professionals and local access to multidisciplinary services for transgender health. Evidence suggests that patient centred, multidisciplinary health teams for transgender people result in improved access to services and improved physical and mental health outcomes (Reisner et al., 2015).

Barriers to accessing services for people who are homeless or at risk of homelessness

There is a substantial body of evidence that suggests that homeless people are more likely to experience mental illness than those whose accommodation needs are met (Homelessness Taskforce, 2008). The Australian Institute of Health and Welfare (AIHW) (2011b) completed a review of studies looking at the prevalence of mental illness among homeless populations. While estimates varied considerably amongst studies, AIHW highlighted a review that found that 31% of homeless people experienced a mental health problem, with 47% experienced mental health issues prior to becoming homeless.

Stakeholders highlighted the need for improved accessibility and provision of mental health services for people who are at risk of homelessness or who are homeless. They highlighted the importance of these services including psychological interventions and psychosocial based support services. Mental health community sector service providers in particular stated that services needed to be based in geographically accessible locations, needed to be flexible to meet the needs of the individual and needed to be free of charge.

Lack of trauma informed care

Many people from culturally and linguistically diverse and refugee backgrounds have experienced torture, trauma, loss and upheaval before coming to Australia. Experiences such as these can result in significant psychological distress and vulnerability to mental illness (Mindframe, 2014). In a study looking at the prevalence of severe mental health conditions in refugees resettling in western countries (Fazel et al., 2005), it was found that refugees could be about ten times more likely to have Post Traumatic Stress Disorder than age matched populations in their country of resettlement. Another study looking at the prevalence of severe mental health conditions in the Vietnamese refugee community in Australia identified that of those who experienced significant trauma experienced more severe, longer term mental health conditions (Steel et al., 2002). Stakeholders from the mental health community sector, GPs and mental health consumers highlighted the lack of trauma informed care in the ACT. In particular, they stated that there is a lack of mental health services in the ACT that deliver trauma informed care, including Access to Allied Psychological Services (ATAPS) and Better Access providers.

Access barriers for Aboriginal and Torres Strait Islander People

The AIHW Health and Welfare of Australia's Aboriginal and Torres Strait Islander People Report (2011d) highlights that while the majority of Aboriginal and Torres Strait Islander people reported feelings of positive wellbeing, nearly one third felt high or very high levels of psychological distress, more than twice the rate for non-Indigenous Australians. While strategies have been introduced to address access barriers to mental health services for Aboriginal and Torres Strait Islander People, such as Aboriginal and Torres Strait Islander ATAPS, according to stakeholders, access barriers still remain. Mental health community sector stakeholders highlighted the need for services to be culturally appropriate, accessible and flexible.

Strategies

1. *Facilitation of training for mental health clinicians in trauma informed care for primary mental health stepped care workforce*

Through the facilitation of training in trauma informed care it is anticipated that there will be improved service provision for consumers who have experienced trauma.

2. *Continued and extended provision of primary mental health services for people with financial barriers to gaining treatment*

Through the continued and extended provision of primary mental health services for people with financial barriers to gaining treatment it is anticipated that there will be increased access to affordable mental health services in the ACT for those with financial barriers to gaining treatment.

3. *Facilitation of training in working with culturally and linguistically diverse groups for primary mental health stepped care service workforce*

Through the facilitation of training in working with culturally and linguistically diverse groups it is anticipated that there will be improved, culturally appropriate service provision for people from culturally and linguistically diverse backgrounds.

4. *Facilitation of training in working with Aboriginal and Torres Strait Islander People for primary mental health stepped care service workforce*

Through the facilitation of training in working with Aboriginal and Torres Strait Islander People it is anticipated that there will be improved, culturally appropriate service provision for this population.

5. *Development and integration of culturally appropriate psychological interventions, for Aboriginal and Torres Strait Islander People, into the primary mental health stepped care model*

In addition to the facilitation of training in working with Aboriginal and Torres Strait Islander People, it is vital that the interventions utilised within the primary mental health stepped care model are culturally appropriate. It is anticipated that this will result in improved service provision and clinical outcomes for Aboriginal and Torres Strait Islander clients.

Suicide prevention

In 2014, 38 people in the ACT died by suicide, with a rate of 9.2 per 100,000 population over a five year period (2010-2014), while this is lower than the national average, the rate of deaths as a result of suicide over the last decade has remained constant, without any significant reduction in rates (Australian Bureau of Statistics, 2016b).

A systems approach to suicide prevention highlights the importance of a multilevel, multifactorial approach, involving primary care, the community sector, and government agencies (Black Dog Institute, 2015). This recognises that suicide can be the result of many risk factors and has many points where intervention can occur. Stakeholders identified a number of issues in regards to suicide prevention, including:

- Lack of community based support services for people discharged from hospital following a suicide attempt
- Lack of primary mental health care services for people with suicidal ideation
- Access barriers to existing primary mental health care services

Lack of community based support services for people discharged from hospital following a suicide attempt

Research indicates that the period immediately after discharge from psychiatric inpatient care following a suicide attempt is an extremely high risk period for death by suicide. Lack of follow-up post discharge is associated with a significant increased risk of suicide attempts and death by suicide (NHMRC Centre of Research Excellence in Suicide Prevention, 2015).

Stakeholders, including GPs, mental health clinicians, the mental health community sector, carers and mental health consumers, stated that currently there are no post-vention services in the ACT to provide follow-up aftercare following discharge from hospital.

Lack of primary mental health care services for people with suicidal ideation

A systems approach to suicide prevention also highlights the importance of primary care based psychological intervention services in treating suicidal ideation and reducing risk (Black Dog Institute, 2015). While there is currently the ATAPS Suicide Prevention Service in the ACT, stakeholders highlighted the need for increased access to psychological interventions based services.

Access barriers to existing primary mental health care services

In addition to the need for increased access to primary mental health care services targeted at suicide prevention, stakeholders, particularly carers, consumers and the mental health community

sector, reported that there were significant access barriers to existing primary mental health care services. Stakeholders stated that limited referral pathways into existing services made it difficult for individuals to seek help. Currently referrals are accepted from only GPs, clinicians working in the Crisis Assessment and Treatment Team (CATT) and clinicians working in the Mental Health Assessment Unit (MHAU). This results in significant access barriers for those who are at immediate risk of self-harm and for those who may not be able to afford to see a GP.

Strategies

- 1. Development and implementation of suicide prevention service, for youth and adults, with open referral pathways*

Through the development and implementation of a suicide prevention service that is consistent with the systems approach to suicide prevention, it is anticipated that there will be improved, timely access to suicide prevention services.

Peer participation

Lack of meaningful peer participation in service development, implementation, delivery and evaluation

People with lived experience of mental illness offer perspectives that enrich how services are delivered. Stakeholders stated that while a number of peer workforce training initiatives have been funded and completed in the ACT, there is a lack of peer participation in the mental health community sector and in primary mental health. Stakeholders highlighted the need for peer participation in all phases of the primary mental health reform commissioning process in the ACT.

Strategies

- 1. Development of a Consumer Engagement Framework, including involvement of consumers in each stage of the commissioning process*

Through the development of a Consumer Engagement Framework it is anticipated that there will be increased involvement of mental health consumers in the primary mental health commissioning process.

- 2. Implementation of peer support role in primary mental health stepped care model*

Through the implementation of a peer support roles in the primary mental health stepped care model it is anticipated that there will be increased peer worker involvement in service delivery.

9. Alcohol and Other Drugs

Overview

People in the ACT region currently need increased options for access to specialist Alcohol and Other Drugs (AOD) services that provide treatment and support of sufficient duration and intensity.

CHN commissioned the Alcohol Tobacco and Other Drug Association ACT (ATODA), the peak body for the alcohol, tobacco and other drug sector in the ACT, to provide expert independent advice on AOD needs in the ACT. This chapter is an edited summary of the ATODA report which is provided as a separate document to accompany this BNA (ATODA, 2016b). As part of the process, ATODA engaged with all ACT specialist AOD treatment services funded by the ACT and/or Australian Government health departments and worked with ACT Health.

AOD use and treatment in the ACT

According to the latest National Drug Strategy Household Survey (NDSHS), the use of AOD in the ACT is consistent with patterns of use in Australia generally (Table 9.1). Table 9.2 presents data for AOD use among Aboriginal and Torres Strait Islander people in Australia. Because of the relatively small size of the Aboriginal and Torres Strait Islander population in the ACT, AOD use data reported in national surveys has a high margin of error. However, the proportions in the ACT are likely to be similar to the national data presented below.

Within the population, use of AOD occurs across a spectrum of levels of use and degrees of associated health and social harms. Some people represented in the data in Table 9.1 and Table 9.2 are one-off, occasional and/or episodic users of AOD, while others are regular and dependent users of AOD. Only a small proportion of people who use AOD are impacted by significant levels of AOD-related harms, with some being impacted by multiple and complex health and social harms. Importantly, the data presented in Table 9.1 and Table 9.2 does not specify the level of AOD use or the degree or severity of dependence, and thus does not reflect the degree of harm or service-need for individuals using AOD.

Table 9.1: Summary of recent drug use^(a), people aged 14 years or older, ACT and Australia, 2013

Drug	ACT (%)	Australia (%)
Current smoker	12.2	15.8
Recent drinker	82.6	78.2
Illicit (excluding pharmaceuticals)		
Cannabis	10.1	10.2
Ecstasy	2.9	2.5
Meth/amphetamine ^(b)	2.2	2.1
Cocaine	2.8	2.1
Hallucinogens	*1.7	1.3
Inhalants	*1.1	0.8
Heroin	**0.3	0.1
Ketamine	**0.2	0.3
GHB	—	*<0.1
Synthetic Cannabinoids	*0.8	1.2
New and Emerging Psychoactive Substances	**0.5	0.4
Injected drugs	**0.2	0.3
Any illicit ^(c) excluding pharmaceuticals	12.4	12.0
Pharmaceuticals		
Pain-killers/analgesics ^(b)	2.8	3.3
Tranquillisers/sleeping pills ^(b)	1.6	1.6
Steroids ^(b)	—	*0.1
Methadone ^(d) or Buprenorphine	—	0.2
Other opiates/opioids ^(b)	**0.4	0.4
Misuse of any pharmaceutical ^(b)	4.2	4.7
Illicit use of any drug ^(e)	15.3	15.0
None of the above	15.3	18.5

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

(a) Used in the previous 12 months. For tobacco and alcohol, recent/current use means daily, weekly and less than weekly smokers and drinkers; (b) For non-medical purposes; (c) Illicit use of at least 1 of 12 drugs (excluding pharmaceuticals) in the previous 12 months in 2013; (d) Non-maintenance; (e) Used at least 1 of 17 illicit in the previous 12 months in 2013.

Source: (Australian Institute of Health and Welfare, 2014f)

Table 9.2: Summary of recent drug use, Australian Aboriginal and Torres Strait Islander people aged 15 years or older, Australia, 2013 (%)

Drug	Australia ^(a) (%)
Current smoker ^(b)	41.6
Recent drinker ^(c)	44.3
Illicit (excluding pharmaceuticals)	
Marijuana, hashish or cannabis resin	18.7
Amphetamines or speed	2.3
Kava	1.3
Other ^(d)	2.8
Pharmaceuticals	
Analgesics and sedatives for non-medical use	3.9

(a) Presented as a proportion of survey respondents; (b) Current use means daily, weekly and less than weekly smokers and drinkers; (c) Consumed alcohol in the last week; (d) Includes heroin, cocaine, petrol, LSD/synthetic hallucinogens, naturally occurring hallucinogens, ecstasy/designer drugs, methadone and other inhalants

Source: (Australian Bureau of Statistics, 2013a)

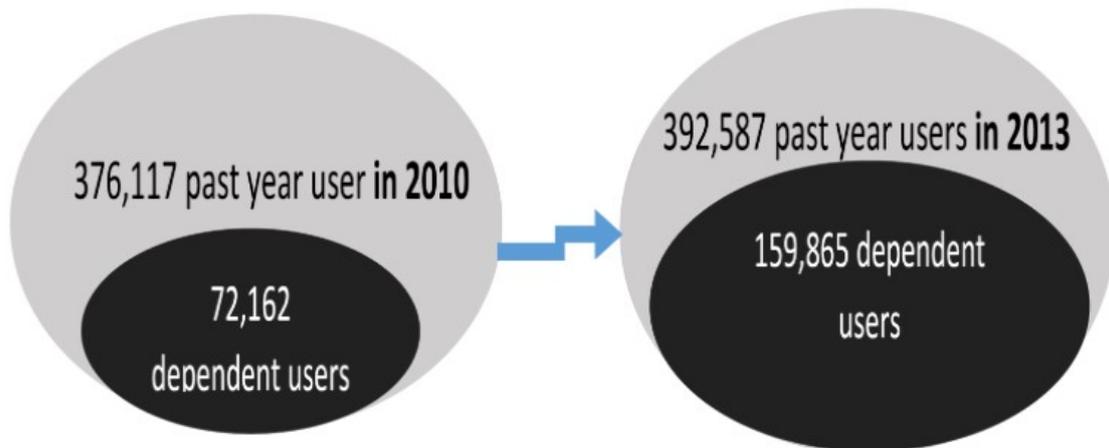
Prevalence of high-risk and dependent AOD use

Australia-wide there has been a long-term trend toward lower prevalence of illicit drug use. Although per-capita alcohol consumption is decreasing, the incidence of alcohol-related harms is increasing (Livingston, 2013). In contrast to most of the other illicit drugs, the prevalence of methamphetamine use is increasing, as are the proportion of people who use methamphetamine who are dependent, and the levels of methamphetamine-related harms generally (Degenhardt et al., 2016, Lai et al., 2016).

While there has been a trend towards lower prevalence of illicit drug use in the population generally, there has been an increase in the prevalence of *dependent* users of illicit drugs. This prevalence has been estimated specifically in relation to methamphetamine use in Australia between 2010 and 2013 (see Figure 9.1). This shows that 19% of people using methamphetamine in 2010 were classified as 'dependent users', and that this increased to 41% in 2013. Figure 9.1 shows that, nationally, the proportions of dependent users of methamphetamines has more than doubled (Dietze, 2016). There has consequently also been a corresponding increase in the potential demand for specialist AOD treatment and support services associated just with methamphetamine use (i.e. this demand has more than doubled in the three-year period, 2010–2013). This trend toward increased demand for specialist AOD treatment and support services associated with amphetamine use is consistent with observations in the ACT.

Projected models have identified an additional 200,000 to 500,000 people Australia-wide who need and would seek AOD treatment (over and above the 200,000 already in treatment) per year (Ritter et al., 2014). While this data is not specifically available for the ACT, the consistency in overall AOD use between the ACT and Australia-wide would suggest a similar increase in dependent users of AOD in the ACT and corresponding increases in demand for specialist AOD treatment and support services.

Figure 9.1: Changes in the proportions of people who are dependent on methamphetamine over 3 years, in Australia



Sources: Graphic from Dietze (2016); data of 'past year users' figures derived from the NDSHS and ABS population estimates for the most recent year; 'dependent users' estimates based on Degenhardt et al. (2016).

Profile of people accessing ACT specialist AOD services

In December 2015, a total of 469 people completed the most recent Service Users' Satisfaction and Outcomes Survey (SUSOS), and provided a snapshot profile of people who accessed all ten specialist AOD treatment and support services in the ACT on a single day (both Aboriginal and Torres Strait Islander-specific and mainstream services) (ATODA, 2016a). This profile is shown in Table 9.3.

Notable in this data is that:

- Two-thirds of the treatment population are male (65.8%).
- Most (73.9%) are in the 20–49 year old age bracket.
- Most (73.5%) are unemployed.
- About 46% of respondents are either homeless or at risk of homelessness, including 18.6% who have no fixed place to live.
- 38% have children.⁶

This data is consistent with that reported in the 2013-14 ACT Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS), which reports males as making up 67% of clients who were receiving treatment for their own drug use in specialist AOD treatment and support services in the ACT (Australian Institute of Health and Welfare, 2015b).

⁶ Including respondents who were parents in both categories, i.e. parents who had 'children living with them' and 'children not living with them'.

Table 9.3: Profile of people accessing specialist AOD treatment and support services in the ACT on a single day (December 2015)

Item	Proportion of respondents*
Gender	
Male	65.8
Female	34.0
Age groups	
Under 20 years old	10.1
20 – 49 years old	73.9
Over 50 years old	15.9
Aboriginal and/or Torres Strait Islander descent	
Accessing all specialist AOD services	25.1
Accessing mainstream AOD services	19.4
Current employment status	
Employed full-time	11.9
Employed part-time	8.7
Unemployed	73.5
Volunteer or unpaid work	5.8
Currently studying	
Yes, full time	5.0
Yes, part time	11.2
No	83.8
Current housing situation	
Settled/permanent accommodation	54.4
Residential treatment program	15.9
Other temporary accommodation	11.1
No fixed place of living	18.6
Parent	
Children living with them	17.1
Children not living with them	27.4

* Proportions of respondents who answered each question (i.e. missing responses are excluded)

Source: (ATODA, 2016a)

Profile of Aboriginal and Torres Strait Islander people accessing ACT specialist AOD services

Aboriginal and Torres Strait Islander people are a sub-set of the SUSOS data reported in Table 9.3, and so several aspects of the demographic profile are likely to be similar for this sub-population.⁷

⁷ An example of where the demographic profiles may be dissimilar is for 'age'. As the age profile of the Aboriginal and Torres Strait Islander population is younger than the general Australian population, the profile of Aboriginal and Torres Strait Islander people utilising specialist AOD treatment and support services is also likely to be younger.

According to the ACT AODTS-NMDS in 2013-2014, 12% of AOD treatment episodes in the ACT were delivered to Aboriginal and Torres Strait Islander people (ACT Health AOD Policy Unit, 2016). A comparison of data from the AODTS-NMDS and the SUSOS, clearly shows the likely level of under-reporting of Aboriginal and Torres Strait Islander status in the AODTS-NMDS. As shown in Table 9.3, the SUSOS (2015) found that 25.1% of clients of all ACT AOD treatment and support services reported being of Aboriginal and/or Torres Strait Islander descent. When only considering mainstream AOD treatment and support services, 19.4% of clients reported being of Aboriginal and Torres Strait Islander descent.

Complex needs of people accessing ACT specialist AOD treatment and support services

Within the ACT and Australian AOD sector, the needs of existing clients are a necessary focus due to the significant and multiple burdens of harm experienced. These may include:

- Overdose
- Various physical health problems, including blood borne virus infection (especially hepatitis C)
- Accidents and injury
- Mental health problems, particularly anxiety and depression
- Family relationship difficulties, including with children
- Financial problems
- Cognitive impairment
- Homelessness
- Un- or under-employment
- Involvement in the criminal justice system
- Contact with the child protection system
- Being a victim and/or perpetrator of crime

People accessing specialist AOD services generally have multiple and complex needs over and above their AOD use. The profile in Table 9.3, for example, shows that issues such as unemployment, homelessness, and parental relationships are applicable for many clients of AOD services, and add complexity to the support that clients require. Some of these needs can be directly dealt with in the context of the specialist AOD treatment services, but many require referral to, or support from, social/welfare services or other types of services (e.g. dental services, legal services).

The burdens of harm and needs of people accessing specialist AOD treatment and support services can change significantly with changes in drug use trends. So for example, harms from overdose and blood borne virus infection may be of greater concern when opioids are the drugs of choice, while

cognitive impairment may be of greater concern when methamphetamines are more frequently used. When resourced appropriately, specialist AOD treatment and support services have shown they have the capacity to adapt existing treatment approaches and respond to these changing trends in drug use and drug-related harms (ATODA, 2015c).

It should be noted that while these AOD-related harms affect all people accessing specialist AOD services, it is well recognised that Aboriginal and Torres Strait Islander people experience a disproportionate burden of multiple and complex AOD-related harms. This has implications for resourcing directed towards Aboriginal and Torres Strait Islander people currently using and who may want to use specialist AOD treatment and support services (Gomez et al., 2014).

While there are complex and competing burdens of harm experienced by people accessing specialist AOD treatment and support services, there are a number of clear priority needs that affect people across the entire sector, regardless of the treatment type that they are accessing. These priority needs are:

- Hepatitis C in particular, but also other blood borne viruses
- Opioid-related overdose
- Specific harms related to methamphetamine use

Specialist AOD services in the ACT

In the ACT there are 10 publicly- funded (ACT Health and/or Australian Government Department of Health) specialist AOD services that deliver more than 30 programs, these are:

- Alcohol and Drug Services, ACT Health
- Canberra Alliance for Harm Minimisation and Advocacy
- Canberra Recovery Services (The Salvation Army)
- Directions
- Gugan Gulwan Youth Aboriginal Corporation
- Karralika Programs
- Sobering Up Shelter, CatholicCare
- Ted Noffs Foundation
- Toora Women
- Winnunga Nimmityjah Aboriginal Health Service

These services collaborate to generate a six monthly profile and service map that is publicly available at www.directory.atoda.org.au.

Specialist AOD services in the ACT for Aboriginal and Torres Strait Islander people

In the ACT, Aboriginal and Torres Strait Islander people who use AOD can access specialist AOD treatment and support through Aboriginal and Torres Strait Islander-specific (including community-controlled) organisations and programs, as well as through mainstream services.

In the ACT there are four non-government services or programs that deliver (or are soon to deliver) specialist AOD treatment and support types specifically for Aboriginal and Torres Strait Islander people. Other than the Ngunnawal Bush Healing Farm that is currently in development, this list of Aboriginal and Torres Strait Islander services has been compiled from information in the ACT ATOD Services Directory; further information about each of these services is available at www.directory.atoda.org.au. The associated National Minimum Data Set treatment types that correspond with each component are listed in parenthesis.

1. Aboriginal Community Controlled Health Organisation (ACCHO) or Aboriginal Medical Service (AMS) that provides primary health care but also provides some specialist AOD services for Aboriginal and Torres Strait Islander people (Winnunga Nimmityjah Aboriginal Health Service) (pharmacotherapy, information and education, support and case management).
2. Youth Aboriginal Community Controlled organisation but also provides some specialist non-clinical AOD services for Aboriginal and Torres Strait Islander people (Gugan Gulwan Youth Aboriginal Corporation) (information and education, support and case management).
3. Aboriginal Community Controlled Health Organisation (ACCHO) lead agency in partnership with a mainstream specialist AOD treatment service (model of care, including the possible partnership approach, under development – Ngunnawal Bush Healing Farm)⁸ (residential rehabilitation).
4. Mainstream specialist non-government drug service that is controlled by consumers—people who use/have used drugs—and provides non-clinical services (The Connection) (information and education, support and case management).

Furthermore, the ACT Government specialist AOD treatment service (Alcohol and Drug Services, ACT Health) employs an Aboriginal Liaison Officer who provides non-clinical support to Aboriginal and Torres Strait Islander clients, including assisting with case management, support, referral,

⁸ This is the proposed model from ACT Health for the Ngunnawal Bush Healing Farm.

advocacy, and negotiating and developing appropriate and achievable AOD treatment plans (ACT Health, 2016e).

AOD specialist workforce

The specialist AOD workforce in the ACT is mapped and profiled through the *ACT Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile*. This profile is undertaken regularly and is used to monitor trends in the ACT AOD workforce. The most recent profile (2014) has estimated an ACT specialist alcohol, tobacco and other drug workforce of 245 workers. Aboriginal and Torres Strait Islander people make up approximately 5% of this workforce, with most of these workers based at Aboriginal and Torres Strait Islander community controlled services, and employed in non-clinical positions (ATODA, 2015a).

Two mainstream agencies have identified Aboriginal and Torres Strait Islander (non-clinical) positions⁹, but the remaining mainstream specialist AOD services do not have specifically identified positions, and do not currently receive Aboriginal and Torres Strait Islander specific AOD treatment funding. However, they do deliver AOD treatment types for Aboriginal and Torres Strait Islander people who access their services.

The ACT has the following treatment services:

- Information and education
- Assessment only
- Withdrawal management
- Rehabilitation
- Counselling
- Pharmacotherapy
- Support and case management

However, the extent to which they are available, and the sub-populations to which they are available varies.

Service usage

Using data from the Service Users' Satisfaction and Outcomes Survey (SUSOS), it is estimated that 400–500 people access specialist AOD services on any single day in the ACT (ATODA, 2016a). While indicative of the daily workload of the ten ACT specialist AOD services, this figure does not equate

⁹ The Connection, and Alcohol and Drug Services, ACT Health

to annual treatment episodes. This information is obtained from the ACT AODTS-NMDS to which almost all ACT specialist AOD services currently report.

ACT AODTS-NMDS data show that there were 4,652 closed treatment episodes provided in specialist AOD treatment and support services in the ACT in 2013–14 to an estimated 3,332 clients. Over the five-year period to 2013–14, there has been a steady increase in the number of treatment episodes provided across services in the ACT—from 3,750 to 4,652, an increase of 24%. In non-government specialist AOD treatment and support services alone, there was a 36% increase in service demand between 2010 and 2014 (ATODA, 2015b).¹⁰

Table 9.4 shows the principal drugs of concern for treatment episodes provided to clients for their own drug use in 2013–14 (as opposed to episodes provided for someone else’s drug use). Importantly, the proportion of treatment episodes involving heroin was higher than the national average (7%), and amphetamines as the principal drug of concern increased from 6% to 15% between 2009–10 and 2013–14 (Australian Institute of Health and Welfare, 2015b).

Table 9.4: Proportions of treatment episodes of principal drugs of concern in the ACT (2013–14)

Principal drug of concern	Proportion of treatment episodes
Alcohol	47 %
Cannabis	18 %
Amphetamines	15 %
Heroin	11 %

Source: (Australian Institute of Health and Welfare, 2015b)

In the ACT, ‘information and education only’ was the most common main treatment type delivered (21% of episodes), followed by ‘assessment only’ (19%), ‘counselling’ (19%), and ‘support and case management only’ (12%). In the five year period to 2013–14, ‘information and education only’ increased in the ACT from 11% to 21% of treatment episodes (Australian Institute of Health and Welfare, 2015b).

Conversely, ‘counselling’ as the main treatment type has declined over the past five years, from 30% of episodes in 2009–10 to 19% in 2013–14. Compared to the national averages over the past five years, the ACT has provided proportionally fewer episodes of ‘counselling’. In 2013–14, for example, ‘counselling’ was provided in 43% of treatment episodes nationally, compared to 19% in the ACT (Australian Institute of Health and Welfare, 2015b). Further, in 2013–14 the ACT had the

¹⁰ Analysis of data from the Service Users’ Satisfaction Survey (2012) and the Service Users’ Satisfaction and Outcomes Survey (2015) also shows a 36% increase in the numbers of people completing the survey in all (government and non-government) specialist AOD treatment and support services in a single day (from 346 in 2012 to 469 in 2015).

lowest proportion of episodes of ‘counselling’ (as a proportion of main treatment types) of any jurisdiction—for example, 19% in the ACT, compared to 35% in NSW, 56% in Victoria and 62% in Tasmania (ACT Health, 2016a). Importantly, ‘counselling’, as reported in this data set, refers to counselling offered outside the residential rehabilitation context.

Service usage by Aboriginal and Torres Strait Islander people

As previously mentioned, 25% of people who completed the SUSOS (2015) identified as being of Aboriginal and/or Torres Strait Islander descent. When Aboriginal and Torres Strait Islander community-controlled services are excluded, the SUSOS data shows that 19.4% of people attending mainstream specialist AOD services identified as Aboriginal and/or Torres Strait Islander (ATODA, 2016a). The current level of presentations by Aboriginal and Torres Strait Islander people to ACT mainstream specialist AOD treatment and support services is expected given the high level of AOD-related harms experienced by the Aboriginal and Torres Strait Islander community.

The limitations of the NMDS data mean that the treatment types for Aboriginal and Torres Strait Islander people accessing Aboriginal and Torres Strait Islander specific services cannot be specifically articulated. However, in discussion with ACT Health about the types of services that they purchase from Aboriginal and Torres Strait Islander specific organisations, it is known that specialist AOD assessment, counselling and non-residential rehabilitation are not specifically and explicitly purchased.¹¹ Aboriginal and Torres Strait Islander people wishing to access these drug treatment service types must currently do so through the mainstream specialist AOD services.

Catchment and boundary considerations

It is impossible to discuss AOD treatment and support service delivery, needs and priorities in the ACT without considering cross-border issues.

Across Australia, Primary Health Network boundaries do not match the reality of how specialist AOD treatment and support services are organised, delivered and to whom. While the ACT is fortunate in some ways that its boundary matches that of the CHN, the reality is that people from beyond the borders of the ACT regularly access specialist AOD treatment and support services (in particular, for example, from Queanbeyan, Yass, Goulburn, Cooma and the South Coast). Many of these local communities have little (if any) local choice of specialist AOD treatment service, and so the population potentially serviced by ACT specialist AOD treatment and support services is 580,000 (rather than the 380,000 population of the ACT). ATODA is collaborating with ACT Health to

¹¹ Residential rehabilitation specifically for Aboriginal and Torres Strait Islander people is in the process of being established at a purpose-built facility, the Ngunnawal Bush Healing Farm.

undertake an analysis of specialist AOD treatment and support cross-border issues, including a postcode data analysis, which will be available in 2016–2017.

Secondly, the nature of utilisation of specialist AOD treatment and support services across Australia requires flexibility in client access across Primary Health Network, state and territory boundaries. Several factors will impact on the choices that people make about where they access specialist AOD treatment and support: shame and stigma associated with AOD treatment; wanting to remove yourself from an environment where your network may be using AOD; and access to different modalities of AOD treatment not available in their local area (e.g. residential care that accepts parents with children).

Clearly, although ACT residents are given priority of access to ACT AOD treatment and support services, access is not just limited to ACT residents. Similarly, ACT residents are able to access specialist AOD treatment and support services in other jurisdictions. This is an important and inherent strength of the Australian specialist AOD treatment and support service system.

Furthermore, Aboriginal and Torres Strait Islander community-controlled services report high mobility of Aboriginal and Torres Strait Islander people across the NSW-ACT border. Visiting the ACT for brief or extended periods to maintain family and work connections contributes to this high mobility, as well as specifically visiting the ACT to access services (including specialist AOD treatment and support) that are not available elsewhere. This is clearly demonstrated by the work of the ACT's Aboriginal and Torres Strait Islander community controlled health service; of the 4,437 individual clients in 2014–15, 19% lived in NSW and 2% were either residents of other jurisdictions or the information was not recorded (Winnunga Nimmityjah Aboriginal Health Service, 2015).

Key Issues

Unmet demand for specialist AOD treatment and support

The relatively recent, quick and building changes in demand for specialist AOD treatment and support have resulted in multiple problems within the ACT specialist AOD service system, such as:

- Barriers to entry into AOD treatment due to, for example, insufficient treatment places and resulting lengthy waiting lists.
- Inability to provide optimal levels of care for an at risk population, their families and the wider community.
- Insufficient funding and planning across the AOD service system.

This has exacerbated and brought to the fore other systems problems, such as an inability to swiftly provide AOD treatment places to people involved in the criminal justice and child protection systems. Based on current trends (in the ACT and nationally) it can be expected that demand for AOD treatment and support will not abate.

In response to this crisis in Australia, the *New Horizons: Review of the Alcohol and Other Drug Treatment Services in Australia* report recommended that treatment places need to double in response to current unmet demand (Ritter et al., 2014). Like elsewhere in the country, the ACT needs further treatment places to meet the increased demand that is being placed on specialist AOD treatment and support services.

High quality specialist AOD treatment and support should be delivered according to established and documented best practice in the AOD treatment field. This includes, for example: conducting comprehensive AOD assessments that channel people into the appropriate treatment modalities; developing, in collaboration with the service user, an individual AOD treatment plan that articulates the goals and outcomes of their treatment. In addition, best practice requires consumer participation in decision-making, and intensive and on-going engagement by AOD treatment services so that individuals remain engaged with the service system, are able to maintain their treatment goals, and reduce relapse.

Regardless of the service context, specialist AOD treatment and support for Aboriginal and Torres Strait Islander people should be based on the best practice principles outlined above, and on adapting and delivering this in culturally safe ways.

Further, sufficient resourcing should be available to deliver the components of high quality and culturally safe care with both mainstream and Aboriginal and Torres Strait Islander specific AOD services. Existing models, such as the *Drug and Alcohol Service Planning Tool* and the *Drug and Alcohol Clinical Care Package adaptation for Aboriginal and Torres Strait Islander people* can be used as an estimate for the resources required to deliver specific types of AOD care across a typical population.

In the ACT, there has been a significant increase in demand for specialist AOD treatment and support services over the past 5 years. Analysis of data and reports from workers in the field point towards the specific needs within specialist AOD services, and the components that require further investment and development. There are, of course, other multiple points of need in the ACT specialist AOD treatment and support service system. However, the priorities identified here do not include, and go beyond, a number of areas of established need that are already being progressed by

other projects or processes (for example, an improved response to withdrawal management is being progressed through a Withdrawal Services Review and Redesign project, and the need for AOD residential rehabilitation for Aboriginal and Torres Strait Islander people is being progressed to through the development of the Ngunnawal Bush Healing Farm).

The focus of additional specialist AOD treatment and support is, therefore, on capacity that can be built across, and that can benefit, the entire AOD service system in the priority areas of:

1. Community based specialist AOD treatment and support
2. Specialist AOD treatment for Aboriginal and Torres Strait Islander people

Priority Issues

Community based specialist AOD treatment and support

Community based AOD treatment and support can be delivered along multiple stages of the treatment pathway, and can be described as requiring increased investment in the following components. Where relevant, the associated National Minimum Data Set treatment types that correspond with each component are listed in parenthesis.

1. Opportunistic assertive outreach to engage 'hard to reach' sub-populations to prevent and reduce AOD related harm and provide supported referrals to specialist AOD treatment services (information and education; support and case management)
2. Increased capacity for specialist AOD treatment and support services to provide immediate triage and brief intervention when clients initially contact the services (information and education; support and case management; counselling)
3. Increased capacity for specialist AOD treatment and support services to provide brief interventions and/or low intensity treatment to people on waiting lists for AOD treatment (information and education; support and case management; counselling)
4. Intensive structured non-residential specialist AOD treatment and support, particularly counselling (counselling; non-residential rehabilitation)
5. AOD specialist structured aftercare (information and education; support and case management; counselling)

6. Targeted service delivery projects that reduce AOD related harms and improve the quality of care embedded in existing specialist AOD treatment and support services:
- Structured and formalised consumer and friend/family participation strategies
 - Hepatitis C treatment provided concurrently with AOD treatment
 - Opioid overdose education programs provided concurrently with AOD treatment
 - Methamphetamine specific programs

Strategy

The funding principles that should underlie the commissioning and funding of specialist AOD treatment and support services in the ACT, includes:

- Commissioning should be based on the *Drug and Alcohol Service Planning (DASP) Model*, and the *Drug and Alcohol Clinical Care and Prevention (DA-CCP) adaptation for Aboriginal and Torres Strait Islander people*.
- The CHN commissioning process should be developed in partnership with AOD experts.
- The scope of the funding should focus on the provision of specialist AOD treatment and support, and build upon and leverage off the existing specialist AOD treatment and support services in the ACT.
- The CHN global commissioning framework must be complemented by AOD specific guidelines and criteria. This includes, for example:
 - Recognising that outcomes-commissioning is not effective for specialist AOD services
 - Utilising existing AOD sector guidelines for the commissioning of specialist AOD treatment for Aboriginal and Torres Strait Islander people
 - Purchasing by and reporting to the ACT AOD Minimum Data Set (that feed into the National Minimum Data Set)
 - Providing funding investment that genuinely enables additional AOD treatment capacity
 - Including investment in AOD specific external specialist supervision for any positions that are funded.

Specialist AOD treatment for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people have different patterns of AOD use than the general population—for instance, higher rates of smoking and lower rates of drinking overall. The evidence indicates that Aboriginal and Torres Strait Islander communities are disproportionately

affected by AOD-related harm, and consequently particular consideration is needed to provide targeted specialist AOD treatment and support services tailored specifically for this population.

ATODA understands that the following ACT AOD Minimum Data Set treatment types are not sufficiently purchased specifically for Aboriginal and Torres Strait Islander people (ACT Government, 2016b):

- Comprehensive specialist AOD assessment
- Specialist AOD counselling
- Non-residential rehabilitation

This means that the majority of treatment types specifically purchased for Aboriginal and Torres Strait Islander people are non-clinical. This creates a major inequity in the provision of high quality clinical AOD treatment for Aboriginal and Torres Strait Islander people in the ACT.

Furthermore, the quality of AOD drug treatment and support will be enhanced by the provision of external clinical and non-clinical specialist AOD supervision to the existing and future workforce providing services for Aboriginal and Torres Strait Islander people. Depending on the site of service delivery, this workforce may also require cultural supervision to enhance the delivery of culturally safe care.

Strategy

Ensuring the cultural safety of *all* specialist AOD treatment settings in the ACT is a prioritised strategy. This strategy is about building workforce capacity to work with Aboriginal and Torres Strait Islander clients in mainstream settings via a range of measures. Only two mainstream agencies have identified Aboriginal and Torres Strait Islander (nonclinical) positions, but the remaining mainstream specialist AOD services do not have specifically identified positions, and do not currently receive Aboriginal and Torres Strait Islander specific AOD treatment funding.

The needs and priorities for culturally safe specialist AOD treatment types specifically for Aboriginal and Torres Strait Islander people in the ACT are:

1. Explicit and specific purchase and increased provision of:
 - Specialist AOD assessment
 - Specialist AOD counselling
 - Specialist AOD non-residential rehabilitation

2. Aboriginal and Torres Strait Islander people seeking treatment from specialist AOD mainstream settings receive culturally safe care and support.
3. Targeted quality improvement— purchase of external AOD specific supervision for AOD workers providing treatment and support for Aboriginal and Torres Strait Islander people.

10. After Hours

Overview

There has been a considerable change in the After Hours service provision landscape since the needs assessment undertaken for the ACT Medicare Local (ACTML), 2014 Comprehensive Needs Assessment (CNA). Changes to the PIP payment and program management structure, new market entrants to fill service gaps, an additional walk-in centre and a continued high proportion of non-urgent presentations (potentially avoidable GP type presentations comprised 44.2% of all emergency presentations from 2004-05 to 2013-14 (ACT Health, 2015a)) to ACT Emergency Departments (ED) at Canberra Hospital and Calvary Health Care Bruce, are the main factors underlying this significant change.

A report on low acuity ED attendees at both Canberra EDs (conducted by ACTML in 2013) shows that generally, community awareness of after hours health service availability is high, however knowledge of availability of these services has not translated to a reduction in non-urgent ED presentations. These behavioural outcomes need further exploration to develop targeted and effective evidence based strategies. Further analysis needs to be undertaken on ED data to provide a higher level of granularity of the specific cohorts that are using EDs inappropriately after hours. Further analysis is also required of the drivers in this evolving market and the range of potential interventions explored against criteria such as cost-effectiveness, implementation feasibility and equity.

A particularly vulnerable cohort of the population during the after hours period is that of community members living in residential aged care facilities (RACFs) and homebound elderly. With a rapidly ageing population in the ACT, these community members are more likely to have complex and multiple health conditions and deteriorate quickly if unable to access timely primary health care. Studies undertaken in Australia (Lowthian et al., 2012, Lowthian et al., 2013) show that presentation at EDs for this cohort are more likely to result in repeat ED attendances, increase in hospital admissions and an associated increased length of stay once admitted, which results not only in hospital “bed block” but further health and social consequences for that patient.

Current after hours primary care services landscape

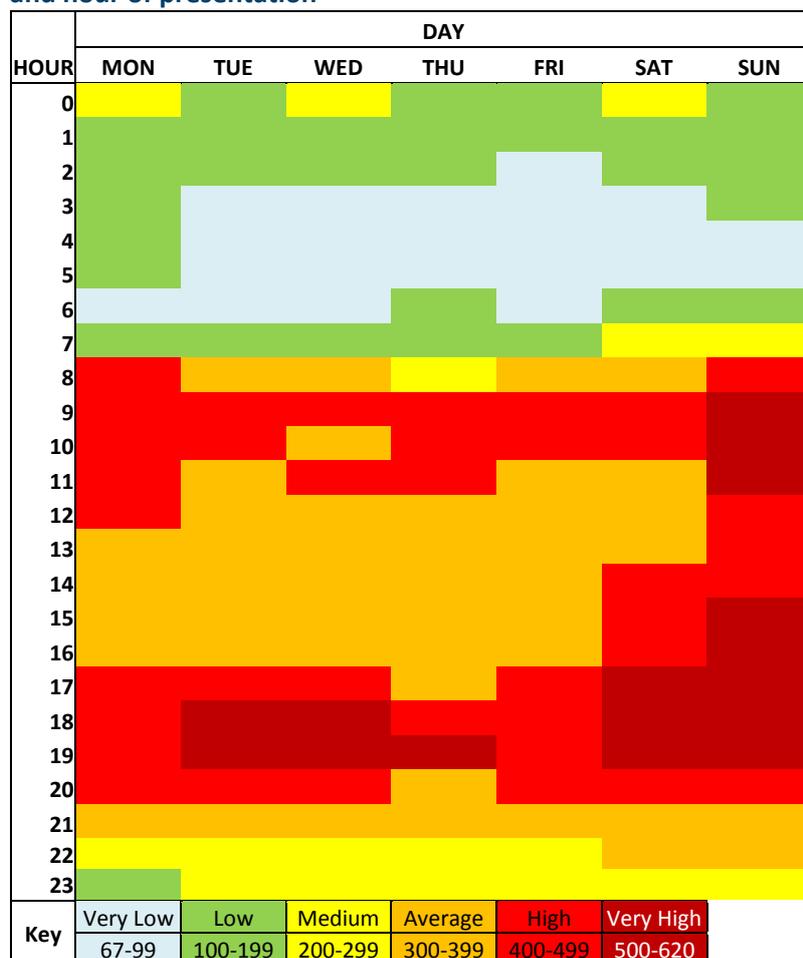
Emergency Department – Potentially Avoidable Presentations (PAPs)

Potentially avoidable presentations (also referred to as potentially avoidable GP type presentations or primary care type presentations) “comprised 44.2% of all emergency presentations from 2004-05 to 2013-14” (ACT Health, 2015a). The highest proportions of PAPs were in the age groups 0-4 years and 18-24 years (ACT Health, 2015a). The peak presentation times for both groups were:

- Saturdays (after 2pm for 0-4 year olds, after 11am for 18-24 year olds)
- Sundays (from 8am to 9pm)
- Weekday mornings (from 9am to 12pm)

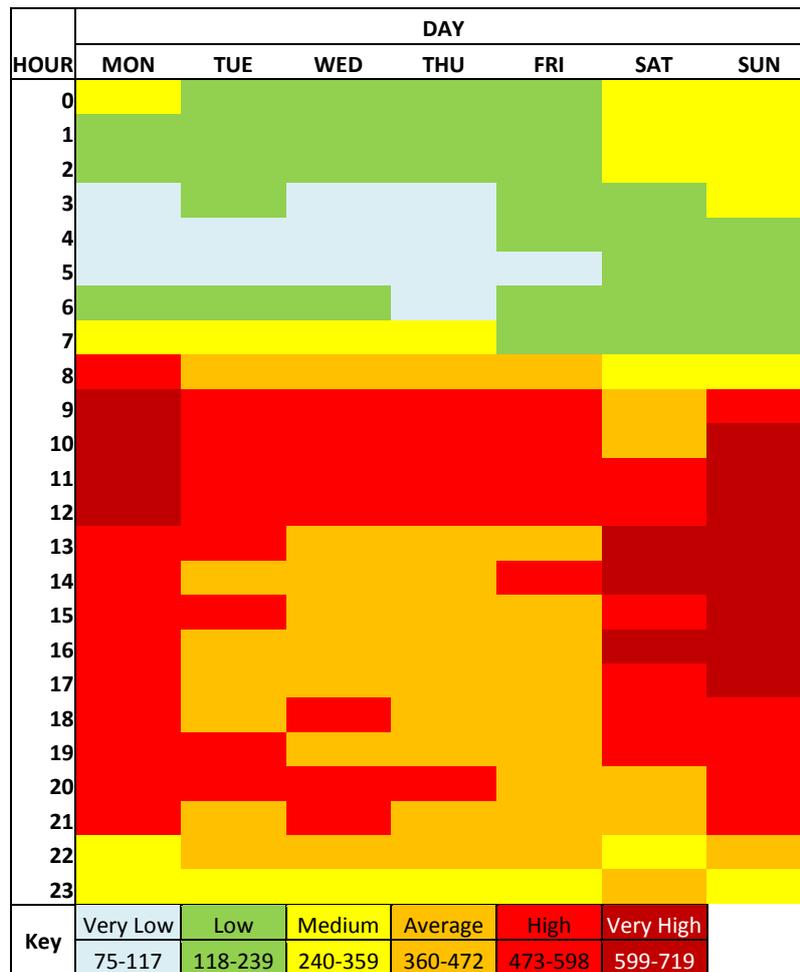
Presentations also peaked on weekdays between 5pm and 8pm for the 0-4 year olds, while 18-24 year olds had peak presentations all day on Monday (8am to 10pm) (ACT Health, 2015a). Figure 10.1 and Figure 10.2 demonstrate that there appears to be a significant element of after hours access issues in these patterns.

Figure 10.1: Potentially avoidable GP type presentations, infants 0-4 years to ACT hospitals by day and hour of presentation



Source: (ACT Health, 2015a)

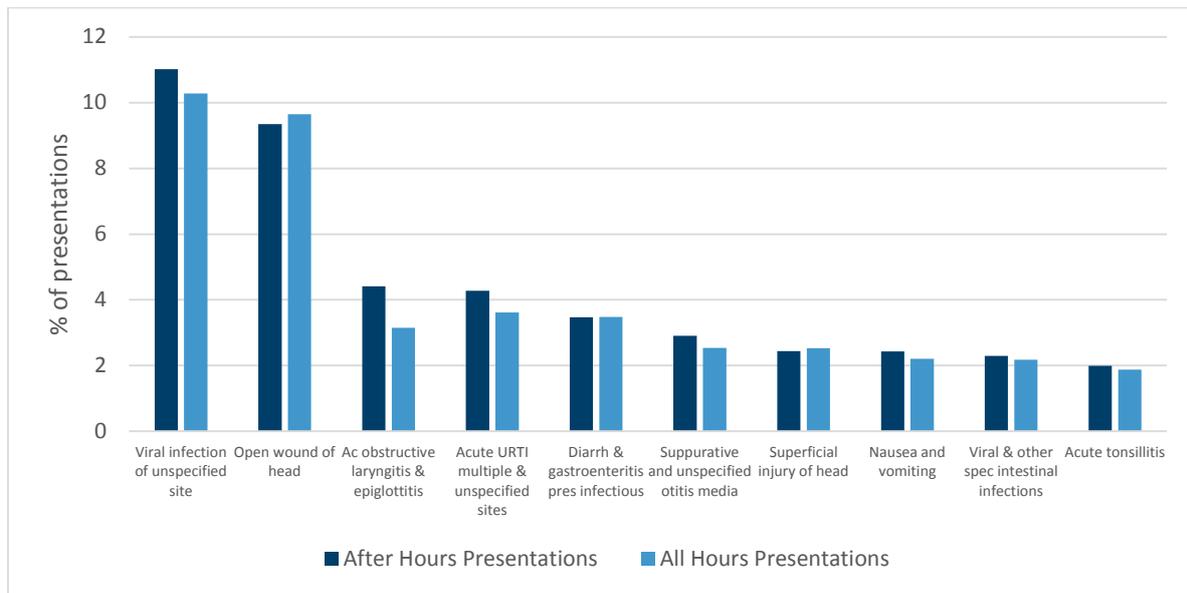
Figure 10.2: Potentially avoidable GP type presentations for adults 18-24 years to ACT hospitals by day and hour of presentation, 2004-05 to 2013-14



Source: (ACT Health, 2015a)

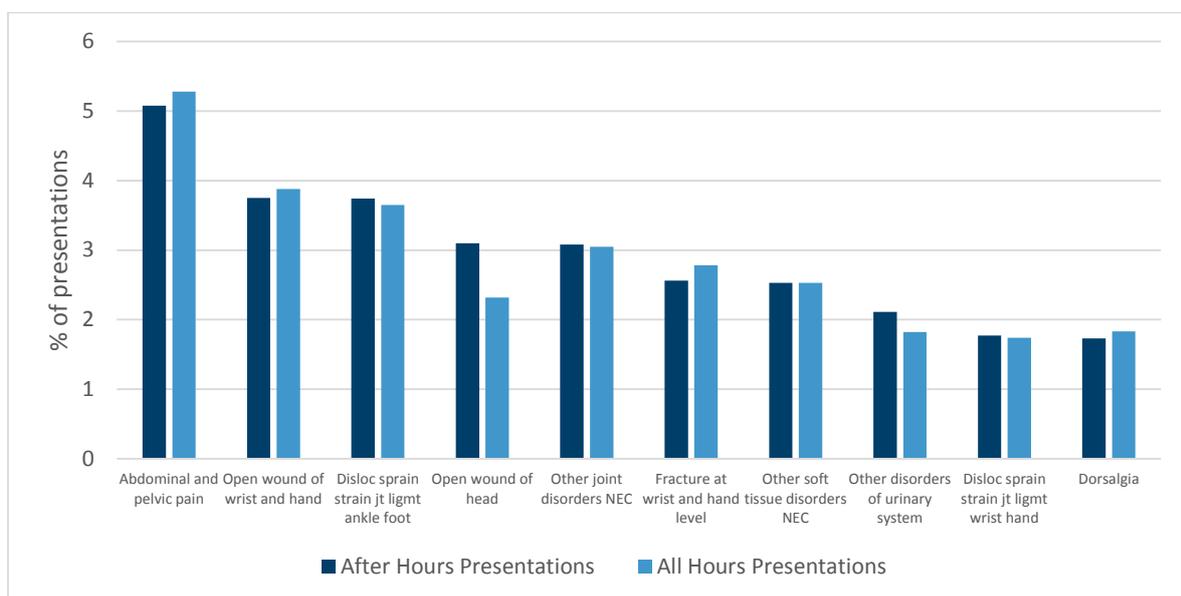
A review of the data collected on principal diagnoses for these patients demonstrates much similarity among presentations in hours and after hours, with only a few conditions being presented more often in the after hours period, including “Acute obstructive laryngitis & epiglottitis” for the 0-4 year group and “open wound of the head” in the 18-24 year old group (ACT Health, 2016c) (Figure 10.3 and Figure 10.4).

Figure 10.3: Potentially avoidable GP type presentations – principal diagnosis, 0-4 years to ACT hospitals, 2004-05 to 2013-14



Source: (ACT Health, 2016c)

Figure 10.4: Potentially avoidable GP type presentations – principal diagnosis, 18-24 years to ACT hospitals, 2004-05 to 2013-14



Source: (ACT Health, 2016c)

This data suggests that the time of day does not influence the principal diagnoses or medical reason for attending ED. Viral infections and open head wounds were both top presentations in the 0-4 year old age group, while in the 18-24 year old group females were more likely to present with abdominal pain and disorders of urinary system. Males aged 18-24 presented most often with hand/wrist open wounds or fractures, and other joint disorders and open wounds to the head.

General Practice

The number of general practices in the ACT has continued to increase in the past few years. New practices are seeing the benefit of extending their hours into the After Hours period, as demonstrated by Ochre Health Garran who operates for 15 hours per week in the After Hours period. Since 2012, 17 general practices extended their opening hours into the After Hours period, with an average increase of 3.2 hours per practice, and a total increase of 25% overall. The geographic distribution of general practices open during the After Hours period is fairly even throughout the ACT, as demonstrated below in Figure 10.5.

Figure 10.5: General Practices open at 4pm on Sundays, in the ACT



Source: (Healthdirect, 2016). Key Health Services, Open Days: Sunday, Open Hours: 4pm, General Practice/GP

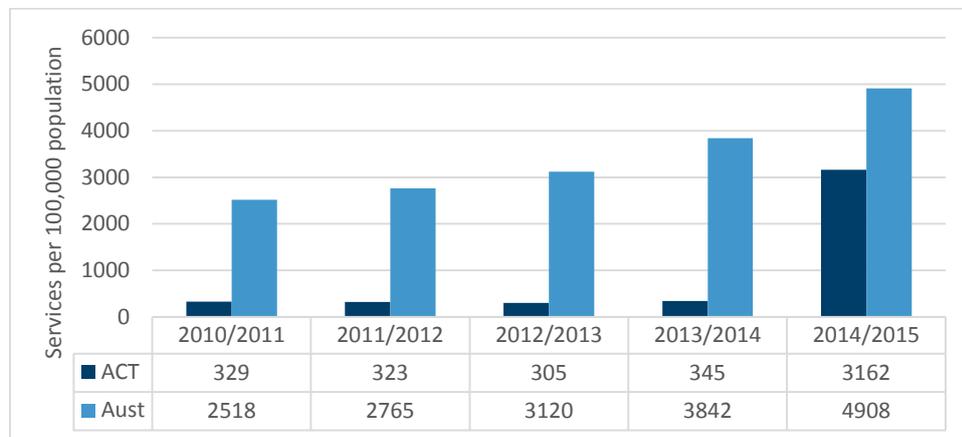
The most significant change has been the entry of National Home Doctor Service into the ACT market in August 2014. It provides home visits between 6pm and 8am Monday to Friday, after 12pm Saturday and all day Sunday and on Public Holidays. This service also bulk bills all patients who hold a Medicare card.

CALMS (Canberra After Hours Locum Medical Service) is an accredited medical deputising service owned and operated by Canberra GPs (CALMS, 2013). CALMS operates a call centre between 6pm and 8.30am weeknights, from 6pm Friday to 8.30am Monday (covering the entire weekend), and 24 hours on public holidays. Clinics are open at the Canberra and Calvary hospitals from 8pm to approximately 11pm weeknights, and from 10am to 11pm on weekends and public holidays. Outside

of clinic hours, a home visit can be scheduled where clinically appropriate and this is triaged through the call centre. There is also a clinic located in Tuggeranong which is open from 2.30pm to 5.30pm on weekends and public holidays. CALMS is a private billing surgery and does not generally bulk bill its clients.

The number of Sociable Urgent After Hours item numbers (597) claimed in the ACT has increased by more than 800% (based on services per 100,000 population) from 2013-14 to 2014-15, which correlates with the establishment of the National Home Doctor Service in August of 2014. Although this is a significant increase, ACT is still well behind the Australian per capita rate of 4,908 per 100,000, as demonstrated in Figure 10.6.

Figure 10.6: MBS item 597 (sociable urgent after hours), ACT and Australia 2010-11 to 2014-15

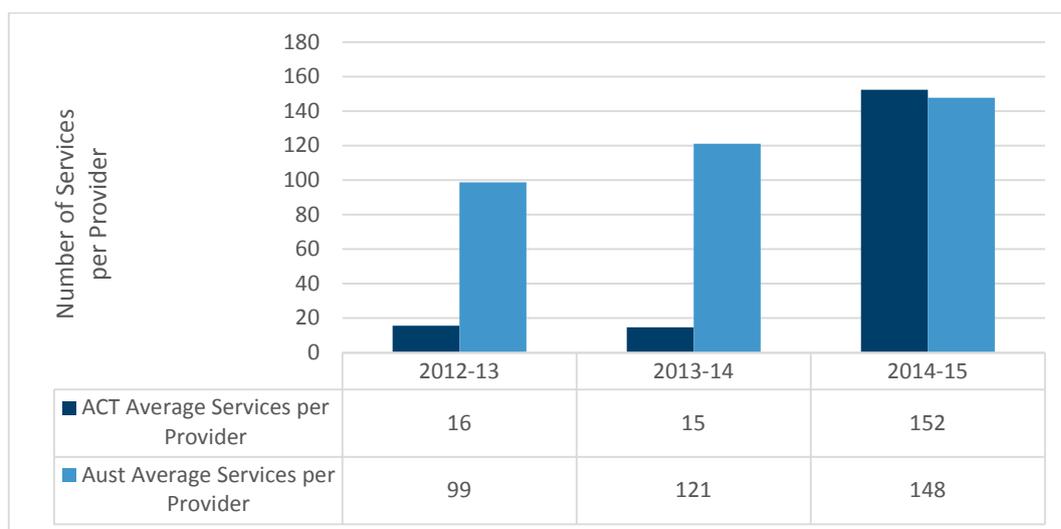


Source: (Department of Human Services, 2016)

The number of providers claiming MBS Item Number 597, while still below the Australian standard, also doubled in the twelve months from 2013-14 to 2014-15, correlating with the introduction of the National Home Doctor Service.

The number of services per provider, however, has increased almost ten-fold from 2013-14 to 2014-15 within the ACT, bringing our numbers to just above the Australian standard for the 2014-15 year (see Figure 10.7).

Figure 10.7: Average number of Services per Provider for 597 (sociable urgent After Hours)

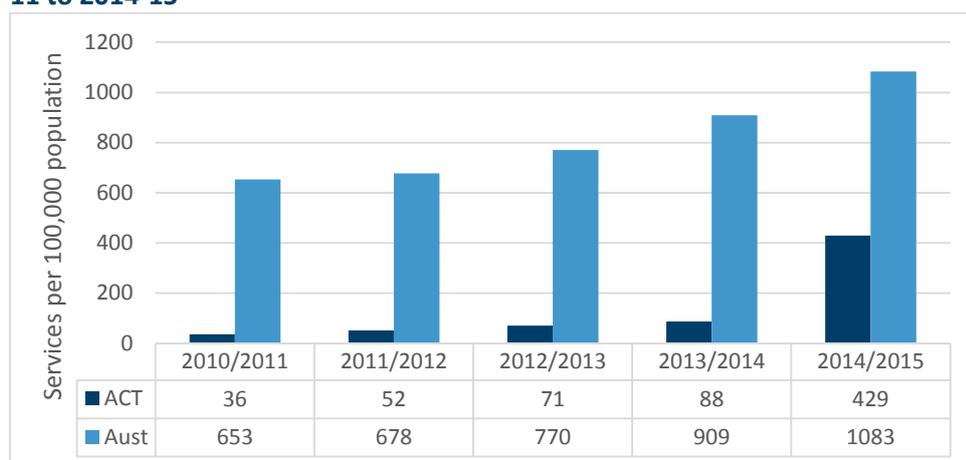


Source: (Department of Health, 2016g)

Data from after hours MBS item numbers claimed during 2013-14 and 2014-15 show an 86.8% increase in the number of Level B non-urgent after hours home visits, along with an increase of 62% in the number of Level B non-urgent after hours RACF visits. Level C non-urgent after hours home and RACF visits also increased by a significant amount, from which we can assume that the National Home Doctor Service has had a significant impact on the number of home and RACF visits provided.

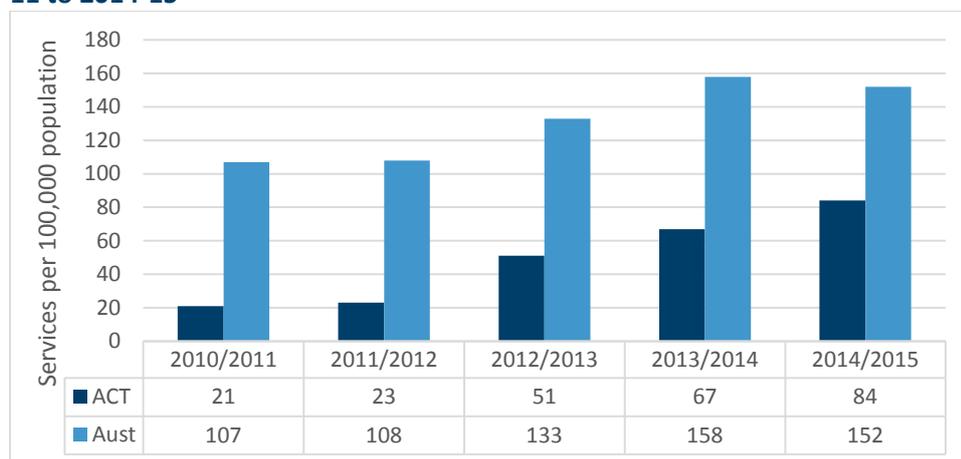
While the introduction of the National Home Doctor service within the ACT has increased the number of after hours home and RACF visits, the ACT remains well below the national average, as demonstrated in Figure 10.8-Figure 10.13 below. There has been consistent growth in the number of Level B and C after hours consults claimed across Australia, and the ACT growth has generally been in line with that. Between 2013-14 and 2014-15, there was almost a 500% increase in the number item 5023s claimed in the ACT, whereas Australia as a whole experienced only a quarter of that growth. Despite this increase, the ACT still sits well behind the rest of Australia in regards to home and RACF visits during the after hours period.

Figure 10.8: MBS item 5023 (Level B non urgent after hours home visit) ACT and Australia – 2010-11 to 2014-15



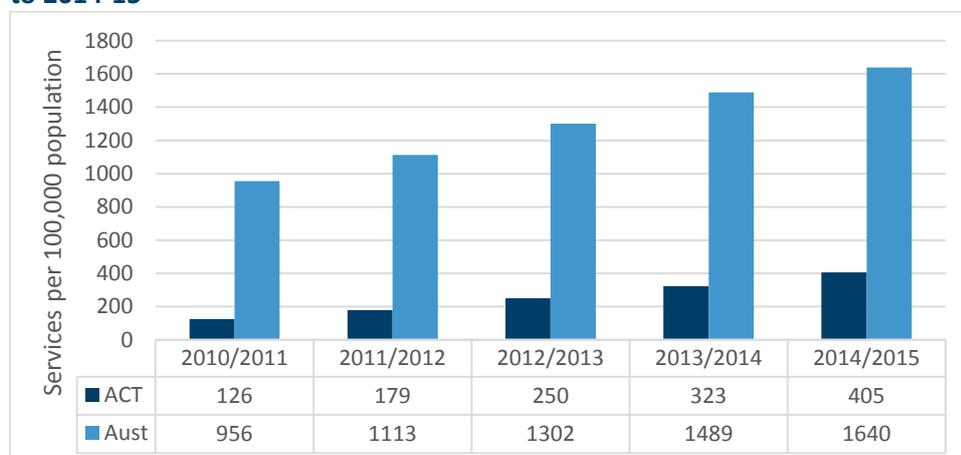
Source: (Department of Human Services, 2016)

Figure 10.9: MBS item 5043 (Level C non urgent after hours home visit) ACT and Australia – 2010-11 to 2014-15



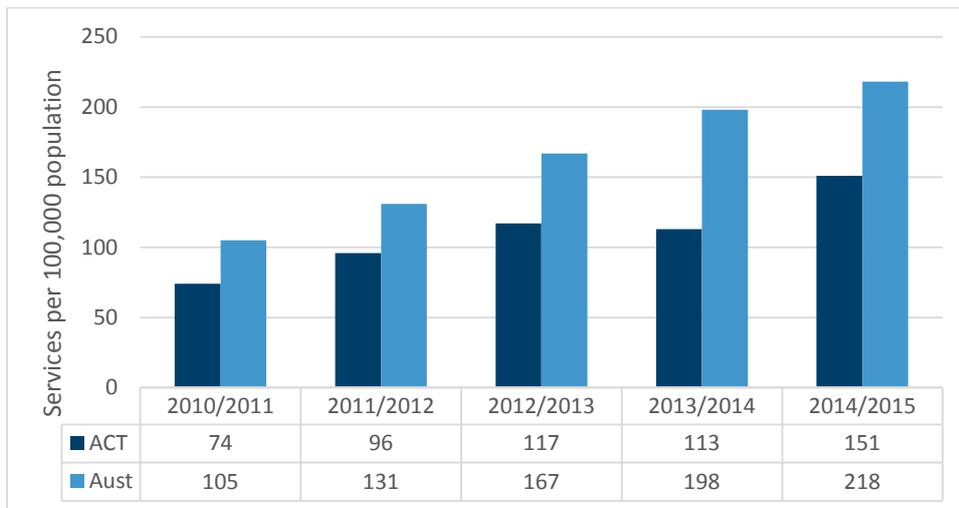
Source: (Department of Human Services, 2016)

Figure 10.10: MBS item 5028 (Level B non urgent after hours at RACF) ACT and Australia – 2010-11 to 2014-15



Source: (Department of Human Services, 2016)

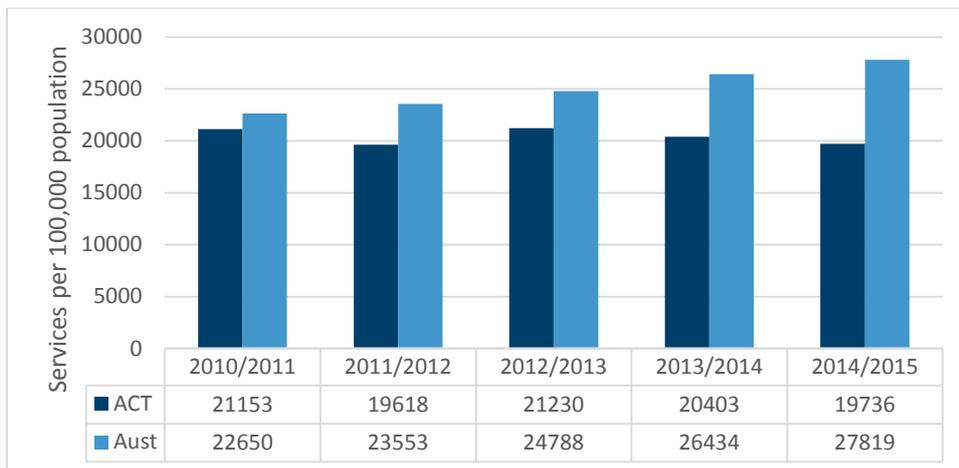
Figure 10.11: MBS item 5040 (Level C non urgent after hours at RACF) ACT and Australia – 2010-11 to 2014-15



Source: (Department of Human Services, 2016)

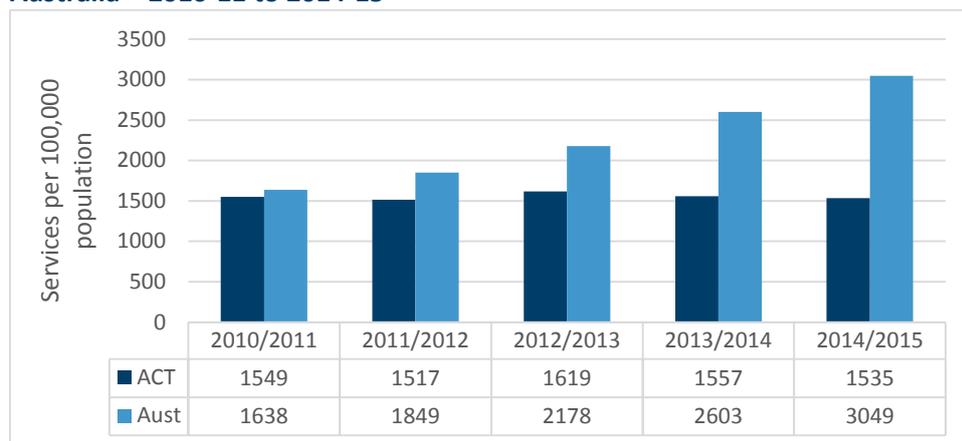
The number of non-urgent after hours services at consulting rooms has had a flat line of growth in the last four years with only a small percentage increase or decrease each year. The ACT continues to be significantly below the rest of Australia in regards to these item numbers (see Figure 10.12 and Figure 10.13).

Figure 10.12: MBS item 5020 (Level B non urgent after hours at consulting rooms) ACT and Australia – 2010-11 to 2014-15



Source: (Department of Human Services, 2016)

Figure 10.13: MBS item 5040 (Level C non urgent after hours at consulting rooms) ACT and Australia – 2010-11 to 2014-15



Source: (Department of Human Services, 2016)

Nurse led Walk-In Centre

Prior to July 2014 the Nurse led Walk-In Centre was located at The Canberra Hospital. The Walk-in Centre is now operating at two locations: one on the north side of Canberra at the Belconnen Town Centre, and one south side at Tuggeranong Town Centre. These services are open from 7am to 11pm daily and employ Practice Nurses and Nurse Practitioners. The Nurse led Walk-in Centres provide health advice and one-off treatment for minor injuries and illnesses. The 2014-15 year saw 32,980 presentations at the two Walk-In centres (combined), which is an increase of 41% compared to the previous year (ACT Health, 2015c).

Utilisation of the Nurse led Walk-in Centre (WiC) is not significant during the After Hours period. Data from the Centre demonstrates that their peak times are Monday and Tuesday mornings from 9am to 12pm. Common presentations during the After Hours period include upper respiratory tract infection (URTI), Common Cold and Wounds and Lacerations, which is consistent with the potentially avoidable presentations at the Canberra EDs (ACT Health, 2015a). The most frequent users of the WiC are females aged between 18 and 30, and males under the age of 6. It is not highly utilised by people aged over 74 years of age (Keun, 2016).

Pharmacy

The number of pharmacies in the ACT has continued to increase in the past few years. New pharmacies are seeing the benefit of extending their hours into the After Hours period, as demonstrated by the Chemist on Northbourne, which is open from 8am to 11pm every day, providing 50 hours of coverage in the After Hours period each week. Since 2012, there has been a 62% increase in the number of hours during the after hours period, where a pharmacy is open.

Access to a pharmacy during the after hours period is more readily available than access to a general practice, as demonstrated in the figures below (data obtained from internal records).

Figure 10.14: Weekday – open until – No. of services

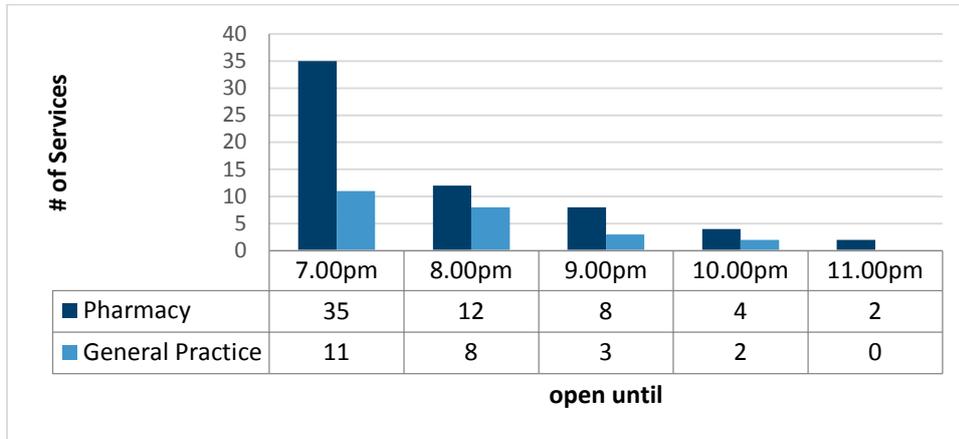


Figure 10.15: Saturday – open until – No. of services

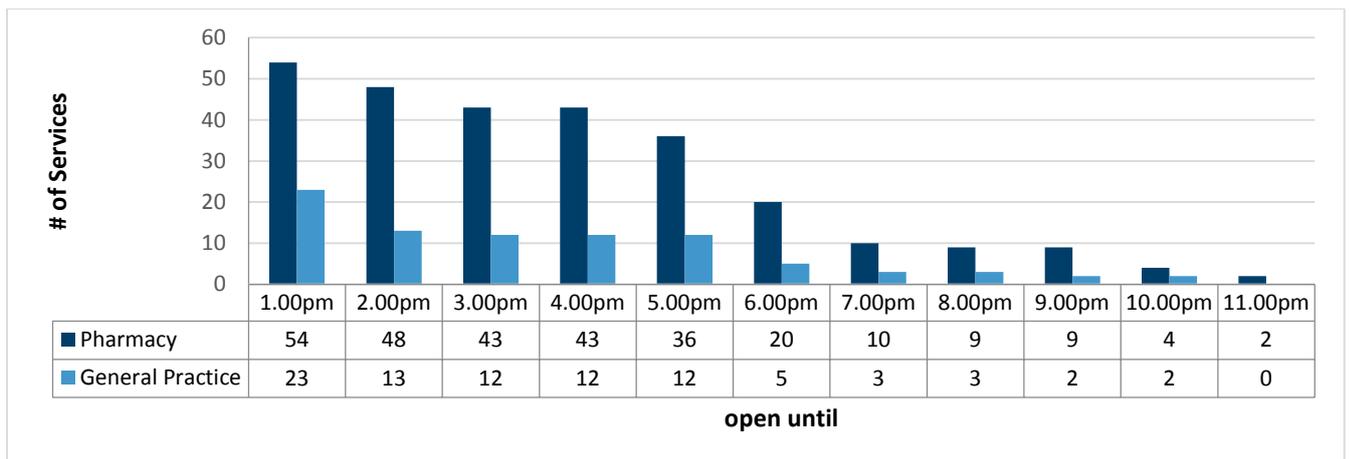
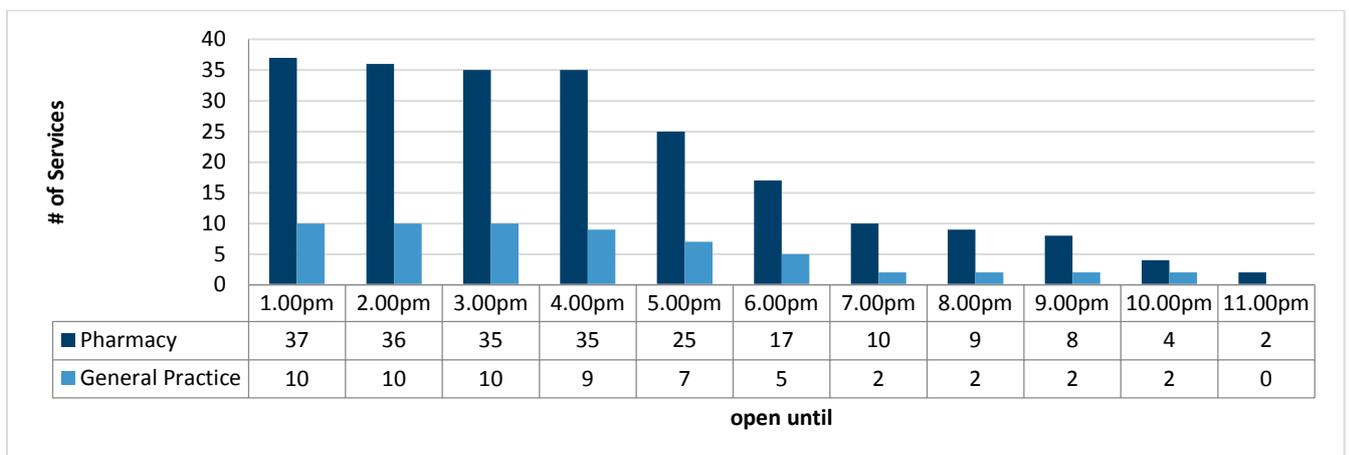


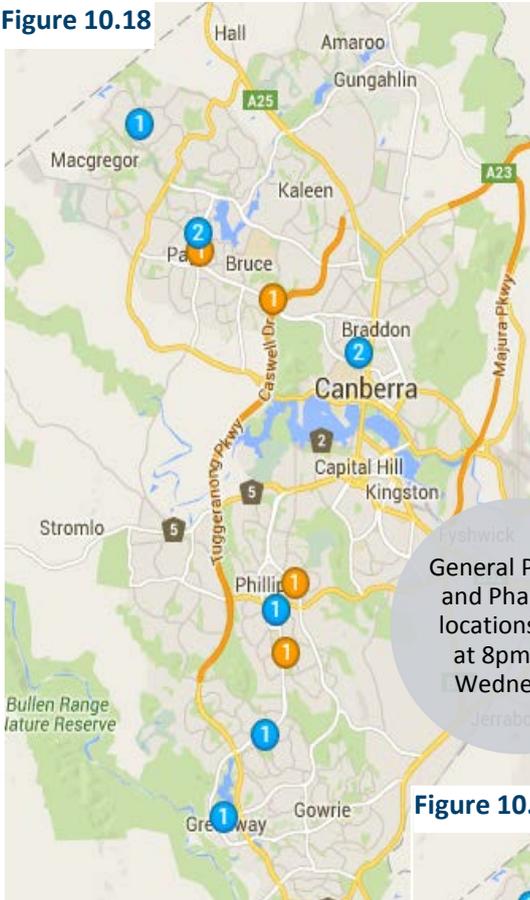
Figure 10.16: Sunday – open until – No. of services



This data reflects the closing time of services. Figure 10.14 represents that there are 35 pharmacies open until 7pm (closing at 7pm), and 11 general practices open until 7pm (closing at 7pm).

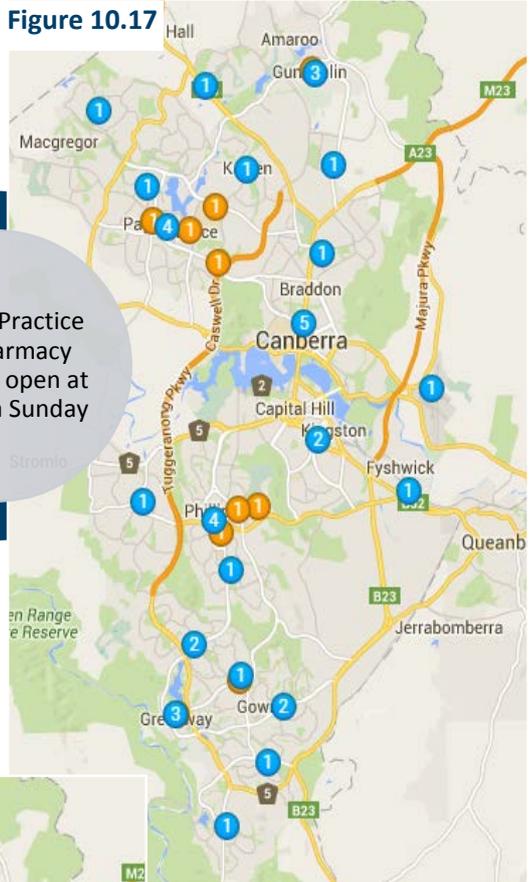
The geographic spread of available services is fairly even, with a pharmacy being located in close proximity to a general practice in most instances, however pharmacy availability far exceeds that of general practice availability (see figures below).

Figure 10.18



General Practice and Pharmacy locations open at 8pm on a Wednesday

Figure 10.17



General Practice and Pharmacy locations open at 3pm on a Sunday

Figure 10.19



General Practice and Pharmacy locations open at 5pm on a Saturday

1 Pharmacy
1 General Practices

The figure in the circle is the number of open pharmacies at that location.

Source: (Healthdirect, 2016)

Healthdirect Australia and the After Hours GP Advice and Support Line

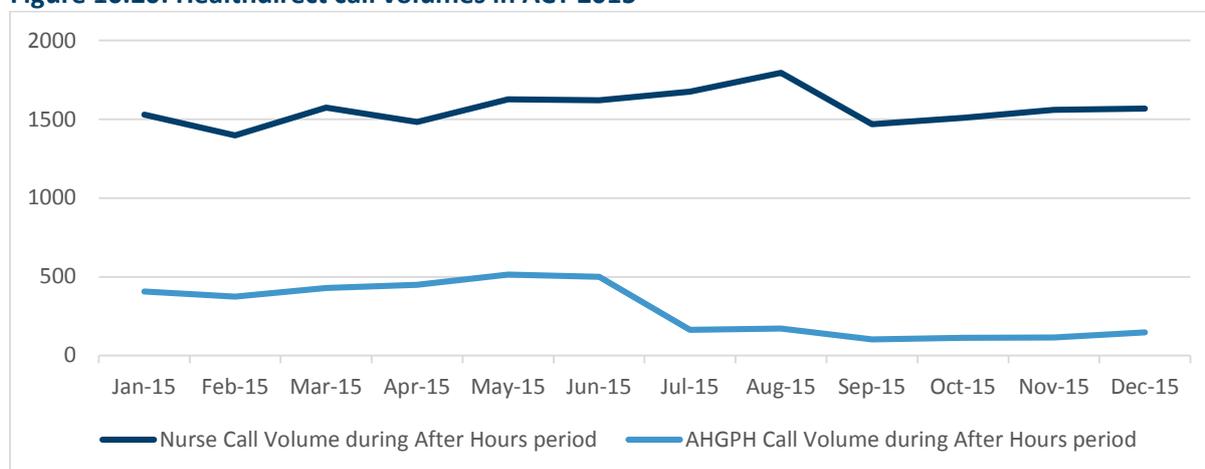
Healthdirect Australia is jointly funded by the Council of Australian Governments to “provide all Australians with access to health information and advice” (Healthdirect Australia, 2016).

Healthdirect provides a number of services including:

- A 24/7 telephone based nurse triage, information and advice service
- The national Pregnancy, Birth and Baby helpline and website service which provides access to information, support and counselling for women, partners and their families 24 hours a day seven days a week in relation to pregnancy, birth and the first 12 months of a baby’s life;
- An After Hours GP Helpline (AHGPH) which provides a telephone based GP medical advice service for people who require medical advice and who cannot access their usual health service
- Online symptom checkers which provide information and guide people to the appropriate type of care at the appropriate time
- Mindhealthconnect which facilitates access to a range of trusted mental health resources and services; and
- The National Health Services Directory (NHSD) which provides easy access to reliable and consistent information about health services (Jackson, 2014).

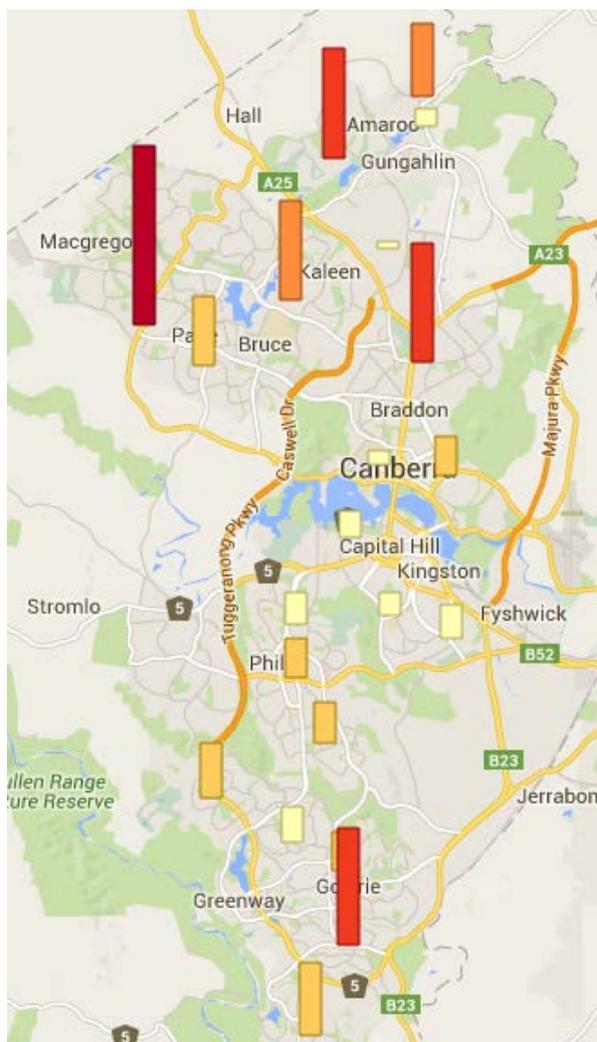
The Healthdirect Nurse Triage line continues to experience a consistent number of calls from Canberra residents, except for a drop in the After Hours GP Helpline calls in June 2015 (Healthdirect, 2016), which coincided with an announcement in the 2015 Budget that the helpline would be abolished (Figure 10.20). This was widely reported (Smith, 2015, Mcinerney, 2015, Chan, 2015), however the move to continue funding has not picked up quite as much media coverage (McDonald, 2015).

Figure 10.20: Healthdirect call volumes in ACT 2015



Geographic distribution of calls (see Figure 10.21) demonstrates that only a low level of call volume is received from the more central suburbs of Canberra which, when taken with the top clinical guidelines accessed by the Nurse Triage Helpline, may be linked to the prevalence of young children in the outer lying suburbs of Canberra. The Pregnancy, Birth and Baby helpline, specifically targeted at mothers, receives only 2% of volume of calls in Canberra. While the phone number for this service is listed in the “Useful Contacts” list of the *My ACT personal health record* (ACT Health, 2014c) (otherwise known as The Blue Book), the services available are not expressly explained to expectant or new mothers, which could account for the low call volume in the ACT compared to the Nurse Triage helpline. However, the call volume per 100,000 of population is mid-range compared to the rest of Australia. This helpline has recently expanded to provide support for children up to the age of 3 years. Figure 10.22 illustrates the top 10 guidelines which were accessed during the period 2014-2015. Paediatric vomiting and abdominal pain/discomfort were among the guidelines most often accessed which is in-line with the most common primary care type presentations to ED.

Figure 10.21: Nurse Triage Helpline: ABS Postal Areas, ACT, call volumes, July 2011 to June 2015



Source: (Healthdirect, 2016)

Each *location* represents an “ABS Postal Area”.

Legend

Nurse Triage Helpline: Call Volumes
Number of NT Episodes

405	to < 3,515	10 locations
3,515	to < 6,625	7 locations
6,625	to < 9,736	4 locations
9,736	to < 12,846	3 locations
12,846	to 15,956	1 location
		25 in total

Grouping based on equal intervals

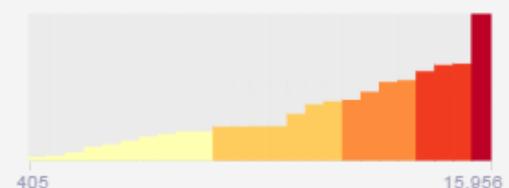
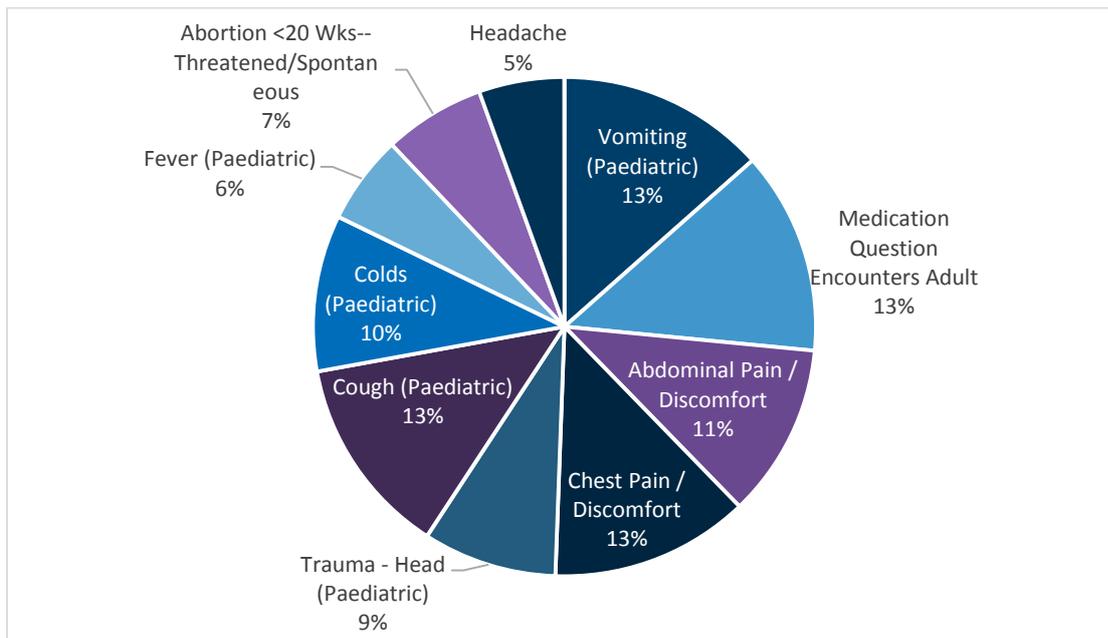


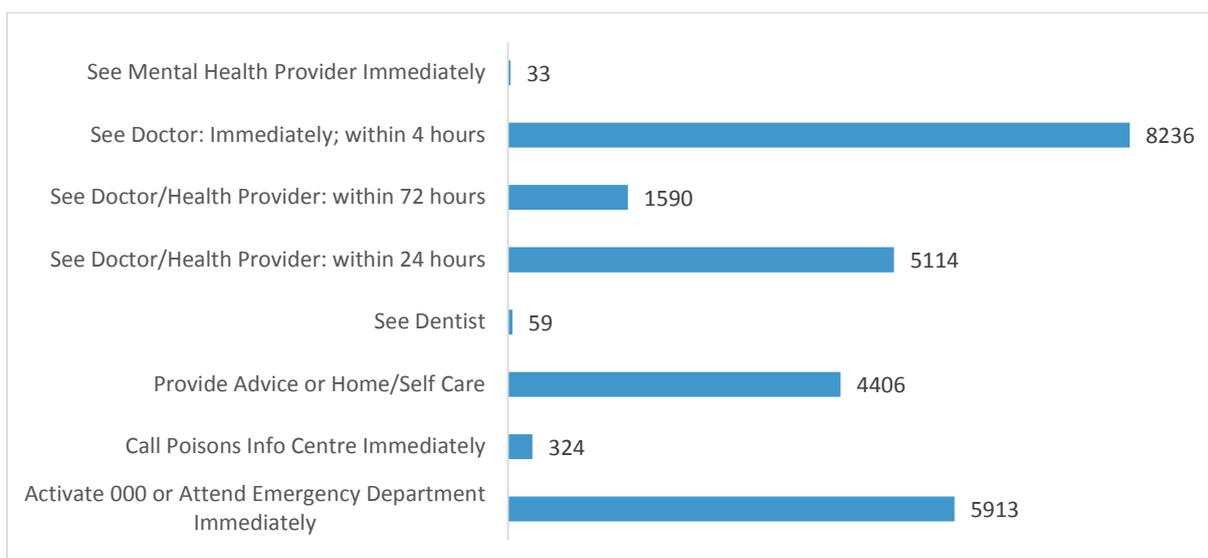
Figure 10.22: Top 10 Patient guidelines accessed by Nurse Triage, ACT 2014-15



Source: (Healthdirect, 2016)

The final disposition of 20% of callers to the Nurse Triage Helpline was “Activate 000 or Attend Emergency Department Immediately”, while almost 30% were advised to “See Doctor Immediately, within 4 hours”. This is coincidentally similar with data obtained during the ACTML *Low acuity Emergency Department Attendees in the ACT* study (ANU Academic Unit of General Practice, 2015), which indicates that almost 30% of patients were referred to ED by a health care professional (see Figure 10.23).

Figure 10.23: Nurse Triage – final disposition, ACT 2014-15



Source: (ANU Academic Unit of General Practice, 2015)

Key Issues

Residential Aged Care Facility (RACF) & homebound elderly

A particularly vulnerable cohort of the population during the after hours period is that of community members living in residential aged care facilities and homebound elderly as they experience an ongoing difficulty in accessing care after hours. With a rapidly ageing population in the ACT, these community members are more likely to have complex and multiple health conditions and deteriorate quickly if unable to access timely primary health care. Often rapid assessment and treatment is required but not readily available. Studies undertaken in Australia show that presentation at Emergency Departments for this cohort are more likely to result in repeat Emergency Department attendances, increase in hospital admissions and an associated increased length of stay once admitted, which results not only in hospital “bed block” but further health and social consequences for that patient (Lowthian et al., 2012, Lowthian et al., 2013).

One response to this issue, which was trialled in the ACT between January 2013 and March 2014, was the Extended Care Paramedics (ECP). This was a Health Workforce Australia (HWA) initiative which consisted of the ACT Ambulance Service recruiting highly experienced Intensive Care Paramedics who treated patients in the usual place of residence utilising advanced skills and pharmacology and referral to other health professionals as appropriate. Impressive results were achieved such as 70% of patients being treated in the community for reasons including headache, fever, fainting, sick, unwell; abdominal pain, vomiting, constipation and laceration, dislocation and burns. therefore avoiding transport to EDs compared to the regular ambulance service which had only a 20% non-transport rate (Thompson et al., 2014).

Entry to the market by the National Home Doctor Service (NHDS) has seen an increase in the number of MBS item numbers representing RACF visits by 50% from 2013-14 to 2014-15, however the number of RACF visits account for only 3% of the total number of NHDS consultations. This is expected to increase over time.

Aboriginal and Torres Strait Islander people

Through the two ED Surveys conducted by ACTML in 2013, it was identified that Aboriginal and Torres Strait Islander people were over-represented within the survey responders - 1.5% population (ABS Census 2011), compared with 6.7% attendance at the same period at Canberra Hospital, and 4.1% at Calvary. Aboriginal and Torres Strait Islander people had significantly more potentially

preventable hospital admissions (33.7 per 1,000 population) than their non-Indigenous Australian counterparts (17.4) between July 2008 and June 2010 (ACT Health, 2014a).

An After Hours Clinic trial conducted at the ACT Aboriginal Medical Service, Winnunga Nimmityjah Aboriginal Health Service, between January and April 2014, demonstrated that an After Hours clinic was well received by the population, with 41% of clients indicating that they would have attended ED had this clinic not been available. Unfortunately, the costs associated with running the clinic have prohibited Winnunga from continuing this program.

Mental health

Limited services are available during the after hours period for people with mental health and behavioural problems (Walk in Centre, 2016). The ACT has the highest percentage of population with mental health problems of all states and territories (15.5%, compared to 13.4% for Australia) (ACT Health, 2014a). The number of hospital separations for ACT residents with a primary diagnosis of mental or behavioural disorder has also continued to increase, from 2009-10 to 2011-12 (2,935 to 2,970 respectively) (ACT Health, 2014a).

Awareness of after hours services (in both the community and profession)

An analysis of survey results from the *2012 MLAH After Hours Online Community Survey* and the *2013 After Hours – Know Your Options* survey indicate that consumer awareness of certain after hours services has increased (for example, 14.5% of survey respondents were unaware of the Healthdirect Nurse Triage line in 2012, compared with 10% in 2013) (ACT Medicare Local, 2012, ACT Medicare Local, 2013).

Although awareness of after hours primary health care options has increased, 20% of survey respondents continued to indicate that they “had needed but been unable to access after hours health care” (consistent with findings in 2011) (ACT Medicare Local, 2012, ACT Medicare Local, 2013). Availability of appointments, cost and “knowing where to go” continue to be issues in regards to accessing after hours care, however there was a significant decrease in responses to the phrase “There were no after hours services available in my area” which could be a positive indication of the effectiveness of the “Know Your Options” consumer awareness campaign. Each target group (0-5 years and 18-24 years) are likely to have quite different drivers, hence a more nuanced strategy is required to successfully target these groups.

Significant studies on the impact of the promotion of the After Hours telephone service are not widely available, however there is evidence from the USA which indicates that the promotion of the

after hours telephone service resulted in an increase of calls from 6 calls per 1,000 patients per month to 24.1 calls per 1,000 patients per month (Fry, 2008). A Dutch study of the integrative framework for effective communication (IFEC) found “that campaign recall and campaign appreciation increase[ed] most strongly when a combination of the likeability strategy and awareness strategy is used. ...However, brand awareness and purchase intention are almost entirely determined by previous purchase behaviour”(van den Putte, 2006).

Priority Issues

Young children (0-5 years old)

There are high rates of primary care type presentations to hospital emergency departments, including during the after hours period. There are a number of studies which indicate that “younger age, convenience of the ED compared to alternatives, referral to the ED by a physician, and negative perceptions about alternatives such as primary care providers all play a role in driving non-urgent ED use” (Uscher-Pines et al., 2013). However, it is important to view the younger children age group separately, as the *perception of urgency* is an important factor when parents are making decisions for their children’s health.

A Queensland study of parents presenting to ED for their children identified that for 60% of parents, the “perceived severity of their child’s illness [was] the primary or secondary reason for ... [ED] attendance, with expertise of doctors (24%) as the next highest ranked reason for attendance” (Williams et al., 2009). It was also identified during this study that presenting to ED was not always a parent’s first choice. In fact, 45% of “parents/carers administered some form of medication for injury or illness” (such as paracetamol or ibuprofen) before presenting to ED, while “39% of the study population had received treatment at another healthcare facility” and 61% “of children who attended a healthcare facility prior to the [ED] were directed and/or referred” for further advice and treatment (Williams et al., 2009).

Strategy

Ensuring that parents are aware of the services available to them 24 hours a day is an important factor when considering the impact of primary care type presentations to ED for this age group. Higher utilisation of the Pregnancy, Birth and Baby Helpline (staffed with Maternal and Child Health Nurses), may assist in limiting unnecessary presentations to ED, while ensuring that a parent’s perception of urgency is not dismissed. The newly opened Paediatric Emergency Department at The Canberra Hospital, while improving the experience of children and their

families attending emergency (Burgess and Hodge, 2016), could encourage the perception of parents that the ED is the best place to take their children without considering what primary care options are available.

Concentrated marketing to the “new parent” demographic through social media, GPs, Midwives and local community health centres, could see an increase in the number of calls to the Pregnancy, Birth and Baby Helpline, however it may be difficult to identify a reduction in primary care type presentations to ED for this group. Brand awareness and purchase intention are almost entirely determined by previous purchase behaviour (van den Putte, 2006), however social marketing when employed to its full extent offers the potential to change [behaviours] (Carins and Rundle-Thiele, 2014).

The “Know Your Options” campaign consisted of a number of key elements including a Fridge Magnet delivered to people’s homes Canberra wide, After Hours ACT website, and Facebook campaign of targeted ads. Health Care Consumers Australia have indicated that they would appreciate having updated fridge magnets as they are utilised in their Health Literacy programs. An update of the fridge magnet would include the additional helpline numbers from Healthdirect, as well as the National Home Doctor Service.

The website www.afterhoursact.com.au continues to receive regular traffic, however this traffic has continued to decrease following a peak in Page Views in early 2014. It is recommended that this site be decommissioned, with the web address re-directing people to a page on the CHN website showcasing the same information. This will enable easier updating of after hours health care information, as well as providing better value for money.

After hours presentations to General Practice

The majority of studies on the utilisation of after hours primary health care focus on primary care type presentations to EDs, and the utilisation of other after hours specific services such as helplines, minor injury units and walk in centres. There is limited evidence to suggest whether the motivation for attending a GP after hours is urgency or convenience. The use of MBS Item Numbers for after hours services has been increasing out of proportion with the population increase, with non-urgent after hours services (in consulting rooms) increasing by 27% in the last 5 years (2010-11 to 2014-15), while urgent after hours services have increased by 91% over the same period (Department of Human Services, 2016).

Strategy

Identifying the motivations for attending a GP during the after hours period will assist in determining whether urgency or convenience is a key factor in the utilisation of after hours primary health care. Understanding these motivations will impact the development and delivery of after hours services as well as provide an insight into more effective models of collaboration between services. It is recommended that patient surveys are conducted for people accessing after hours primary health care services, such as general practice, walk-in centres and CALMS to understand motivations for patients attending these services more clearly.

Diagnostic services

Studies show that perceived severity and convenience are key factors associated with non-urgent ED presentations (Uscher-Pines et al., 2013). The ACTML ED survey (2013) demonstrated similar perceptions, while ACT ED data shows that fractures are one of the most common non-urgent presentations. This could indicate that the “only option was ED” thinking is associated with the services patients think they will potentially need, such as X-Ray.

General Practitioners were invited to complete a survey in August 2014 in regards to the potential demand for an after hours imaging service accessible via GP referral at Canberra Hospital. More than half of the respondents indicated that they would refer to after hours imaging services at Canberra Hospital 1 to 2 times per week. Practitioners also indicated that patients presenting to general practice “later” in the day, who required plain x ray or Doppler for suspected DVT, were currently being directed to hospital Emergency Departments, despite the ability to manage this presentation appropriately in a general practice setting.

Respondents to the survey indicated that the availability of an after hours imaging service would reduce the requirement to send patients to the ED. Almost a third of patients (29%) surveyed through the *Low acuity Emergency Department Attendees in the ACT* surveys indicated that they had been referred to ED by their GP (ANU Academic Unit of General Practice, 2015).

Strategy

Making an after hours imaging services at both hospital locations available for direct GP referral, and promoting this service (90% of survey respondents were unaware of an after hours imaging service available at Calvary Public Hospital), could reduce the number of ED presentations during the after hours period.

Derived data from ACT EDs¹² shows that in the year to end of Feb 2014, there were upwards of 820 RACF residents that presented at ED, 92% of whom arrived by ambulance and 74% of whom were admitted to either an ED unit or a ward. 33% were triage Cat 4 & 5, while 50% were Cat 3. The highest primary diagnosis was “unspecified falls” at 9% (the majority of which are understood to be fractures), while fractured neck or femurs only added another 1%. This supports the anecdotal advice that suspected fractures from falls have been reported as being a significant issues in RACFs. No information is available regarding older people who live at home, but similar concerns are likely. In the ACT more than one in five (21.8%) older persons reported falling within the 12 months to January 2016 (ACT Health, 2016d). Of this group, almost half (49.3%) fell more than once, and 22.4% were hospitalised as a result. A mobile X-Ray service, specific to RACFs, may work to alleviate some of this pressure on ED in regards to presentations for the purposes of accessing imaging services.

The mobile X-ray Service (MXS) piloted in Melbourne in January 2013, demonstrated that there was a “reduction in hospital ED attendances for high users of the MXS,” although the cost-effectiveness of this model is unclear and a report on MXS suggests that “special rebates for home-based radiology service provision should be considered (Montalto et al., 2015)”.

In the UK, Minor Injury Units (MIU), while not specific to after hours care, have reduced demand for emergency care services (Fry, 2008). Within the ED setting, patients choose to or are triaged to the MIU, which are implemented as either nurse or GP led (Fry, 2008). The establishing of an MIU co-located with both EDs in Canberra could better accommodate patients requiring diagnostic imaging in the after hours period.

Whole of system

In the three years from 2012 to 2015, \$24.8 million has been invested in the provision of After Hours Primary Health Care in the ACT from three distinct streams: ACT Health, Medicare Benefits Schedule and the Department of Health. This funding has been utilised quite distinctly from the financial support of CALMS, direct payments to general practice through the utilisation of MBS items, and direct payments to general practice and pharmacy from Medicare Local grants and incentive payments.

¹² ED data is derived as Calvary does not code a person’s residence as an RACF, but rather their “home”. The data for Calvary is as a result likely to be underestimated.

Although there has been significant financial investment in the support of after hours primary health care, as well as the introduction of a new market entrant in the National Home Doctor Service, the number of potentially avoidable presentations to ED during the after hours period in the ACT remains consistent and is still a concern. The ACT continues to be well below the national rates for Home and RACF visits during the after hours period.

Strategy

Considering that separate funding streams have failed to resolve after hours service gaps, ACT PHN and ACT Health will undertake a joint commissioning approach as a jurisdiction combining available funding pools. This will allow a joint and more detailed needs assessment (including access to data), market testing and a planning process to ensure that investment decisions in after hours services are made on a cost effective basis and are well-targeted.

In particular we would seek to target those population cohorts in the community that experience difficulty in getting urgent after hours care, increase awareness of what services are available for what circumstances, support continuity of care within the primary health system, and support connectivity between various stand-alone services that deliver after hours primary care in the ACT (extended hours practices, CALMS, National Home Doctor Service, Walk-in-Centres, healthdirect and after hours GP help line, EDs and the ACT Ambulance Service). This would result in the support of the ACT primary health system, support continuity of care and enable connectivity between various stand-alone services that deliver after hours primary care in the ACT.

The resulting commissioning plan will be sent to DoH for approval prior to any contractual arrangements being entered into and will be subject to ACT Health agreed processes.

APPENDIX 1

11. Immunisation

The National Immunisation Program can be considered both a primary and secondary chronic disease prevention measure providing both direct benefit to individuals who are vaccinated and where there is high vaccine coverage a secondary benefit to unvaccinated people who receive indirect protection due to less disease circulating amongst the community:

- primary prevention measures encompassing Hepatitis B (HepB) vaccination and the Human Papillomavirus (HPV)
- secondary prevention measures (safeguarding the health of older people, pregnant women, Aboriginal and Torres Strait Islander people, very young children and people with underlying chronic disease) encompassing Pneumonia (Pneumococcal Conjugal) , Influenza and Whooping Cough (Acellular Pertussis).

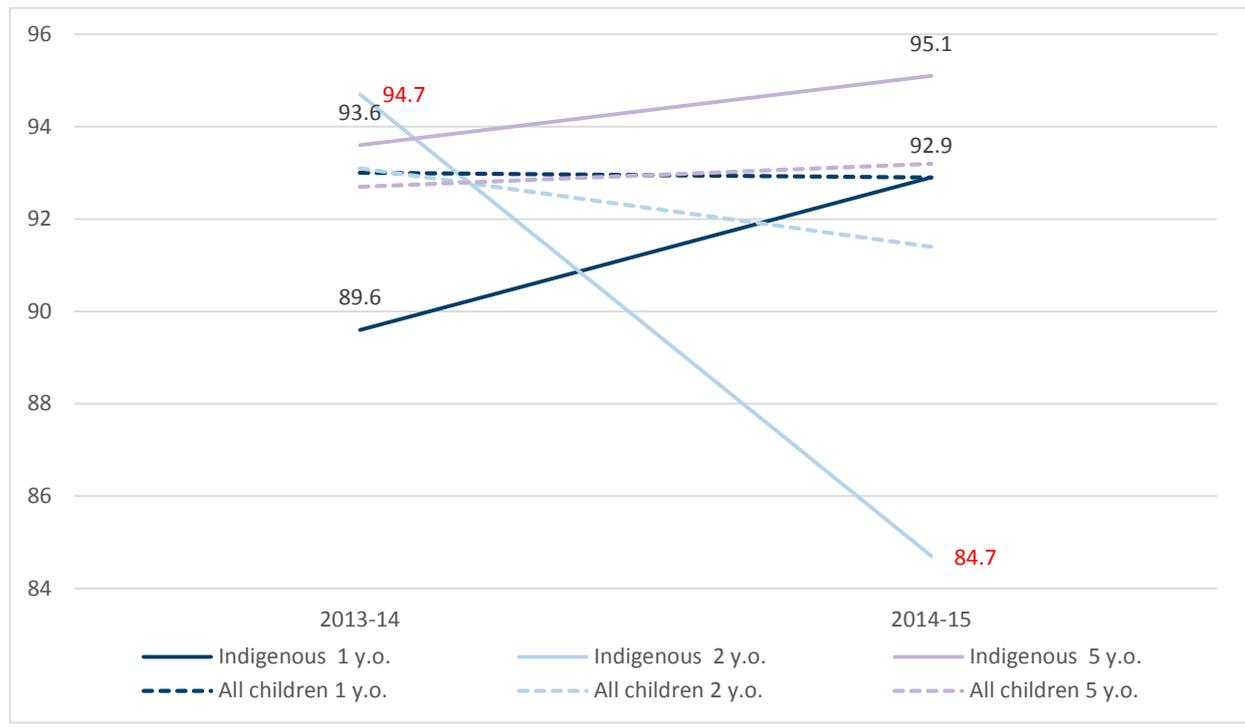
Childhood immunisation

As at March 2016, ACT demonstrated higher than average performance in childhood immunisation with some 93.4% of all children 12-15 months (Australia 92.7%), 91.7% of all children aged 24-27 months (Australia 90.1%) and 93.7% of all children aged 60-63 months (Australia 92.7%) fully immunised in line with requirements of the National Immunisation Program (Department of Health, 2016a). These results are consistent with the immunisation rates of Aboriginal and Torres Strait Islander children in the ACT. Although ACT performance in this respect is somewhat lower than in the highest performing PHN regions (92% ACT- range 76.7%-100% at 12-15 months, 88.1% ACT – range 77.1%-100% at 24-27 months, 88.5% ACT – range 80%-100% 60-63 months) (Department of Health, 2016d, Department of Health, 2016b).

The average rate of immunisation coverage for ACT Aboriginal and Torres Strait Islander children increased from 89.6% in 2013-14 for children aged 12-15 months, to 92.9% in 2014-15.

Immunisation rates for 5 year old Aboriginal and Torres Strait Islander children also increased from 93.6% (2013-14) to 95.1% (2014-15), whereas the rates for 2 year olds has decreased (from 94.7% to 84.7%) (Figure 11.1). This could be due to a change in the definition of 'fully immunised' for 2 year olds which occurred on 31 December 2014. The inclusion of three additional vaccines has caused a decrease in the reported immunisation coverage rates for 2 year olds. Along with the change in definition, the low numbers of Aboriginal and Torres Strait Islander children in the ACT indicate that caution should be used when interpreting these numbers.

Figure 11.1: Percentage of fully immunised children at 1, 2 and 5 years old, by Indigenous status, in the ACT, 2013-14 and 2014-15



Source: (National Health Performance Authority, 2016a)

The data on the immunisation rates for Aboriginal and Torres Strait Islander children can only be drilled down as far as the SA3 level, and in the ACT figures can only be obtained for Belconnen and Tuggeranong, as the other areas either have less than 26 children registered for their age group, or the number of children not fully immunised is between 1 and 5 inclusive.

The following figures demonstrate, per postcode, the trend of immunisation rates over the past 4 years, from 2011-12 to 2014-15. This evidence demonstrates that there is a lack of consistency across the ACT, with some suburbs experiencing a steady increase or decrease of rates, while others have experienced various peaks and troughs across the 4 year period.

Figure 11.2: ACT 1 year old immunisation rates by postcode

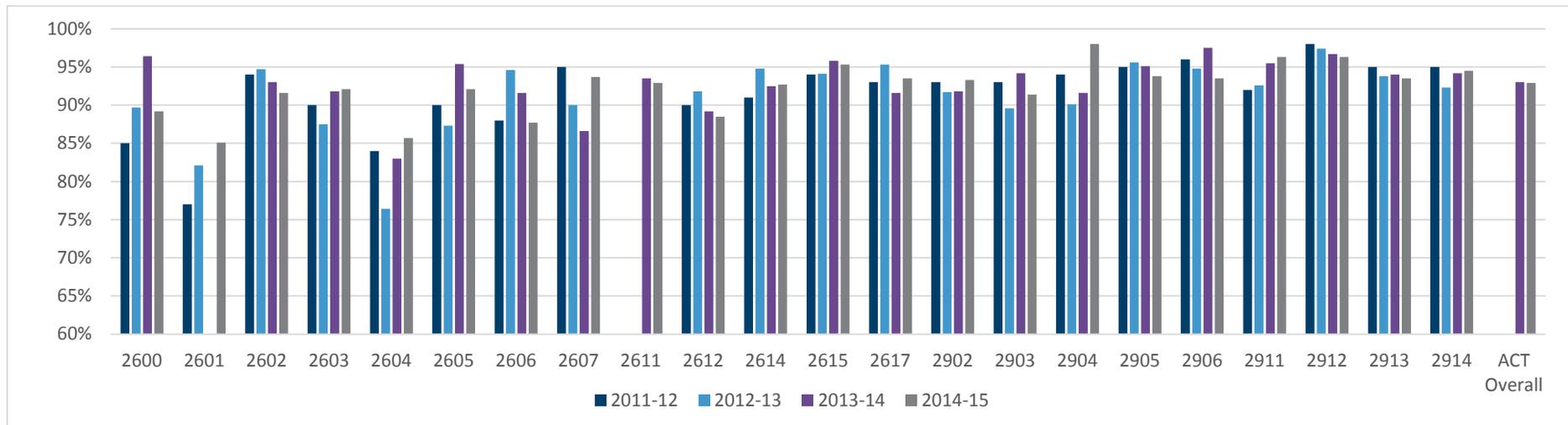


Figure 11.3: ACT 2 year old immunisation rates by postcode

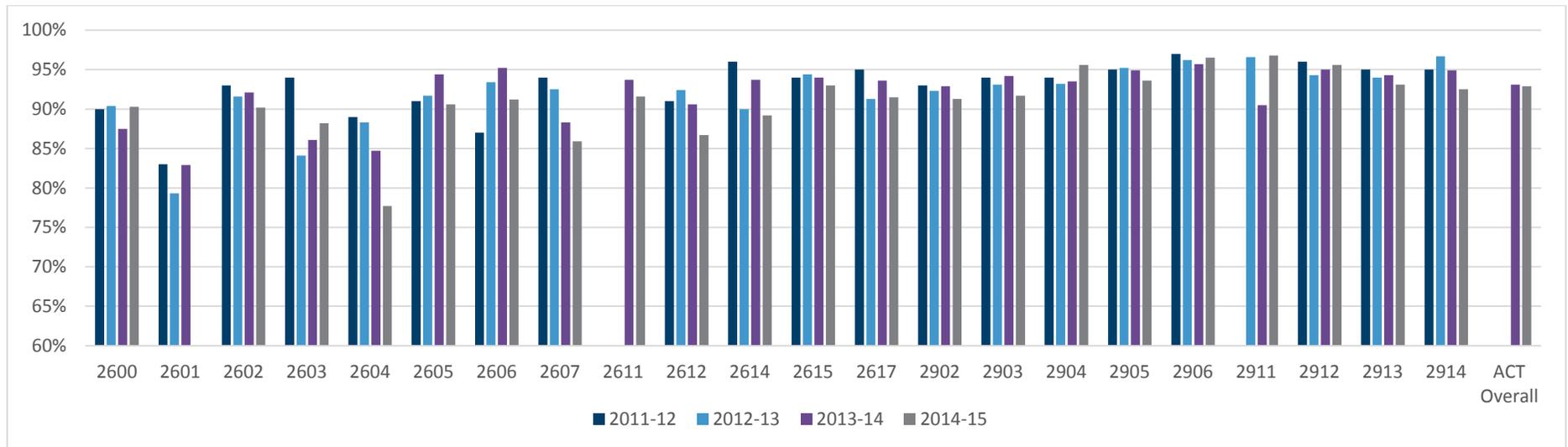
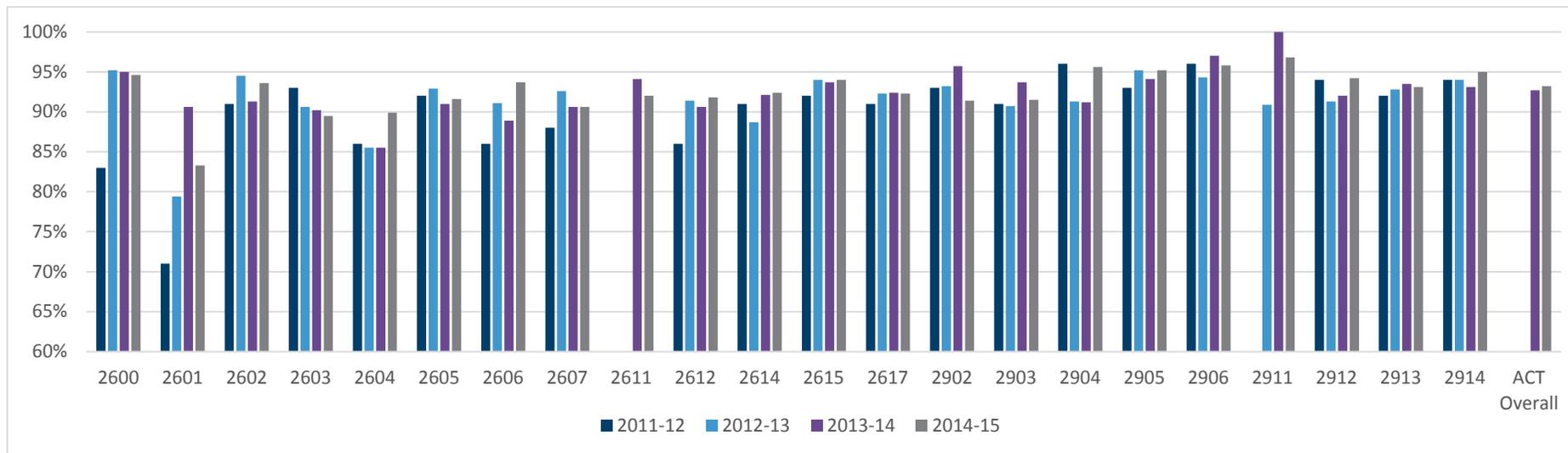


Figure 11.4: ACT 5 year old immunisation rates by postcode



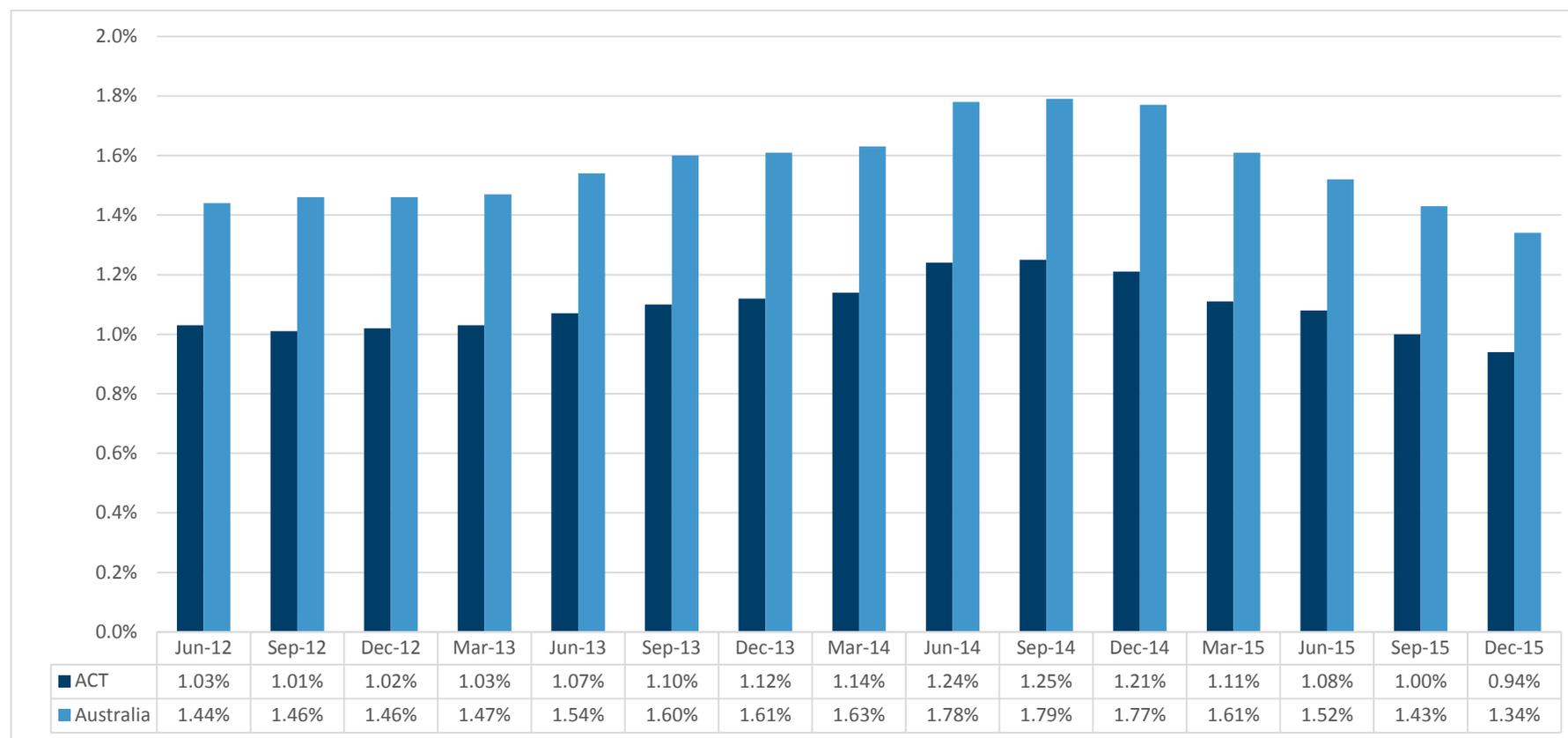
Source: (National Health Performance Authority, 2016a)

Postcode areas 2911 (Crace & Mitchell) and 2904 (Fadden, Gowrie, Maccarthur and Monash) consistently have a high percentage of their population fully immunised, however there are either less than 26 children registered, or the number of children not fully immunised is between one and five inclusive, in each of the age groups in 2911, and less than 26 children aged 1 year in 2904, which suggests that these numbers should be interpreted with caution.

Producing some of the lowest rates of immunisation in Canberra are post codes 2601 (Acton, Black Mountain, Canberra City) and 2604 (Kingston and Narrabundah), however there are either less than 26 children registered, or the number of children not fully immunised is between one and five inclusive, in each of the age groups in 2601, so this should be interpreted with caution. In regards to the immunisation rates in Kingston and Narrabundah, there are 147 one year old children registered (with 21 not fully immunised in 2014-15), 139 two year olds (with 31 not fully immunised), and 119 five year olds (with 12 not fully immunised). While these numbers are not high, they are still interesting when compared to the rest of Canberra.

The ACT has a low rate of conscientious objectors when compared with the rest of Australia, and this rate has decreased steadily in the 15 months from September 2014 to December 2015, as demonstrated in Figure 11.5 below.

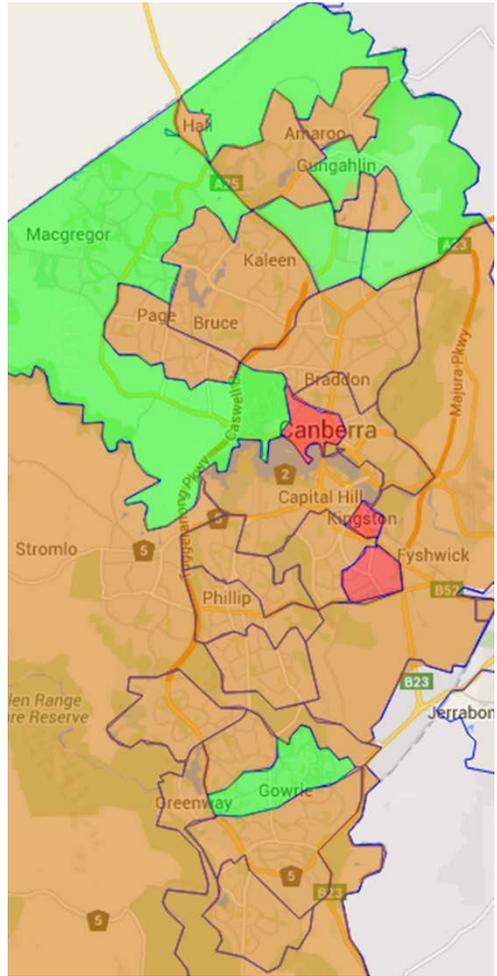
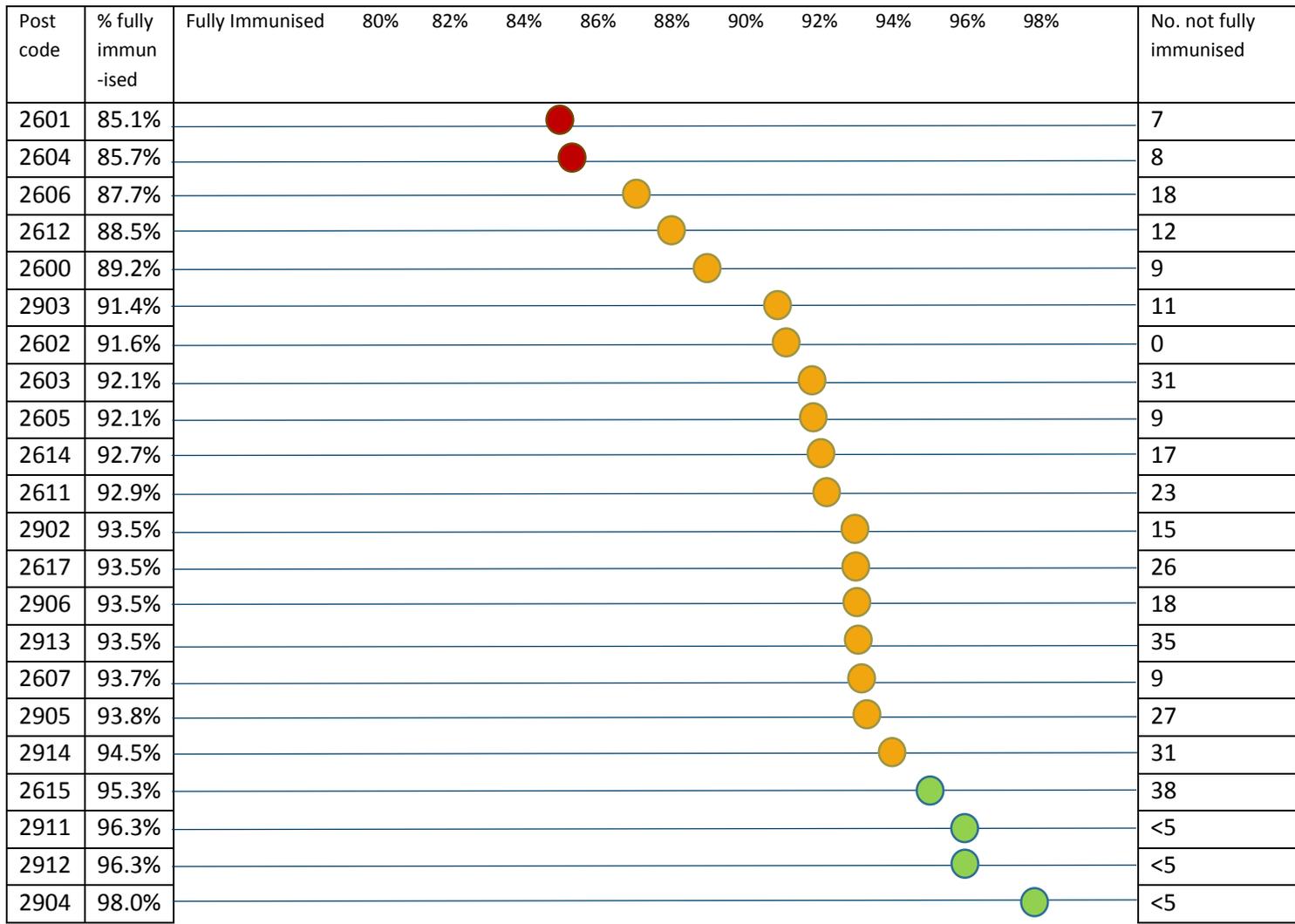
Figure 11.5: Percentage of children with conscientious objection recorded, ACT and Australia



Source: (Department of Health, 2016a)

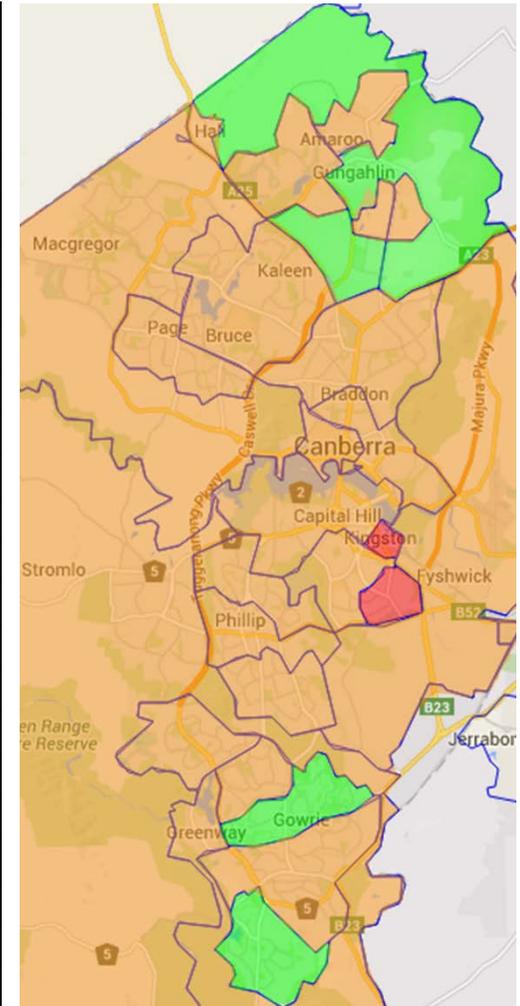
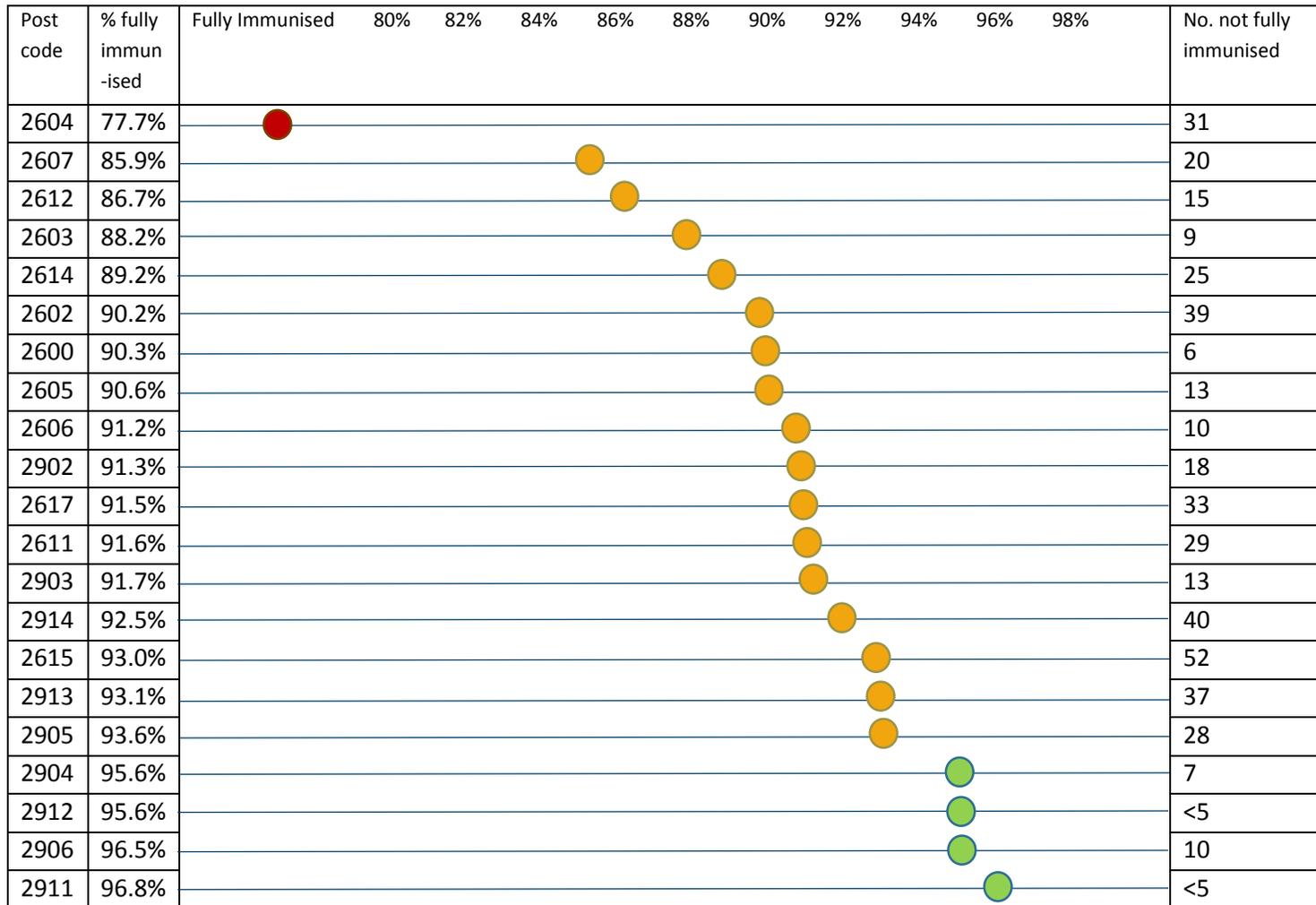
Figure 11.6, Figure 11.7 and Figure 11.8 show the percentage of children immunised and number of children not fully immunised by postcode in the ACT, for children aged 1 year, 2 years and 5 years respectively.

Figure 11.6: ACT 1 year old immunisation rates, 2014-15



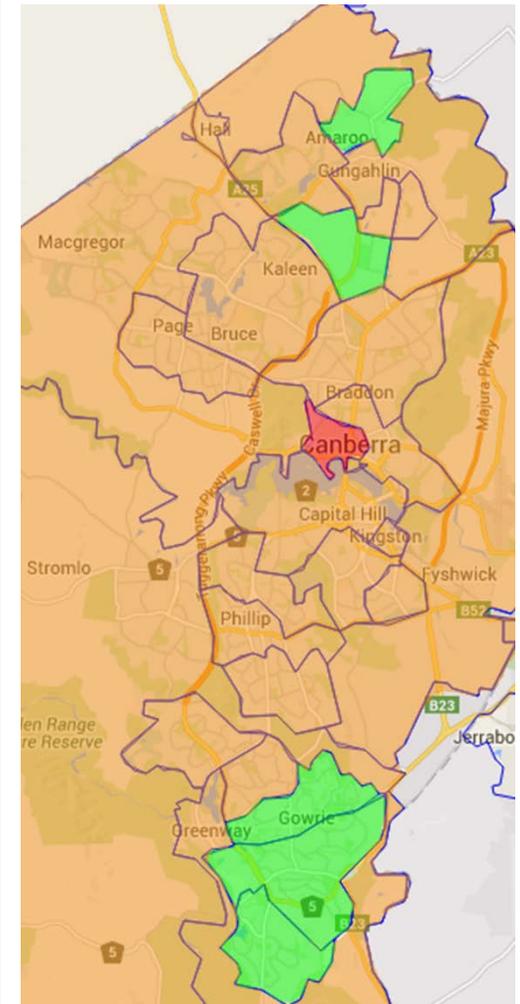
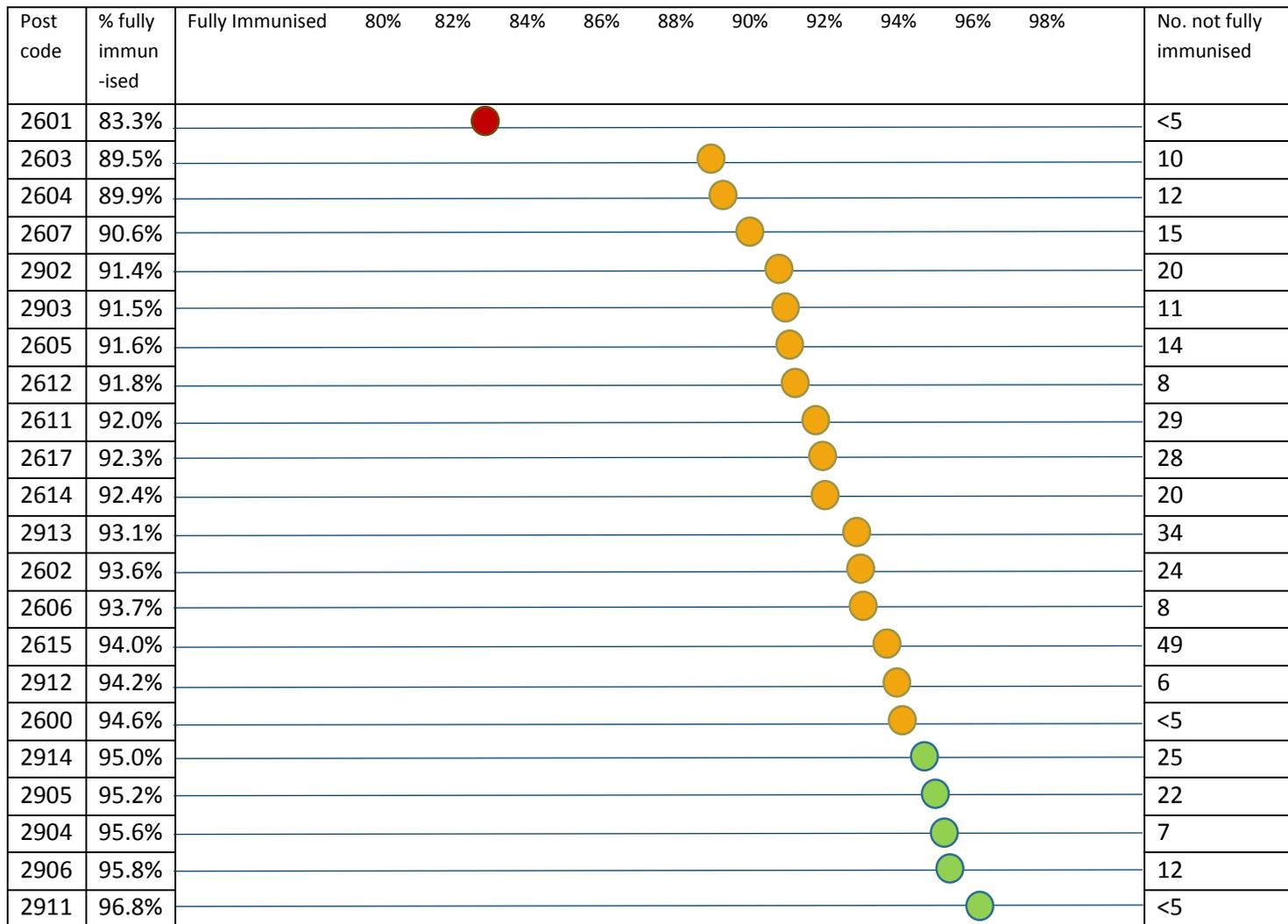
Source: (National Health Performance Authority, 2016a)

Figure 11.7: ACT 2 year old immunisation rates, 2014-15



Source: (National Health Performance Authority, 2016a)

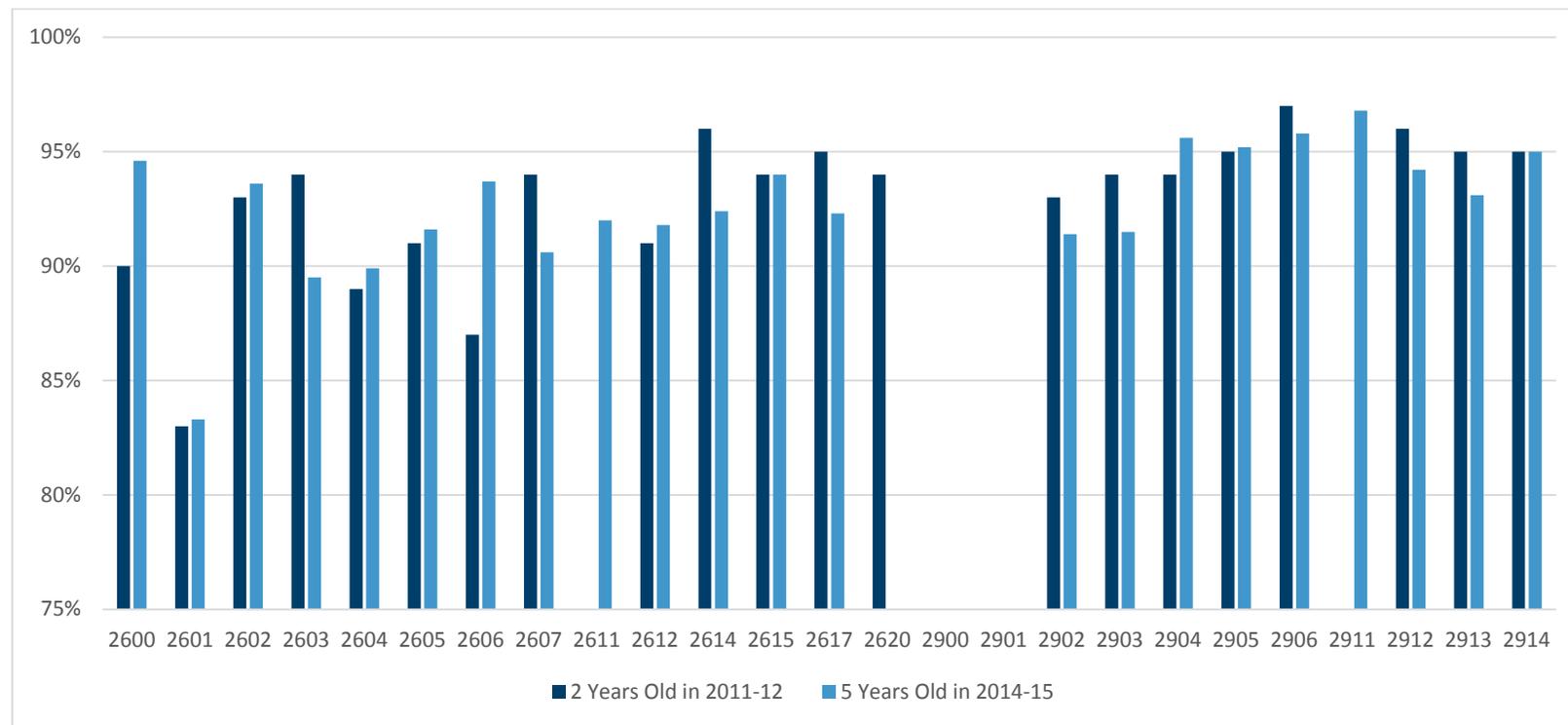
Figure 11.8: ACT 5 year old immunisation rates, 2014-15



Source: (National Health Performance Authority, 2016a)

A comparison of the immunisation rates of 2 Year Olds in 2011-12 and 5 Year Olds in 2014-15 was conducted to simulate the potential pattern of immunisation compliance across the life of a child. As shown in Figure 11.9, while there are postcodes where children maintained their immunisation status (2615, 2905, 2914), other postcodes experienced either decreases or increases in the percentage of children fully immunised at that age, with a fairly equal amount of postcodes either increasing or decreasing their immunisation coverage.

Figure 11.9: Comparison across child's life - 2 year old rates in 2011-12, 5 year old rates in 2014-15, in the ACT

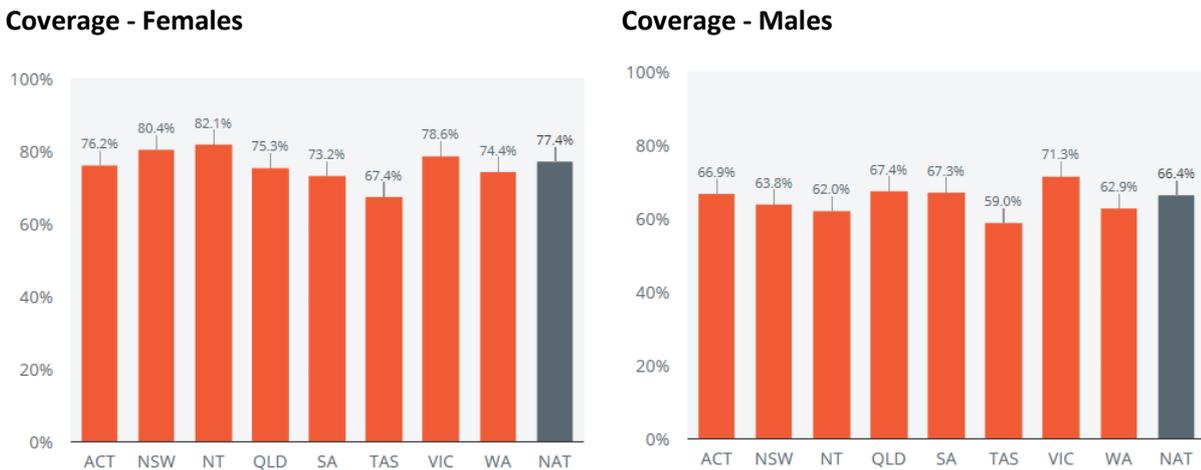


Source: (National Health Performance Authority, 2016a)

Human Papillomavirus (HPV) immunisation

In 2015, the ACT was below the national average for female coverage of HPV at 76.2% coverage (Australia 77.4%; range: 67.4% - 82.1%) while male coverage was slightly above the national average at 66.9% coverage (Australia 66.4%; range 59% - 71.3%) (Figure 11.10).

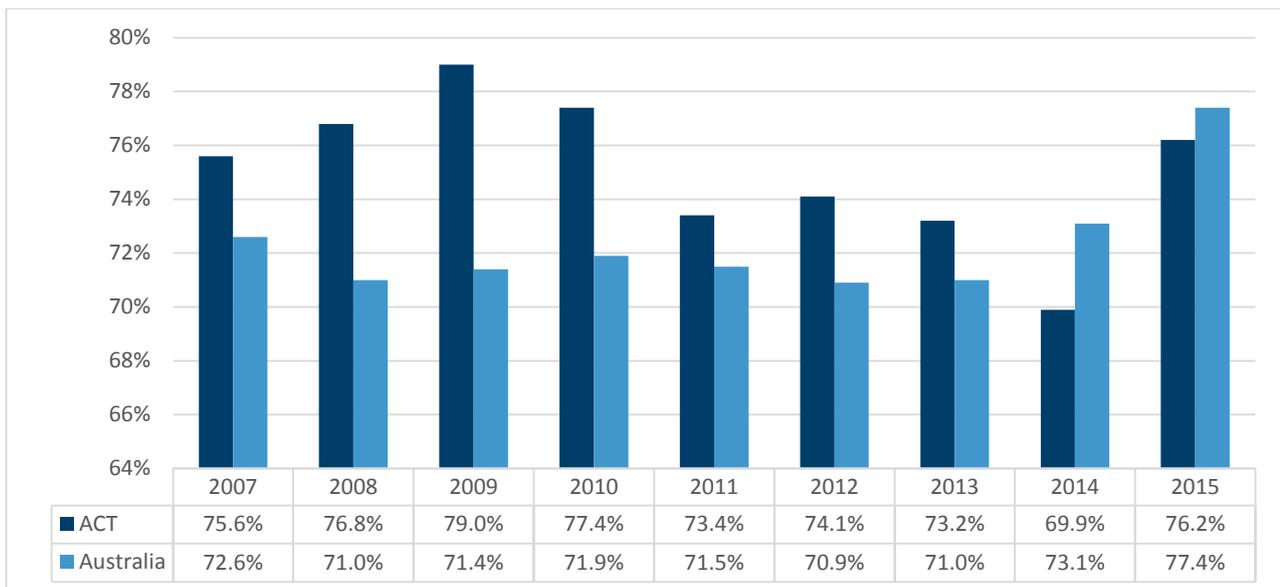
Figure 11.10: HPV 3 dose vaccination coverage, females and males turning 15 years in 2015



Source: (National HPV Vaccination Program Register, 2016)

Since the introduction of the HPV immunisation in 2007, the ACT has recorded high numbers of 15 year old girls having received the full three doses of the HPV vaccine, consistently better than the national rates. However, in 2014 and 2015 the coverage rates have dropped below the national average in regards to completing the entire vaccine schedule (Figure 11.11).

Figure 11.11: Percentage of HPV 3 dose coverage for all females turning 15 years of age from 2007-2014



Source: (National HPV Vaccination Program Register, 2016)

Taking a closer look at the data for females turning 15 years of age in 2014, we can see that this cohort started out well, with high rates of coverage (89.9% in the ACT), however over 400 girls failed to complete the schedule by receiving the third vaccination (Table 11.1).

Table 11.1: Number and percentage of ACT and Australian HPV vaccination

State	Est. Resident Pop (as at 30/06/2014)	Coverage Dose 1		Coverage Dose 2		Coverage Dose 3	
		n	%	n	%	n	%
ACT	2133	1918	89.9%	1837	86.1%	1490	69.9%
Australia	139,029	114,684	82.5%	110,209	79.3%	101,689	73.1%

Source: (National HPV Vaccination Program Register, 2016)

It should be noted that participation in the HPV Register is not compulsory and it must be done manually by GPs or organisations providing the vaccinations, as it is not part of the Australian Childhood Immunisation Register.

Other vaccinations

The most recent adult vaccination survey published in 2009 focused on adult experience of influenza and pneumococcal vaccination and included questions on pertussis (whooping cough) vaccination for adults (Australian Institute of Health and Welfare, 2011a). These conditions can lead to serious complications and death in very young children, older people and those people with chronic disease and comorbidities. For example, people suffering with various circulatory, respiratory and immuno-suppressant conditions are at high risk of influenza and its complications.

As at 2009 an estimated:

- 74.6% of Australians and 78% of ACT residents aged over 65 years were vaccinated against seasonal flu (range 69.3% - 81.3%)*.
- ACT had the highest number of women aged over 65 years (80.7%, Australia 76.5%) vaccinated against seasonal flu and 60.1% (Australia 69%) vaccinated against pneumococcal disease.
- 74.8% (Australia 72.2%) and 45.2% (Australia 48.8%) of men aged over 65 years vaccinated against seasonal flu and pneumococcal disease respectively.
- 54.5% of Australians aged over 65 years were vaccinated against pneumococcal disease*.
- Nationally 51.5% of the target population aged over 65 years were vaccinated against influenza and pneumococcal disease and 22.1% of the target population aged over 65 years were not vaccinated for either disease.

- 18.9% of Australians over the age of 18 years and 42.6% of those aged over 65 years had received pandemic (H1N1 – swine flu) vaccination, or 43.3% vaccinated in the ACT.
- 11.3% of Australians and 12.6% of ACT residents aged over 18 years had received a pertussis vaccination as an adult or adolescent with uptake substantially higher among parents of infants aged less than 12 months at 51.5% nationally.

*Note: 96% of these vaccinations were provided free of charge, either under the government-funded immunisation program (including people with chronic disease) or by employers. Put another way, 96% of the vaccinated target population were vaccinated with program-provided vaccine.

Suburbs and postcodes

- [2600](#)
 - Barton
 - Canberra
 - Capital Hill
 - Deakin
 - Duntroon
 - Fairbairn Raaf
 - Harman
 - Hmas Harman
 - Parkes
 - Parliament House
 - Russell
 - Russell Hill
 - Yarralumla
- [2601](#)
 - Acton
 - Black Mountain
 - Canberra
 - City
- [2602](#)
 - Ainslie
 - Dickson
 - Downer
 - Hackett
 - Lyneham
 - O'connor
 - Watson
- [2603](#)
 - Forrest
 - Griffith
 - Manuka
 - Red Hill
- [2604](#)
 - Causeway
 - Kingston
 - Narrabundah
- [2605](#)
 - Curtin
 - Garran
 - Hughes
- [2606](#)
 - Chifley
 - Lyons
 - O'malley
 - Phillip
 - Swinger Hill
 - Woden
- [2607](#)
 - Farrer
 - Isaacs
 - Mawson
 - Pearce
 - Torrens
- [2608](#)
 - Administrative Postcode Only
- [2609](#)
 - Canberra International Airport
 - Fyshwick
 - Pialligo
 - Symonston
- [2610](#)
 - Canberra Mc
- [2611](#)
 - Brindabella
 - Chapman
 - Duffy
 - Fisher
 - Holder
 - Mount Stromlo
 - Pierces Creek
 - Rivett
 - Stirling
 - Uriarra
 - Uriarra
 - Uriarra Forest
 - Waramanga
 - Weston
 - Weston Creek
- [2612](#)
 - Braddon
 - Campbell
 - Reid
 - Turner
- [2614](#)
 - Aranda
 - Cook
 - Hawker
 - Jamison Centre
 - Macquarie
 - Page
 - Scullin
 - Weetangera
- [2615](#)
 - Charnwood
 - Dunlop
 - Florey
 - Flynn
 - Fraser
 - Higgins
 - Holt
 - Kippax
 - Kippax Centre
 - Latham
 - Macgregor
 - Melba
 - Spence
- [2616](#)
 - Belconnen
- [2617](#)
 - Belconnen
 - Belconnen Dc
 - Bruce
 - Evatt
 - Giralang
 - Kaleen
 - Lawson
 - Mckellar
- [2900](#)
 - Greenway
 - Tuggeranong
- [2901](#)
 - Administrative Postcode Only
- [2902](#)
 - Kambah
- [2903](#)
 - Erindale Centre
 - Oxley
 - Wanniasa
- [2904](#)
 - Fadden
 - Gowrie
 - Macarthur
 - Monash
- [2905](#)
 - Bonython
 - Calwell
 - Chisholm
 - Gilmore
 - Isabella Plains
 - Richardson
 - Theodore
- [2906](#)
 - Banks
 - Conder
 - Gordon
- [2911](#)
 - Crace
 - Mitchell
- [2912](#)
 - Administrative Postcode Only
- [2913](#)
 - Franklin
 - Ginninderra Village
 - Ngunnawal
 - Nicholls
 - Palmerston
- [2914](#)
 - Amaroo
 - Bonner
 - Forde
 - Harrison

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