

Supplementary
Submission
No 73a

INQUIRY INTO INQUIRY INTO ELDER ABUSE IN NEW SOUTH WALES

Organisation: Australian Medical Association

Date received: 14/12/2015

AMA Position Statement on Care of Older People 1998 – amended 2000 and 2011

General

1. Ageing is a normal process and does not, of itself, imply illness, impairment or disability. However most older people will be subject to a range of physical and/or psychological conditions resulting in functional impairment that can be reduced by involvement of medical practitioners and other health care workers.
2. The quality of medical care for older people at home, in hospital and in residential aged care facilities should reflect those principles considered to be optimal medical practice. Standards of care should not be compromised through discrimination on the basis of age, restriction of resources or economic rationalisation. It is a basic right for all older people to have access to a medical practitioner of their choice.
3. Health care and social services, including comprehensive assessment and effective rehabilitation, should be directed towards the restoration and maintenance of each person's optimal level of independence.
4. With the increasing proportion of older people in the population, health care services for older people should be expanded within the community setting, in hospitals and in residential care. The effectiveness of these services must be evaluated regularly to ensure that older peoples' needs are being met.
5. Health services for older people should both acknowledge and meet the special needs of older people and respect cultural values.
6. Formal prior delegation of authority and an advanced care directive should be sought whilst the patient is still competent, and should be regularly reviewed. When an older person is incapable of requesting or refusing health care services, the views of family or a legally recognised guardian should be sought.
7. The resources allocated for the health of older people by federal and state governments should be reassessed regularly, in consultation with older people, as well as with health care professionals, providers of residential care, and carers.
8. Medical practitioners should encourage health service planners and funders to provide funding for the needs of older people and of their carers, and to consult older people on all issues which affect their needs.

Home and community care

9. Community care, including domiciliary services for older people, is of crucial importance. Services should be matched to the needs of each individual, be comprehensive, linked to the medical services received by the patient, and co-ordinated at the practice level.
10. Services for older people should complement and enhance, rather than replace, the supportive care of family members and should, therefore, include respite for carers.
11. The role of individual carers, and voluntary private organisations in the care of older people is to be recognised and encouraged, and not used as a substitute for deficiencies in the provision of government services.

12. The points of access to domiciliary support services should be easily identifiable and available to the older person, their carers and their general practitioner.

13. The AMA acknowledges the increasing use of team care arrangements. However, co-ordination of, and responsibility for, the health care of an older person should remain with their general practitioner with increasing use of practice nurses. General practitioners must be involved in the decision-making process relating to the care of their older patients, including involvement with Aged Care Assessment Teams, geriatric and rehabilitation services, Home and Community Care and other community services.

14. Medical practitioners should be able to authorise urgent access to government-subsidised aged care services.

Residential aged care facilities

15. When an older person is no longer able to remain at home, a range of residential care options, which can cater to their physical and psycho-social needs should be available.

16. High level care in a residential aged care facility should be available to any person who is in need of such care irrespective of their financial position.

17. The application of standards for residential aged care facilities should enhance and improve delivery of resident care, promote efficiency and be practical.

18. The associated documentation should facilitate face-to-face contact or services by staff and medical practitioners. There should be close communications between general practitioners and residential aged care facilities including the capacity for remote electronic access to files by doctors.

19. All staff employed in residential aged care facilities should be appropriately trained and be involved in continuing educational programs.

20. Regular discussion of patient care issues between the patient's general practitioner and the other providers of care should be encouraged. Quality assurance procedures must be established in residential facilities to facilitate monitoring by medical practitioners of the clinical services provided to residents.

Hospital care

21. Older persons must not be denied access to hospitals on the basis of their age or because of their co-morbidities.

22. Hospitals should provide a designated geriatric medical service with beds for acute care, assessment and rehabilitation, according to their size and specialisation.

23. Medical practitioners with expertise in aged care should be an integral part of each hospital's service and be available for consultation and advise.

Dementia and psychogeriatric care

24. Dementia and psychogeriatric care require access to specialised medical and other staff, and facilities, to complement geriatric services. The staff and facilities should be able to provide appropriate assessment and management, whether the older person is at home, in hospital or in residential care. Adequate staff must be available to provide quality care.

Elder abuse

25. Elder abuse includes physical, psychological or financial abuse or neglect and may be intentional or unintentional. It violates basic legal and human rights. Older people should be able to live in dignity and security and be free from abuse.

26. Carers should receive adequate information, education and support at the time the person is registered for care to reduce the risk of elder abuse.

27. Education and training programs on the recognition, intervention and management of elder abuse should be available to all health professionals involved in the care of older people.

28. Medical practitioners, especially general practitioners, have a pivotal role in the recognition, assessment, understanding and management of elder abuse and neglect, with effective reporting mechanisms available when required.

Research related to the care of older people

29. Improvements in care will result from properly designed, analysed and reported biological, clinical and public health research. Resources should be made available by governments to ensure the funding of research programs that focus on age related issues.

30. As a matter of urgency, research, especially clinical research into age-related issues, should be encouraged and supported.

31. This research should be multidisciplinary because of the complex inter-relationships between genetic, psycho-social, environmental and economic factors causing dysfunction from disease, disuse, and the effects of biological ageing.

Health promotion and education

32. Disability in old age is often influenced by prior lifestyle.

33. Health authorities, hospitals and community based services, should co-operate with general practitioners in developing programs to promote the optimal health of older people before disabilities develop. Programs should target high risk persons.

34. Undergraduate, postgraduate and continuing education of health care providers has an important role in promoting recognition of special needs of older people as well as the value of health promotion in reducing disability in older age.



AUSTRALIAN MEDICAL
ASSOCIATION
ABN 37 008 426 793

T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au

42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

10/117

Mr Mike Woods
Deputy Chairman
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Productivity Commission Inquiry into Caring for Older Australians

Dear Mr Woods

I am pleased to provide the Productivity Commission with the Australian Medical Association (AMA) submission to the Commission's inquiry into Caring for Older Australians.

The geriatricians, old age psychiatrists, general practitioners, and rehabilitation and palliative care specialists that met with the Productivity Commission inquiry team in Canberra on 2 July 2010 were very appreciative of the opportunity to present their views on how to improve access to medical care for older Australians. The AMA hopes that the team found the extensive consultation with the doctors, who care for older Australians every day, informative and valuable to the inquiry.

The AMA submission to the inquiry is based on AMA policies and the key issues discussed during the consultation.

Yours sincerely

Dr Andrew Pesce
President

9 August 2010

ap:sc



AMA

**AMA Submission to
Productivity Commission Inquiry into
Caring for Older Australians**

Introduction

Demand for health care services to meet the needs of older Australians is growing rapidly. Future generations of older people are likely to have more complex health care needs and expect a higher quality and level of service. There will be an increasing preference by older Australians to live and be cared for at home wherever possible and for as long as possible.

One of the critical requirements for quality care for older Australians is timely patient access to a doctor. With the number of older people (65 to 84 years) expected to more than double from 2.6 million to 6.3 million, and the number of very old (85 and over) to more than quadruple from 0.4 million to 1.8 million, between 2010 and 2050, there is a clear imperative for the Australian Government to develop a sustainable service delivery framework to provide access to medical services for older people in the community and residential aged care. “Medical services” means services provided by a medical practitioner.

Improving access to medical services for older people who live in the community and residential aged care will reduce unnecessary hospital and emergency department admissions and improve the quality of care. The interface between the aged care sector and medical practitioners must be timely and functional. Adequate incentives must be developed, and access to nursing and allied health services must be improved, to support the medical workforce to provide medical care to older Australians living at home and in aged care facilities.

Community Care

For the many older Australians living at home, access to community care is essential to support them to maintain their health, well being and independence and to continue living in their own home when they might have otherwise needed to move into residential aged care. Access to regular medical care and supervision is an essential component of their care needs.

General practitioners (GPs) are the primary medical care providers for older people living in the community and form long-term relationships with their patients and their families. They play a crucial role in managing and coordinating care for an older person.

However current Medicare benefit arrangements do not reflect the time it takes to provide care to older people with chronic long-term conditions and do not cover the costs of delivering medical care outside of the doctor’s surgery. As a result, home

visits no longer feature in general practitioner care as much as they once did. As older people seek to live independently in their own homes rather than move into residential aged care facilities, there will need to be greater support for providing medical care in the community setting.

Government funding arrangements must support models of medical care where the doctor goes to the patient, rather than the patient goes to the doctor. The Department of Veteran Affairs has a number of good service delivery models in place that could be translated more broadly into general practice.

The delivery of medical care to older people outside of the doctor's surgery, including models of care where the doctor delegates tasks to practice and/or specialised nurses, and/or other health practitioners within a team based model of care, will have an immediate impact on improving access to medical care.

For example, a practice or community nurse could regularly visit an older person living at home with a chronic condition and liaise with the doctor to ensure they have access to timely medical care, allowing them to maintain their health and independence and continue living at home.

In the case where an older person living at home becomes very unwell, a practice or community nurse could step up the number of visits and care provided to the older person in addition to a doctor's visit, and in consultation with the doctor. Such a model would improve the care of older people, prevent inappropriate hospital and emergency department admissions and free up acute care resources.

This could be better facilitated if the Medical Benefit Schedule (MBS) reflected:

1. the complexity and significant amount of clinically relevant non face-to-face time involved in providing medical care and medical supervision to older Australians who live in the community;
2. a team-based model, including expanded roles for practice nurses acting for and on behalf of the GP's; and
3. the true cost of providing services to older people who live either at home or in residential aged care.

There are some rural models offering seamless access to care i.e. Multi-purpose services; district nursing services. We need to explore the possibilities of adapting these models for use in urban areas.

Entry points to care

Right now there is no clarity about where and how an older person living in the community who needs a range of medical, health and community care should enter the system to receive that care. Patients who enter at different points can have a variety of different outcomes. AMA members report that access to community care services is often impenetrable for older people and health care professionals. Often community care is divorced from the rest of the health care system and lacks direction or coordination. Delayed access to community care increases the risk of unnecessary hospital and emergency department admissions and all too often, care for an older person is only arranged in a crisis situation.

Australia needs a solid plan for the future care needs of older Australians and mechanisms for connecting the person with the medical and health services they need when they need them. Entry points into community care must be clear, and coordinated service delivery models that streamline access to medical care and related services must be developed.

Aged care assessment

The current aged care assessment arrangements fall short on efficiency and responsiveness to the care needs of older people. The effectiveness of the aged care assessment process can be improved by including the patient's usual medical practitioner in the assessment arrangements.¹ Our members tell us aged care assessment currently makes little use of the information doctors can provide about their patients. Medical practitioners form long-term relationships with their patients and an older person's usual doctor can bring his or her background knowledge of the whole person and their current circumstances to the assessment process. This information would ensure the person's assessment results in them receiving the care that is most appropriate for them, be it community or residential aged care.

Respite care

Demand for respite services is likely to increase over the next ten years as the trend toward community care increases and the carer base diminishes. The need for respite care usually occurs when the carer has become unwell and/or is temporarily unable to provide care. In these situations it is often very difficult to access to respite care.

Approval for respite care depends on a formal Aged Care Assessment Team (ACAT) assessment. In some jurisdictions, difficulty in accessing an ACAT assessment means it can take months before approval for respite care is given. In the meantime, sometimes the only option is to admit the patient to hospital in order to give the carer some relief. This causes great distress for patients and their carers, and risks delivering respite care that is inappropriate both in timing and in the nature of care given.

A streamlined process is required to improve access to respite care for people who have not yet been assessed by an ACAT or who have not yet entered the aged care system. GPs who work in aged care know their patient's circumstances and requirements. In these circumstances, access to respite care could be streamlined by allowing GPs to approve respite care for older people in need of urgent respite care in much the same way a doctor determines that hospital admission is necessary.

Transport

As more very old Australians continue to live in their own homes, their ability to access to services will need to be better supported through transport schemes that provide older Australians with access to medical and other health services that cannot be delivered to them.

¹ AMA submission to the Senate Community Affairs Committee on the Aged Care Amendment (2008 Measures No.2) Bill 2008.

Residential aged care

Many residents are transferred into residential aged care facilities from hospital after a long and complex admission, and have multiple and complex health care needs that require ongoing medical care. In the future, residential aged care will need to develop the capacity to provide a range of services - residential, respite, sub-acute and transitional care – and have the flexibility to provide services as the health care needs of residents change.

Doctors are not traditionally counted as part of the aged care workforce. Yet access to ongoing medical care for people living in residential aged care facilities is fundamental to achieving good health and quality of life. Doctors report many obstacles to providing medical services to older people in residential aged care:

1. a lack of access to registered nurses with whom to coordinate care;
2. an increasing use by residential aged care facilities of agency staff who are not familiar with residents which compromises continuity of care;
3. poor access to properly equipped clinical treatment rooms which limits the medical treatment that can be provided in that setting;
4. an absence of information technology infrastructure to facilitate access to electronic patient records and medication management, including software appropriate to the needs of GP's;
5. a strong financial disincentive for the doctor to leave their surgery, with all its attendant costs, to provide services in residential aged care; and
6. a growing tendency to build aged care homes in the outer growth corridors or 'urban fringe' of metropolitan areas which further adds to the time spent by doctors away from their surgeries.

In an AMA survey of 750 GPs in 2008² (Box 1), 15% of GPs said they intended to decrease the number of visits to residential aged care facilities over the next two years and 7% reported they would stop visiting altogether if the current barriers to the delivery of medical care were not addressed. Residential aged care providers have also reported difficulty in accessing GP services for residents in nursing homes.

While there are dedicated doctors who continue to bulk bill services to residents in aged care facilities and provide services in less than adequate care delivery environments, many of them are nearing retirement age. Demand for medical services in the sector will exceed supply unless policies and incentives are put in place to support doctors to deliver medical services to older Australians in residential aged care facilities.

An aged care accreditation standard for medical care

Aged care providers have an inherent responsibility to guarantee residents access to ongoing medical care and supervision. Yet there is no aged care accreditation standard which requires aged care providers to arrange medical care for their residents. In the absence of such a standard, there is no process for monitoring

² AMA Survey of GP Services to Residential Aged Care Facilities. May 2008.

Box 1. Key findings of an AMA survey of 750 GPs in 2008 were:

Three quarters (75.2%) of GPs surveyed visit RAC.
Average age of respondents undertaking visits was 52.5 years.
Average number of visits per month = 8 (8.36)
Average number patients seen per visit = 5 (4.77)
Patient contact time and non-contact time was roughly equivalent.
Three quarters (78.36%) indicated that they had either maintained or increased the number of visits they made to RAC over the last 5 years.
Over one-quarter of respondents had increased their visits because there was no-one else available (27.19%) or because of the ageing patient profile (25.35%).
Of the quarter (24.8%) of GPs that had decreased the number of visits made to RAC over the last 5 years, 22.73% cited inadequate patient rebates as the reason.
Three quarters (77.13%) of GPs indicated that they would either maintain or increase the number of visits over the next two years, or would visit current patients but not take on any new patients.
Increased patient rebates to compensate GPs for time spent away from surgery was listed as the first priority by both GPs who did and did not visit RAC to encourage GP visits to RAC.

Average number of visits to an RACF per month	8.36 visits
Average numbers of patients seen per visit	4.77 patients
Average face-to-face time with each patient	3.12 minutes
Average amount of non-contact time for each patient	13.2 minutes
Average time away from surgery while visiting an RACF	1 hour, 47 minutes

whether residents are receiving medical care, and there is no incentive for providers of residential aged care to facilitate attendance by GP's.

While the current accreditation standard for clinical care covers the expected outcomes for care provided by all health professionals, it does not guarantee that residents are medically supervised and have ongoing access to timely and high quality medical care. A specific aged care accreditation standard for medical care will ensure that access to medical care is monitored and scrutinised under aged care accreditation arrangements like other important quality, service and care requirements.

Arrangements to provide medical care to residents

Innovative service delivery and funding frameworks must be explored to support access to medical care in residential aged care. These could include retainer arrangements, extending the role of the practice nurse into aged care, and Medicare rebates that reflect the complexity of care.

Retainer arrangements

The National Health and Hospital Reform Commission (NHHRC) recognised the poor access to medical care in residential aged care and recommended "funding be provided for use by residential aged care providers to make arrangements with primary health care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes".

Dedicated funding from Government would allow aged care providers to enter into arrangements with local doctors to provide ongoing medical services to residents. Payments under these arrangements would offset the lost business costs that medical practitioners incur while they are not providing services in their surgeries and would be over and above the MBS fee for service payments which would continue to be

claimed for each medical service provided to a resident in a residential aged care facility.

The AMA proposal for additional funding for access to medical services in residential aged care³ facilities calls for:

- accreditation arrangements that more closely monitor and guarantee that aged care residents receive medical care and supervision on an ongoing basis;
- access to adequately equipped clinical treatment areas that afford patient privacy and information technology to enable access to medical records and to improve medication management;
- specific financial support to approved residential aged care providers to allow and encourage them to enter into local agreements with medical practitioners to ensure residents can access appropriate medical care;
- access to sufficient number of registered nurses to monitor, assess and care for residents and liaise with doctors; and
- MBS items that better reflect complexity and the significant amount of clinically relevant non face to face time involved in providing medical care and medical supervision to residents of aged care facilities.

Extending the role of general practice nurses

General practitioners support and desire appropriate expansion of the role of nurses within a team based model of care. The AMA supports a model of care that allows the doctor to delegate tasks related to the care of older people to the general practice nurse (or, on occasion, other team members with clinical training). We believe this model would have an immediate impact, enhancing the quality of clinical assessment of patients, expanding the role of GP's in acute interventions, and reducing avoidable referrals to the acute hospital sector.

It is worth noting that proposals for nurse practitioners will not in themselves ensure residents in aged care have access to the medical care they need. Nurse practitioners will not be providing medical care and residents will still require access to general practitioners and medical specialists under collaborative care arrangements. Furthermore, the barriers to the delivery of medical care in residential aged care facilities still exist and nurse practitioners will encounter the same barriers experienced by doctors in the delivery of care.

In the context of nurse practitioners employed by residential aged care providers, an accreditation standard for access to medical care would ensure that the aged care provider has secured the services of medical practitioners with whom the nurse practitioners can practice collaboratively, as per the proposed Medicare and Pharmaceutical Benefits arrangements.⁴

Medicare rebates that reflect the complexity of care

There is a disconnect between the Medicare rebate and the true cost of providing the service in residential aged care. While many doctors are still bulk billing residents, this will become unsustainable.

³ AMA policy paper. Additional funding for access to medical services for residents of aged care facilities. 2008.

⁴ Letter from AMA to Office of Aged Care Quality and Compliance, Department of Health and Ageing re Appropriate models of practice for nurse practitioners in aged care. 2 February 2010.

Medicare rebates for medical services in residential aged care need to reflect the complexity and amount of clinically relevant non-face to face time in providing medical care to residents. Medicare Benefits Schedule items must reflect innovations that exist in other areas of the MBS by expanding the scope of tasks practice nurses can perform on behalf of doctors in the residential aged care setting.

Investing in more aged care places and better facilities

Federal Government investment in the residential aged care sector must ensure the sector can provide the level and quality of infrastructure and services to meet the needs of an ageing population. This includes funding to expand the number of places to meet demand and to upgrade facilities to the condition the community expects and values for older Australians. For instance, facilities must be able to provide adequately equipped clinical treatment areas that afford patient privacy. The development of clinical treatment rooms could be a condition for providers receiving capital grant money.

Aged care facilities must also have the information technology in place for medical practitioners to access patient information and manage patient care electronically.

An appropriately resourced and skilled aged care workforce

Of significant concern is the difficulty in attracting and maintaining an appropriately skilled aged care workforce, and in particular registered nurses. Over the last five years, the number of registered and enrolled nurses working in residential aged care has decreased while the use of agency staff and personal carers has increased. This places additional pressure on the nursing staff working in the sector to provide quality nursing care to residents. A lack of wage parity with the acute care sector for nurses who work in aged care is one of the main reasons nurses are not attracted to working in residential aged care.

Having sufficient numbers of registered nurses in aged care will help ensure that residents' health is properly monitored and that they receive adequate medical and nursing care. Residents who require medical attention will be quickly identified, and nursing care will be of the same quality provided in the acute care setting. This level of nursing care is appropriate to the needs of people who do need to enter residential aged care, and is desperately lacking today.

Teaching nurses homes

The provision of appropriate and accredited clinical training places in residential aged care would add to the overall breadth and depth of medical training and improve the quality of care of residents. It would encourage younger doctors to visit residential aged care, and educate the next generation of doctors about caring for the aged as part of routine medical practice. This concept is consistent with the principles of expanded training settings being explored elsewhere in the health education environment.

The Teaching Nursing Homes initiative announced in the 2010-11 Federal Budget is a step in the right direction in as much as it will provide the Australian aged care sector with 'centres of excellence' in education, training, research and development. The target group for this initiative must include medical, nursing and allied health professionals, and personal care workers, ancillary support workers and carers, both volunteer and paid.

Sub-acute/Rehabilitation care

Following an acute episode, timely access to specialist sub-acute services (Geriatric Medicine, Rehabilitation and Palliative Care) that minimise disability and subsequent handicap gives older people the best chance of recovery and provides them with the best opportunity to either return home or to access a low care residential aged care place if necessary.

While recovery from illness and minimisation of impairment and handicap takes time, that amount of time can be minimised with access to an appropriate mix of multi-disciplinary specialist care such as geriatric medicine and rehabilitation services. Waiting in an acute care bed for placement in an aged care facility should not be the standard default clinical pathway for older Australians who have experienced an acute episode.

The AMA Priority Investment Plan 2009⁵ calls for an immediate increase in restorative services and sub-acute beds for rehabilitation and convalescence so that there are appropriate services for people who leave hospital but need further care:

Funding efficient sub-acute care services will allow older people with a complex illness to access an appropriate treatment environment that allows full recovery without forcing a premature decision to go to the residential aged care sector. Similarly, early risk assessment by a medical practitioner during an acute admission and access to appropriate, hospital guided medical care and management can also prevent older people who return to live in the community from being inappropriately readmitted to hospital emergency departments and/or an acute care bed after an acute care episode.

It is important to note that providing access to sub-acute care must not be confused with providing access to transitional care places (or care awaiting placement). Sub-acute care is very different and cannot be provided at the same cost as residential aged care. Well-resourced sub-acute care provides older people with access to specialist medical, nursing and allied health professionals to ensure that older people who suffer an acute illness get the best chance of returning home in the shortest possible time. Conversely, sub-acute care can also be used to stop or slow the deterioration of a person's condition before they require admission to acute care.

Private health insurers must also accept responsibility for this type of care for their members.

⁵ AMA Priority Investment Plan. 16 September 2009.

End of life care

Having a conversation about how a person wishes to be cared for at his or her end of life is a difficult social issue. Our health care system must give older people the opportunity to die a proper and dignified death. Our community needs to be educated about the reality of death and dying. Similarly, health care professionals need to be up skilled and supported to provide quality end of life care. The health care professional discussion with their patient about end of life issues and palliative care should be properly remunerated, as it is a clinically relevant professional service. Advanced care planning will ensure more appropriate end of life care is provided to older people, particularly in the aged care sector.

The AMA Position Statement on the Role of the Medical Practitioner in Advance Care Planning⁶ endorses the key role of the doctor in providing guidance, advice and in discussing treatment issues related to incapacitating conditions and/or future health care options with patients, as part of the therapeutic relationship. Given that there are currently jurisdictional differences in the law pertaining to advance care documents, the AMA has called for all States and Territories to enact consistent legislation that establishes advance directives as legally enforceable.

Older Indigenous Australians

The delivery of medical and aged care services to older Indigenous Australians must be holistic and culturally appropriate across a range of services and health care settings. Older Indigenous Australians should be able to access community and residential aged care services within their own communities, and should have the opportunity and flexibility to decide what care they need and how that care should be delivered to them.

Funding

The AMA acknowledges the difficult task the Commission has to offer funding models that are sustainable. However, we urge the Commission to consider that the asset base of the future generations of older people may not match that of the current generation of older people.

The residential aged care sector

A number of independent reviews have reported that current funding for aged care threatens the viability of the aged care sector and is inadequate to provide the services required, meet increased costs such as wages, and implement the expansion needed to meet future demand. In particular, development of high care facilities is no longer deemed to be viable under current capital arrangements.

Frail and elderly Australians deserve a level of investment that allows them to maintain their health and their dignity in their new environment. Funding issues for

⁶ AMA Position Statement. The Role of the Medical Practitioner in Advance Care Planning. 2006.

the residential aged care sector must be resolved. It is difficult to see how the provision of residential aged care high care will be sustainable unless bonds are introduced. Funding models must be sustainable and take into account the fact that the asset base of the current generation of older people might not be the same as that of future generations of older people.

Medical and health care services

Funding must be directed to ensure older Australians, their families and carers, have access to medical and health care when they need it. A funding model whereby funding follows the person rather than being allocated to an agency to distribute may result in more timely access to more appropriate care, and provide greater equity of access and flexibility in how that care is delivered. This model could be particularly appropriate for indigenous Australians. Consideration should include the practical application of models of consumer directed care in the Australian context.

eHealth

The health care of the patient is best served, and is delivered most safely, when the medical practitioner has access to the full health record. This is particularly important in unplanned transfers between the aged care sector and the acute sector. The multidisciplinary nature of care that older people need – general practice, acute, emergency and sub-acute care – will be improved by the application of an electronic medical record. In particular, electronic discharge summaries and electronic medication management systems have the capacity to improve communication between health care professionals and across care settings, to improve continuity of care and reduce the potential for adverse events. The Federal Government must build the overarching infrastructure to connect patient information electronically.

Reforming the care arrangements for older Australians

The AMA offers the following key considerations for reforming the care arrangements for older Australians:

- Access to medical assessment and diagnosis is fundamental to planning for a person's care needs;
- The care needs of older Australians must be managed and coordinated, to ensure they access the services they require;
- Much of those care needs will have to be provided where the person is, rather than the person going to where the care is provided;
- Funding arrangements will need to reflect the costs of mobile service providers and the complexity of care required for the very old;
- There will need to be transparency of the suite of care that is available and the funding arrangements for that care;
- Advanced care planning must be in the suite of care;
- The suite of care must be supported by eHealth measures; and
- Residential aged care services providers will need to offer a range of services and be flexible to step up and step down care as residents' needs change.

When she talks to you about the violence

**A toolkit
for GPs
in NSW**

Over 1 in 5 women make their first disclosure of domestic violence to their GP.¹

You may be the only person she will tell.

Your skills and sensitivity are essential.

This resource has been developed to assist you in identifying and responding to women and children who have experienced or are experiencing family violence (also known as 'domestic violence' or 'intimate partner violence')

'It has been estimated that full time GPs are seeing up to five women per week who have experienced some form of intimate partner abuse (physical, emotional or sexual) in the past 12 months.'²

The toolkit contains guidelines for patient care, from a range of sources, as well as some legal information relevant to your role as her GP.

'The Medical Profession has key roles to play in early detection, intervention and provision of specialized treatment of those who suffer the consequences of domestic violence, whether it be physical, sexual or emotional.'³

Responding effectively to 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 health professionals about violence.⁴

Contents

1. What is family violence?
2. Indicators
3. How to ask your patient
4. Responding to a disclosure
5. Initial safety planning
6. Victims support scheme
7. Note-taking for legal purposes
8. Mandatory reporting
9. Immigration family violence provisions
10. Continuing care
11. When your patient is the perpetrator
12. When both partners are your patients
13. Subpoenas
14. Referrals
15. Training & resources



WOMEN'S LEGAL SERVICES NSW

This toolkit has been developed by Women's Legal Services NSW, with the generous assistance of several individuals and organisations. It updates and extends 'Identifying Family Violence: A Resource Kit for General Practitioners in New South Wales,' 1999, Domestic Violence Advocacy Service NSW.

Information about the law is presented in summary form and should not be relied upon as a substitute for professional legal advice.

Organisations have permission to reproduce parts or the whole of the publication for the purposes of workshops, seminars, etc as long as the original meaning is retained and proper credit given.



LAW AND JUSTICE
FOUNDATION OF NEW
SOUTH WALES

This publication has been produced with the financial assistance of the Law and Justice Foundation of NSW. The Foundation seeks to advance the fairness and equity of the justice system and to improve access to justice, especially for socially and economically disadvantaged people. www.lawfoundation.net.au

Disclaimer: any opinions expressed in this publication are those of the authors and do not necessarily reflect the views of the Law and Justice Foundation's Board of Governors.

Published in October 2013.

Available online at <http://itstimetotalk.net.au/gp-toolkit>

1. What is family violence?

Family or domestic violence is **an abuse of power** within a close relationship, or after separation. It involves one person dominating and controlling another, causing **intimidation and fear**.

It is **not necessarily physical** and can include:

- sexual abuse,
- emotional or psychological abuse,
- verbal abuse,
- spiritual abuse,
- stalking and intimidation,
- social and geographic isolation,
- financial abuse,
- cruelty to pets, or
- damage to property.

Often the terms 'family violence' and 'domestic violence' are used interchangeably. 'Family violence' is sometimes thought of as the broader term, covering intimate, family and other relationships of mutual obligation and support.

Family violence is **often experienced as a pattern of abuse** that escalates over time.

Most domestic violence is perpetrated by men, against women and children.⁵ However women can also be perpetrators of violence, and domestic violence also happens in same-sex relationships.

Women are at greater risk of violence from intimate partners during pregnancy, or after separation. A safety survey conducted by the Australian Bureau of Statistics in 2005 found that 17% of women who had experienced violence from a partner during a relationship, experienced it for the first time during pregnancy.

2. Indicators

*'When assessing your patient... remember that most presentations of family violence are probably hidden and not the obvious black eye.'*⁶

The following are indicators associated with victims of family violence.

Indicators in adults	Indicators in children
<p>Physical</p> <ul style="list-style-type: none"> • Unexplained bruising and other injuries • Bruises of various ages • Head, neck and facial injuries • Injuries on parts of the body hidden from view (including breasts, abdomen and/or genitals), especially if pregnant • 'Accidents' occurring during pregnancy • Miscarriages and other pregnancy complications • Injuries to bone or soft tissues • Injuries sustained do not fit the history given • Bite marks, unusual burns • Chronic conditions including headaches, pain and aches in muscles, joints and back • Ulcers • Dizziness • Sexually transmitted disease • Other gynaecological problems <p>Psychological/behavioural</p> <ul style="list-style-type: none"> • Emotional distress, eg, anxiety, indecisiveness, confusion, and hostility • Sleeping and eating disorders • Anxiety/depression/pre-natal depression • Psychosomatic and emotional complaints • Drug abuse • Self-harm or suicide attempts • Evasive or ashamed about injuries • Multiple presentations at the surgery/client appears after hours • Partner does most of the talking and insists on remaining with the patient. • Seeming anxious in the presence of the partner. • Reluctance to follow advice • Social isolation/no access to transport • Frequent absences from work or studies • Submissive behaviour/low self esteem • Alcohol or drug abuse 	<p>Physical</p> <ul style="list-style-type: none"> • Difficulty eating / sleeping • Slow weight gain (in infants) • Physical complaints • Eating disorders <p>Psychological / behavioural</p> <ul style="list-style-type: none"> • Aggressive behaviour and language • Depression, anxiety and/or suicide attempts • Appearing nervous and withdrawn • Difficulty adjusting to change • Regressive behaviour in toddlers • Delays or problems with language development • Psychosomatic illness • Restlessness and problems with concentration • Dependent, sad or secretive behaviours • Bedwetting • 'Acting out', for example cruelty to animals • Noticeable decline in school performance • Fighting with peers • Over protective or afraid to leave mother • Stealing and social isolation • Abuse of siblings or parents • Alcohol and other drug use • Psychosomatic and emotional complaints • Exhibiting sexually abusive behaviour • Feelings of worthlessness • Transience

Figure 1: Indicators associated with victims of family violence.

*'Frequently there are no visible signs of assault or rape in domestic violence presentations. This does not mean that the emotional or psychological effects of the assault are... any less devastating to the victim.'*⁷

3. How to ask your patient

*'In any situation that you suspect underlying psychosocial problems you can ask indirectly and then directly about partner abuse.'*⁸

If you have concerns that your patient is experiencing family violence, you should ask to speak with her alone, separate from her partner or any other family members.

You can always ask **broad questions** about whether your patient's relationships are affecting her health and wellbeing. For example:

- 'How are things at home?'
- 'How are you and your partner getting on?'
- 'Is anything else happening which might be affecting your health?'

*'It is important to realise that women who have been abused want to be asked about domestic violence and are more likely to disclose if asked.'*⁹

If appropriate, you can ask **direct questions** about any violence. For example:¹⁰

- 'Are there ever times when you are frightened of your partner?'
- 'Are you concerned about your safety or the safety of your children?'
- 'Does the way your partner treats you make you feel unhappy or depressed?'
- 'Has your partner ever physically threatened or hurt you?'
- 'Violence is very common in the home. I ask a lot of my patients about abuse because no one should have to live in fear of their partners.'

If you see **specific clinical symptoms**, you can ask **specific questions** about these (eg, bruising). These could include:

- 'You seem very anxious and nervous. Is everything alright at home?'
- 'When I see injuries like this, I wonder if someone could have hurt you?'
- 'Is there anything else that we haven't talked about that might be contributing to this condition?'

If your patient's fluency in English is a barrier to discussing these issues, you should work with a qualified interpreter. Don't use her partner, other family members or a child as an interpreter. It could compromise her safety, or make her uncomfortable to talk with you about her situation. The Doctors' Priority Line, phone 1300 575 847, is a 24/7 free telephone interpreting service to assist GPs to communicate with patients from non-English speaking backgrounds.

4. Responding to a disclosure

Your immediate response and attitude when a woman discloses family violence can make a difference.

*'Patients... value emotional support from healthcare professionals, careful and non-judgmental listening, and reassurance that the abuse is not their fault and that negative feelings are understandable.'*¹¹

Listen

Being listened to can be an empowering experience for a woman who has been abused.

Communicate belief

'That must have been frightening for you.'

Validate the decision to disclose

'I understand it could be very difficult for you to talk about this.'

Emphasise the unacceptability of violence

'Violence is unacceptable; you do not deserve to be treated this way.'

Be clear that she is not to blame

Avoid suggesting that the woman is responsible for the violence or that she is able to control the violence by changing her behaviour.

Do not ask

- 'Why don't you leave?'
- 'What could you have done to avoid this situation?'
- 'Why did he hit you?'

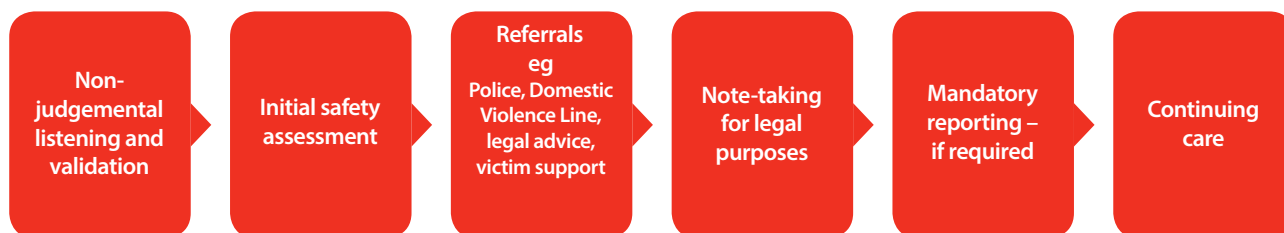


Figure 2: Key steps after a disclosure of family violence

5. Initial safety planning

Assist your patient to evaluate her immediate and future safety, and that of her children. Best-practice risk assessment involves seeking relevant facts about her particular situation, asking her about her own perception of risk, and using professional judgment. You may need to refer your patient to a specialised domestic violence service such as the Domestic Violence Line. See 'Abuse and violence: Working with our patients in general practice' (white book) for detailed guidance on your role as a GP.



Figure 3: Aspects of best-practice risk assessment

For initial safety planning, you will at least need to:

- Speak to the woman alone
- Check for **immediate concerns**
 - Does she feel safe going home after the appointment?
 - Are her children safe?
 - Does she need an immediate place of safety?
 - Does she need to consider an alternative exit from your building?
- If immediate safety is not an issue, check her **future safety**
 - Does he have weapons?
 - Does she need a referral to police or a legal service to apply for an Apprehended Violence Order?
 - Does she have **emergency telephone numbers**?
 - NSW Police: 000 or 106 (TTY)
 - Domestic Violence Line (24/7 emergency, referral and counselling line for people experiencing

domestic violence. Can explain basic information about AVOs and assist with risk assessment): 1800 656 463 or 1800 671 442 (TTY)

- Does she need a referral to a domestic violence service to help make **an emergency plan**:
Where would she go if she had to leave?
How would she get there?
What would she take with her?
Who are the people she could contact for support?
- Document any plans made, for future reference.

Risk assessment is an ongoing process. You may need to check in on your patient to follow up on this initial safety plan. See section 9 (Continuing care).

'It is important to remember that the true goal... is to prevent violence, not predict it.'^{1,2}

6. Victims support scheme

Victims of violent crime that occurred in NSW may be entitled to various forms of support through the victims support scheme, administered by Victims Services NSW.

If your patient has experienced family violence, she can apply for free counselling. She may also be eligible for financial assistance for her immediate needs (such as relocation expenses, if required for her safety, or emergency medical and dental expenses.) Further financial assistance for economic loss can be applied for to cover ongoing costs such as medical or dental expenses, loss of earnings. Financial assistance is capped to set limits. Some victims may also be granted a recognition payment depending on the nature of violence that occurred.

Most types of support require victims to apply within set time frames (usually within 2 years from the incident).

Your patient may need you to write a medical report or provide evidence of injuries she suffered, if she is applying for financial assistance or a recognition payment. Applications for free counselling only do not need any supporting documentation.

Refer your patient to Victims Services NSW for more information. A support co-ordinator will assist her to apply for any benefits available under this scheme.

7. Note-taking for legal purposes

Your notes may be required as evidence, if charges are laid against the perpetrator.

If family violence is a concern, you should keep detailed notes that:

- **Describe physical injuries** (including the type, extent, age and location). If you suspect violence is a cause, but your patient has not confirmed this, include your comment as to whether her explanation accurately explains the injury.
- **Record what the patient said** (using quotation marks)
- **Record any relevant behaviour observed**, being detailed and factual rather than stating a general opinion, eg, rather than 'the patient was distressed', write 'the patient cried throughout the appointment, shook visibly and had to stop several times to collect herself before answering a question'.

Consider taking photographs of injuries, or certifying photographs taken of the injuries presented at the time of consultation.

To be good evidence in court, file notes must include date and time, and clearly identify the client. You must clearly identify yourself as the author, and sign the file note. Do not include generalisations or unsubstantiated opinions. Correct and initial any errors, set out your report sequentially, and use only approved symbols and abbreviations.

8. Mandatory reporting

If a patient talks about experiencing or perpetrating violence, you may need to report this to Community Services. You have an obligation to report if you believe you have reasonable grounds to suspect that a child is at risk of significant harm.

Exposing children to domestic violence can have a serious psychological impact on children. In some cases you may feel there is risk of significant harm to a child even though it seems unlikely that the violent person in their home would physically hurt them. Use your professional judgment about the individual circumstances and the nature of the violence.

Community Services has online resources for mandatory reporters at www.community.nsw.gov.au/docs_menu/preventing_child_abuse_and_neglect/resources_for_mandatory_reporters.html. These include a Mandatory Reporting Guide to assist GPs and other mandatory reporters with making 'risk of significant harm' assessments.

9. Immigration family violence provisions

There are special family violence provisions in immigration law that are intended to relieve the fear of a 'partner visa' applicant who may believe that she needs to stay in an abusive relationship in order to remain in Australia. These provisions allow certain applicants to obtain permanent residence even if the relationship with their Australian sponsor has broken down, where there is evidence of family violence against the applicant or her dependent child.

A report or statutory declaration from a GP detailing physical injuries and/or treatment for mental health issues that are consistent with family violence can be used as part of the evidence given to the Department of Immigration and Citizenship to access the provisions.

If your patient has concerns about her visa to stay in Australia, you may wish to refer her to Immigrant Women's Speakout, phone (02) 9635 8022, or the Immigration Advice & Rights Centre, phone (02) 9279 4300.

10. Continuing care

- Consider your patient's safety as a paramount issue. A woman is usually a good judge of her own safety. You can help to monitor the safety of her and her children by asking about any escalation of violence.
- Empower her to take control of decision-making; ask what she needs and present choices of actions she may take and services available.
- Respect the knowledge and coping skills she has developed. You can help build on her emotional strengths, for example, by asking 'How have you dealt with this situation before?'
- Provide emotional support.
- Ensure confidentiality – the woman may suffer additional abuse if her partner suspects she has disclosed the abuse.
- Be familiar with appropriate referral services and their processes. Patients may need your help to seek assistance. Have information available for the patient to take with her if appropriate.

*'I dropped some hints to test the water. [The GP] was supportive without being interfering and because of this I made the decision to tell her. She was fantastic and told me about the [Domestic Violence Line] who I called and put me into contact with a women's refuge. I am rebuilding my life, and looking forward to a happy future.'*¹³

11. When your patient is the perpetrator

Consider the safety of female victims and their children as the highest priority. Note that perpetrators of violence have a tendency to minimise the violence, or shift blame.

If violence is suspected and further information is needed, start with broad questions such as:

- *'How are things at home?'*

Then if violence is disclosed, ask more specific questions such as:

- *'Some men who are stressed like you hurt the people they love. Is this how you are feeling? Did you know that there are services that can help you?'*

Acknowledge the existence of violence by statements such as:

- *'That was brave of you to tell me. Sometimes people who are stressed hurt the people they love. However, violent behaviour towards your partner and other family members is never acceptable. It not only affects your partner but your children as well. Did you know there are services which may be able to assist you?'*

12. When both partners are your patients

Special care is required if a patient discloses family violence, and the violent person is also your patient or is a patient within the same service.

If you have seen the victim or her children, your primary duty is to them. If the perpetrator is also your patient, you should refer them to another practitioner or another practice.

If both partners remain within your practice, you will need to take extra caution, for example:¹⁴

- Establish staff protocols that ensure confidentiality of records.
- There should be no discussion about suspected or confirmed abuse with the violent partner unless the woman consents to it.
- If a woman agrees that you can talk with her partner about the violence, it is important that a safety plan is in place.

Couple or marital counselling is not appropriate in circumstances where there has been domestic violence, due to the power imbalance in the relationship and the threat to the woman's safety.

13. Subpoenas

As a GP, you could be served with a subpoena relating to a patient. Where family violence is present, dealing with a subpoena requires even more care than usual. For example, a woman who has experienced sexual assault may be able to claim the *Sexual Assault Communications Privilege* to maintain the confidentiality of your records if subpoenaed.

A subpoena is a stamped court order to hand over documents (a subpoena to produce), to attend court as a witness (a subpoena to give evidence) or both (a subpoena to produce and give evidence). Subpoenas are issued as part of a court case such as a criminal law proceeding or a family law dispute, at the request of one of the parties.

It is important to treat subpoenas with caution, especially when the person seeking the information is not your patient, eg, is her ex-partner. First, check that the subpoena is valid: has a court stamp, has been served on you before the stated deadline and that conduct money has been provided.

You must *respond* to a valid subpoena – either to obey the orders, or to object. There are various grounds for objecting to a subpoena, for example: the request is too onerous, or the information is 'privileged' (protected by law).

Always contact your patient to let her know that you have been served with a subpoena, and to ask her how she would like you to respond. Note that you may be legally required to go against her wishes.

Subpoenas requesting documents will have a schedule of what material is being sought. *Never hand over more* than what is listed in this schedule.

In some cases, you or your patient may need legal advice. You could seek guidance from the AMA, the RACGP, your insurer, or a private lawyer. Your patient could get legal advice from her own lawyer, a community legal centre, or – if appropriate – the Sexual Assault Communication Privilege Service at Legal Aid.

14. Referrals

Here are some key contacts for patients.

Domestic Violence Line	1800 656 463 or 1800 671 442 (TTY) www.community.nsw.gov.au	24/7 emergency, referral and counselling line for people experiencing domestic violence. Can explain basic information about AVOs and assist with risk assessment.
MensLine Australia	1300 78 99 78 www.mensline.org.au	24/7 support, information and referral service, helping men deal with relationship problems.
Law Access	1300 888 529 www.lawaccess.nsw.gov.au	Free legal information, referrals and in some cases, advice for people who have a legal problem in NSW
Victims Services	1800 633 063 www.lawlink.nsw.gov.au/vs	Support, referrals and information for victims of crime in NSW. Support coordinators help victims apply for assistance under the NSW victims support scheme.
Legal Aid NSW – Sexual Assault Communication Privilege Service	sacps@legalaid.nsw.gov.au http://www.legalaid.nsw.gov.au/what-we-do/civil-law/sexual-assault-communications-privilege-service	Free legal advice for victims of sexual assault if their records are the subject of a subpoena in criminal proceedings.

See <http://itstimetotalk.net.au/gp-toolkit> for more extensive referrals.

15. Training & resources

- **RACGP – Abuse and violence: Working with our patients in general practice (white book)**
www.racgp.org.au/your-practice/guidelines/abuse-and-violence
- **AFP – Intimate partner violence: Identification and response in general practice**
www.racgp.org.au/afp/2011/november/intimate-partner-violence
- **NSW Health – The Education Centre Against Violence**
www.ecav.health.nsw.gov.au

References

1. Jo Spangaro & Anthony Zwi, *After the Questions: Impact of Routine Screening for Domestic Violence in NSW Health Services*, (School of Public Health and Community Medicine, The University of New South Wales, 18 August 2010), 22.
2. Gwenneth Roberts et al, *Intimate Partner Abuse and Health Professionals: New Approaches to Domestic Violence*, (London: Churchill Livingstone Elsevier, 2006), 19–40, cited in Jane London, *Abuse and Violence: Working with Our Patients in General Practice* (The Royal Australian College of General Practitioners, 3rd ed, 2008) 11.
3. Australian Medical Association, *AMA Position Statement on Domestic Violence*, (Canberra, AMA, 1998) 1.
4. Keys Young, *Against the Odds: How Women Survive Domestic Violence*, (Office of the Status of Women, 1998).
5. Access Economics & Commonwealth of Australia, *The Cost of Domestic Violence to the Australian Economy: Part II*, (Office for the Status of Women, 2004) 9.
6. Kelsey Hegarty, 'Identification and management role of GPs for women experiencing partner abuse' (Paper presented at the 25th Congress Medical Women's International Association, Sydney, 19 April 2001) 1, available at <http://www.regional.org.au/au/mwia/papers/full/17_hegarty.htm>
7. Jane London, above n 2, at 7.
8. Kelsey Hegarty, above n 6, at 1.
9. Kelsey Hegarty, 'The hidden epidemic of domestic violence: when to ask and how to respond' (2012) 13(7) *Medicine Today* 54–57; Kelsey Hegarty & Lorna O'Doherty, 'Intimate partner violence – identification and response in general practice' (2011) 40(11) *Aust Fam Physician* 852–6.
10. Kelsey Hegarty, above n 6, at 1.
11. Charles George, *Domestic Violence: A Report from the BMA Board of Science*, (British Medical Association, 2007) 35.
12. Don G Dutton & P Randall Kropp, 'A review of domestic violence risk instruments', (2000) 1(2) *Trauma, Violence and Abuse*, 171–181 at 179.
13. Charles George above n 10 at 36.
14. Based on Lorraine E. Ferris et al., 'Guidelines for managing domestic abuse when male and female partners are patients of the same physician', (1997) 278 (10) *Journal of the American Medical Association*, 851–857.