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Re: Inquiry into Chronic Disease Prevention and Management in Primary Health Care

The Australian Health Promotion Association (AHPA) is pleased to provide the following submission to this inquiry into chronic disease prevention and management.

AHPA is the peak body for health promotion professionals in Australia. AHPA has more than 1000 members from diverse disciplinary backgrounds drawn from a variety of government departments and agencies, universities, non-Government organisations, industry, and community-based organisations across Australia.

AHPA seeks good health for everyone by building leadership in health promotion, supporting professional development opportunities; working in partnership and alliances and increasing advocacy, capacity and action within the sector. AHPA runs a successful annual conference, provides authoritative and peer-reviewed professional publications, including a peer-reviewed national journal, the Health Promotion Journal of Australia, (http://www.healthpromotion.org.au/journal), and strengthens health promotion practice, policy and research through networking and partnership opportunities.

Our focus is on health promotion. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Health promotion not only embraces actions directed at strengthening the skills and capabilities of individuals but also actions directed towards changing social, environmental, political and economic conditions to alleviate their impact on populations' and individuals' health.

Chronic disease prevention and management

AHPA contributed to the invitation to provide feedback on the proposed Terms of Reference for the inquiry noting the importance of recognising the difference between "chronic disease prevention" and "chronic disease management". Our submission stated that these two spheres of activity operate under a separate set of principles, strategies, stakeholders and costs.

Chronic disease 'prevention' operates from an overall population health promotion perspective. The most cost-effective health promotion interventions utilise broad behaviour-change levers that reach the whole population, such as legislation, public policy, education and comprehensive social marketing and improvements to the social and physical environment.

Chronic disease ‘management’ on the other hand includes activities such as patient education, information and early intervention using best clinical practice, and reaching individuals and their families with chronic conditions.

AHPA members work in a variety of settings and organisations and hence contribute significantly to both the prevention and management of chronic disease.

This submission addresses each of the Terms of Reference in turn. We would be pleased to provide additional information if required.

Yours sincerely

Michele Herriot
Vice President
30 July 2015

Attachment 1 – Australian Health Promotion Association submission

Attachment 1 Australian Health Promotion Association Submission

1. Examples of best practice in chronic disease prevention and management, both in Australia and internationally

There are a myriad of examples of successful chronic disease prevention strategies that have been put into place in Australia. The (former) Australian National Preventive Health Agency's *State of Preventive Health 2013* includes case studies and more detailed examples of tobacco, alcohol, diet and physical activity related programs and is a useful reference.[1]

In relation to tobacco control for example, Australia is a world leader in reducing smoking rates because of the comprehensive, multi-strategy approach implemented in recent years to preventing the uptake of smoking and assisting people to quit. This includes policy and legislative reforms including pricing, supply, smoke free regulations, sponsorship etc.; concerted and continuous social marketing; support services to assist people to quit; upskilling health providers on the importance of the issue and how to assist people to quit and many other strategies. Certainly more can be done, especially for Aboriginal and Torres Strait Islander communities and people with mental illness, but this is a good practice exemplar.

The Newcastle Alcohol Management Strategy has achieved up to a 58% reduction in assaults through curbing venue trading hours, lock-outs and other restrictions. This local government-led approach combines policies with education and multi-agency agreements to play a part in addressing what was a serious alcohol fuelled violence problem with an impact on hospital emergency departments, health status and community lives.[2,3]

LiveLighter is an initiative developed by the Heart Foundation (WA Division) in partnership with Cancer Council WA. NHF and CCWA were contracted in 2011 by the Department of Health WA to conduct a new public health education program in WA to encourage people to eat well, be physically active and maintain a healthy weight. The LiveLighter campaign aims to encourage healthier changes in behaviour through targeted mass media, effective stakeholder relations, sponsorship and branding opportunities, and planned advocacy. The campaign is currently in the third year of implementation. Evaluation results from the campaign area available.[4]

OPAL (Obesity Prevention and Lifestyle) is an initiative that supports children, through their families and communities, to be healthy now, and stay healthy for life. Established in South Australia in 2009 by SA Health, OPAL is coordinated through local government and works with communities to create opportunities to eat well and be active. OPAL has been rolled out across South Australian in four stages and has been active in 20 local communities across the State and one additional community in the Northern Territory.

All OPAL sites to date have had a five-year investment with the first six sites coming to their natural conclusion in September 2014. The work of OPAL is now embedded in those sites with many activities continuing as they are linked to delivering their local public health plans as required by state legislation. Unfortunately cuts to the National Partnership Agreement on Preventive Health met that the program was curtailed and regrettably the evaluation was significantly reduced, however the program has been successful in changing policies, environments, attitudes and skills to support healthy eating and physical activity. Some of the major achievements of the OPAL sites have been made available in the case studies.

Healthy Together Victoria was established in 2011, to tackle the rising rates of overweight and

obesity and related chronic disease. Obesity is a complex issue caused by multiple factors, many of which are beyond an individual's control. Healthy Together Victoria targets change in the places where Victorians live, work, learn and play including childcare centres, schools, workplaces, food outlets, sporting clubs, businesses, local governments, health professionals and more to create healthier environments for all. The website (http://www.healthytogether.vic.gov.au/aboutus/index) provides extensive information about the approach including the commitment to prevention at scale (ensuring delivery at scale across systems rather than through 'weak prevention" and a commitment to implementing evidence based practice whilst evaluating progress.

The *Northern Respiratory Partnership (NRP)* project implemented by the Northern Adelaide Medicare Local was a two year initiative designed to implement prevention across the continuum of care in relation to asthma, COPD and smoking. Based on a strong partnership between government agencies, non-government agencies (eg Quitline, Asthma Foundation SA), the Medicare Local and primary care it reached 38% of pharmacies and 35% of general practices in the priority locations where social disadvantage, admissions and ED attendances were high. As an example, the NRP assisted organisations to ensure their tobacco control policies were in place, there was strong leadership on no smoking, and staff and clients were assisted to quit. The final report will be available shortly.

Mental illnesses are often chronic in nature and can be prevented and better managed. People with mental illness have higher morbidity and mortality rates of chronic diseases than the general population. This is largely due to inadequate screening, delayed diagnosis and lack of or delayed treatments – all preventable.[5]

VIcHealth has decades of experience in supporting mental health, wellbeing and resilience as well as action against violence and discrimination that contribute to poor mental health. Their website provides examples of good practice (https://www.vichealth.vic.gov.au/our-work/improving-mental-wellbeing).

Chronic disease prevention and management models
More generally in relation to ways of thinking about chronic disease prevention and management the Committee may find the following useful:

The Preventing Chronic Disease strategic framework developed by the National Public Health Partnership has stood the test of time and informs AHPA's approach to this issue.[6]
ANPHA developed several useful papers on Medicare Locals and prevention that are still relevant[7] and developed a model of prevention that is included in the Australia's Health 2014 report.[8]

2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management

AHPA does not wish to make any comments on this TOR but notes the *Vision for a Sustainable Health System* prepared by the Royal Australian College of GPs to reform Medicare (http://www.racgp.org.au/support/advocacy/vision/) with rewards for comprehensive approaches and integrated care which are supported.

3. Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care

The PHNs can play a major role in coordinating and supporting chronic disease prevention and

management in primary health care. The following suggested roles are drawn from members experience in working with Medicare Locals and other organisations to support chronic disease. Potential roles include:

Supporting and implementing interventions that seek to support and promote good health and eliminate or reduce the factors that contribute to poor health. This can be directed at the population as a whole across the PHN, or groups at risk (eg young people, Aboriginal and Torres Strait Islander communities). Achieving even small reductions in risk and improvements in behaviors across large populations can reduce the incidence and prevalence of disease.

As an organisation PHNs can:

- Supporting a local **Health in All Policies approach** by encouraging and working with other organisations to provide supportive local policies and environments that make it easy for individuals and the community to be healthier. For example, local governments can undertake a range of actions to reduce alcohol related violence and harm and PHNs can advocate for this as well as providing expert advice, data and evidence. They could also encourage improvements to physical environments eg cycling paths and social environments eg community gardens for people with disabilities.

- Ensure all staff have a comprehensive understanding of the impact of the social determinants of health on health outcomes and integrate this into all commissioning work. These determinants contribute to inequitable health outcomes and impact on the use of preventive services. AHPA is a member of the Social Determinants of Health Alliance and made a submission to the Senate Community Affairs Committee on the social determinants of health and their relationship with health inequities (see http://socialdeterminants.org.au).

- Ensure they are a **health promoting workplace**, modeling good practice, ensuring policies and practices are health promoting (eg healthy food policies, access to staff support programs etc) and supporting staff to be healthy.

- Through **commissioning**, engage with agencies that can influence policies that address the underlying causes of poor health, invest in evidence based policies and programs that serve the most vulnerable and have the greatest potential to be sustained.

- Adopt an **evidence informed approach** through all work and promote evidence on the efficacy of health promotion related programs and services. Ensure existing evidence and planning data is used in developing new initiatives.

- Ensure sufficient funding, resources and expertise for **evaluation and research**.

- Intentionally adopt a focus on **redressing inequities**, define the methodologies to be used, promulgate the approach and integrate into all work.

- Ensure effective **consumer and the community participation.** Participation in planning, implementing and evaluating health services is good for health of the individual as well as the service.

- Ensure **an integrated approach to chronic disease prevention and management** and **prevent duplication** through:

- Developing partnerships with all those who play a (current and potential) role in prevention and management of chronic disease across key agencies including acute care, primary care and health promotion services, to ensure a collaborative rather than silo focused approach
- Integrating and building on current activities and reducing duplication
- Building common understanding of the challenge and solutions and a common language around health promotion and prevention of disease
- Investing in evidence based actions that can be scaled up and replicated across settings or population groups
- Engaging clinical and community leaders as champions for evidence based action
- Support individuals and the community at every stage of care e.g community based cardiac rehabilitation walking programs and use every opportunity to promote services, connect services such as general practice with these programs, cross promote, link in with funded programs etc.
- supporting a concerted and intensive focus on key chronic diseases (either individually or collectively)
- Work with aligned organisations to provide community education about how to prevent chronic conditions.

- Increase **workforce capacity** (both in the PHN and related provider organisations) through ongoing training and support both with a focus on clinical and preventive health skills, recognition of the role of different providers, understanding the impact and implications of health literacy and the social determinants of health; and implementing systemic approaches. This includes:
  - Where possible ensuring health practitioners are skilled in the promotion of health at the population level as well as for individuals; consider building health promotion competencies in to job descriptions and employing staff with health promotion backgrounds.
  - Providing ongoing training that builds understanding of the continuum of care in clinical and primary prevention settings building clinical and preventive health skills.
  - Increasing recognition of the value and role of providers across the continuum of care.
  - Developing understanding of the impact and implications of health literacy and the social determinants of health; and the importance of implementing systemic approaches.
  - Building common understanding of the challenge and solutions of chronic diseases in general and specifically and a common language around health promotion and prevention of disease.

- **Helping create a quality improvement culture by:**
  - **Supporting e-health solutions** to improve access to health care for rural and remote communities, reduce travel costs for community members, help overcome workforce shortages eg of allied health, and facilitate communication.
  - Supporting improvements to the **quality of patient-based clinical information systems** which can be quite limited. For example all practices should be able to know the characteristics (age, gender, location, condition severity) of their patient population with chronic conditions, how this matches with the prevalence in the region, be able to implement screening programs where appropriate, regular recall systems, monitor referrals and use of preventive services eg quit smoking supports.

- Support the implementation of a consistent approach to **self-management** of chronic disease tailored to the needs of the community by:
    - Integrating patient advice provided through general practice with national campaign messages and resources on tobacco, healthy eating, alcohol and physical activity
    - Reducing prescribing and use of publicly funded health coaching and health promotion services for those at low risk
    - Supporting more targeted, evidence-based prescribing for medications, including statins and anti-hypertensives and behaviour change/lifestyle interventions to those at higher risk
    - Ensure that patient education is inclusive, accessible and focuses on building understanding and skills for the prevention of chronic conditions and effective self-management.

Aboriginal health is a priority for AHPA and chronic disease prevention and better management needs ongoing support through PHNs. A few suggestions for PHNs include:

- Employ Aboriginal Health Workers and build their health promotion skills through training and mentoring
- Ensure an organisational commitment to reconciliation
- Build cultural competence skills in all staff and support/require funded agencies to do the same through commissioning
- Work collaboratively with local Aboriginal communities to understand the determinants of health and develop collaborative solutions
- Encourage continuity of good practice programs
- Work in partnership with Aboriginal Community Controlled Health Organisations and local Aboriginal teams through other organisations eg NGOs or state/territory governments.

4. The role of private health insurers in chronic disease prevention and management;

The Australian Health Promotion Association supports the principle of universal health care on which Medicare is based, and calls for an equitable health system underpinned by social justice principles, a well-resourced public health workforce, and a commitment to addressing the social determinants of health. We have expressed concerns (letter to the Prime Minister of Australia http://www.healthpromotion.org.au/images/stories/AHPA_letter_to_Ministers_BUDGET_2014.pdf) that moving toward a user pays system akin to the American health system puts us on a road to high costs, poor health outcomes and social disintegration.

Whilst private health insurers clearly play a role in supporting their members to be healthy the risk of developing a two-tiered health system is of concern to AHPA.

5. The role of State and Territory Governments in chronic disease prevention and management;

State and Territory governments (S/T governments) are key partners in the strategies to promote good health and prevent and better manage chronic disease. Roles include:

Healthy Public Policy – S/T governments have a major role in ensuring policy and legislation supports good health and is not 'anti-health'. Chronic disease related examples include:

- Tobacco legislation and policies including smoke free environments in public places, workplaces, hospitals etc; preventing display of tobacco products

- Healthy food policies in all health services, education settings, for all funded organisations, public events.
- Reduction in the pervasiveness of the promotion and advertising of unhealthy foods
- Alcohol serving restrictions to reduce violence, requiring alcohol servers to be trained
- Policies designed to encourage liveable cities, reduced speeds and use of public transport and thus support physical activity
- Water and air quality controls that reduce exposure to harmful elements and assist in reducing chronic conditions such as asthma and COPD
- Fluoridation policies to reduce dental harm thereby reducing the risk of chronic disease (and worsening of conditions). Oral diseases can exacerbate chronic diseases.

Supporting healthy environments and settings – S/T governments can support children and adults to be healthy by ensuring the places where people live, work, learn and play are health promoting. For example governments should be ensuring all employees are supported to be healthy through raising awareness on mental health, having healthy food policies, encouraging staff to be active as well as addressing systemic issues such as work related stress, bullying, job satisfaction, access, parental leave and childcare etc. S/T governments can also use their funding contracts to spread this approach to the private and non-government sector. Health services should be required by government to lead the way as exemplars. Education settings should also be encouraged and supported to ensure their policies and practices support children and their families to be healthy.

For example, research indicates that big food, alcohol and soda companies regularly target children and families through sport, schools, point of sales materials and more. Efforts have been made nationally to introduce tighter regulations without success but S/T governments need to explore options given the significance on chronic disease.

Funding – providing funding for community based programs and services, especially for those most at risk, that can assist in supporting health literacy, influencing attitudes and behaviours, changing social norms etc. This includes:

- Community based interventions such as the obesity prevention programs or HIV strategies that work with population groups to support better prevention of conditions
- Community development programs that build community assets through skill development, social connectedness etc (eg community gardens, men's sheds)
- Community education and support programs such as walking groups, awareness raising and advice on preventing and managing conditions such as diabetes; support for healthy pregnancy
- Preventive health services that provide risk assessment, brief interventions, screening programs etc. People who are disadvantaged and more likely to have higher rates of chronic disease are less likely to use preventive health services so ensuring these services are community supported and accessible is critical.

Importantly funding of health promotion professionals who have the skills and expertise to undertake these roles is an important role for government.

Leadership – S/T governments (and indeed all levels of government) play a crucial role in setting directions for chronic disease prevention and management through the development of strategies and implementation of directions in partnership with others. We urge Ministers and senior government officials to have a clear understanding of the threat to people's lives and the economic implications of chronic disease and to convey to others that this is preventable.

Their leadership includes understanding and supporting the promotion of good health as a key component of chronic disease prevention and bringing people together to ensure joined up approaches both across government and with the non-government sector. For example, there are critical links between homelessness, chronic disease and mental health requiring joined up policy approaches taking into account the needs of all sectors. Similarly those in prison are a highly vulnerable group with high risks of chronic illness. Collaborative approaches such as smoke free prisons, support for prisoners to quit, mental health support etc can help prevent future problems.

The South Australian Health in All Policies initiative is an example of an approach to working across government to better achieve public policy outcomes and simultaneously improve population health and wellbeing. The model seeks to build strong intersectoral relationships across government and facilitate policy work of mutual benefit to the health sector and partnering sectors. More information on this initiative is available.[9]

Whilst not a S/T responsibility AHPA would also like to advocate for the reinstatement of the Australian National Preventative Health Agency, or equivalent, which was disbanded in 2014. An agency such as this plays a leadership role in supporting, coordinating and implementing a comprehensive prevention agenda. AHPA made a joint submission with the Public Health Association of Australia on the Australian National Preventive Health Agency (Abolition) Bill 2014 setting out our concerns (http://www.healthpromotion.org.au/images/stories/Submission_on_the_Australian_National_Preventive_Health_Agency_Abolition_Bill_2014_.pdf).

6. Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management

The most efficient way to prevent chronic disease is to create conditions that enable our whole population to remain healthy and out of hospital. In this way, Health Promotion provides a 'front line' model that prevents our hospital and medical services from being overrun by chronic disease.

Health Promotion practice is guided by the Ottawa Charter (WHO, 1986) which recognises that the major social and environmental determinants of health (such as education, income, social inclusion and access to services) lie outside the health system. Health Promotion agencies therefore work mostly with the agencies that impact on our everyday lives - local government, schools, workplaces, community groups and key state agencies such as planning and transport.

Health Promotion generates long-term health improvements for our whole population, yet for every $100 spent on health in Australia, Health Promotion receives just 38 cents. Therefore Health Promotion agencies focus on cost-effective interventions within established priority areas. The three risk factors that contribute most to our total disease burden are obesity, tobacco and alcohol.
AHPA's infographic illustrates the cost-effectiveness of prevention – see http://www.healthpromotion.org.au/images/stories/AHPAInfographicPreElectionAug13.jpg

The essential Ottawa Charter principles of equity and inclusion must be incorporated all health promotion activities through 'targeted' approaches. Despite having lower population-reach and being more expensive to implement, these targeted activities are necessary to engage disadvantaged and vulnerable populations including Aboriginal people and those with mental

illness. Mental illness has the third highest DALYs and that longer term cost of not addressing vulnerable populations is far more expensive for the undiagnosed or untreated resultant chronic disease.

A Health Promotion model incentivising access, quality and efficiency in chronic disease prevention should support state-based Health Promotion agencies which prioritise the following goals and activities:

1. Promote healthy eating and active living
- Scaled-up programs that embed healthy eating and physical activity into the curriculum and daily activities of all schools and early childcare services.
- Create healthy built environments by working with local government, planning agencies and developers to ensure population health is prioritised in all urban planning and development processes
- Active transport programs within schools, workplaces and local government to increase rates of walking, cycling and public transport and reduce car dependency
- Restrict junk food and sugary drink advertising and sponsorship through legislation
- Improve food and nutrition security

2. Reduce smoking rates
- Expand smoke-free public spaces through legislation
- Implement smoke free hospitals policy and related by-law
- Health protection and compliance activities
- Targeted tobacco control programs with Aboriginal people, young people and other priority populations such as those living with mental health problems or people who are sexuality or gender diverse.

3. Prevent alcohol related harm
- Reduce the supply of alcohol to minors through greater community awareness of (and compliance with) secondary supply legislation
- Restrict the proliferation of liquor outlets through liquor licensing controls
- Restrict alcohol advertising, sponsorship and donations through legislation
- Partnership projects with police, local government, liquor accords and community groups to reduce alcohol related harm
- -Address underlying social determinants that contribute to alcohol related harm and consider concurrent mental health problems.

7. Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals

AHPA supports health promotion professionals who are key members of the multidisciplinary approach required to better prevent and manage disease. AHPA developed Health Promotion Core Competencies[10] which cover:

1. Program planning, implementation and evaluation competencies
    1. 1.1 Needs (or situational) assessment competencies
    2. 1.2 Program planning competencies
    3. 1.3 Competencies for planning evidenced-based strategies
    4. 1.4 Evaluation and research competencies
2. Partnership building competencies
3. Communication and report writing competencies

4. Technology competencies
5. Knowledge competencies.

These are important skills to have in developing an integrated approach (eg across a region, population group or disease) to the prevention of chronic disease. Many AHPA members work at the population level complementing the work of primary health care services such as general practice or pharmacies. Community health services and Aboriginal Community Controlled Health Services provide both population level programs as well as clinical chronic disease management services. A team approach is important.

The competencies do not cover individual clinical care competencies though people with health promotion expertise may also have clinical skills. Integrated approaches between regional hospitals and primary health care services in relation to addressing chronic disease is important and health promotion practitioners have expertise in the areas above that can facilitate this collaboration and integration.

8. Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services.

The social determinants of health – lower income and intergenerational poverty, poor employment conditions, reduced housing security, reduced educational opportunities, racism and discrimination, poor neighbourhood conditions to name just a few – impact on health outcomes and use of health services. Individual behaviours also impact on chronic disease but these are affected by social and economic factors which both cause and compound the poorer health outcomes.

Aboriginal and Torres Strait Islander people, people with a mental illness, people with lower incomes, education levels or less secure employment, recently arrived migrants are some of the population groups that may be frequent users of medical services due to poorer health. Those living in rural and remote communities also have poorer health outcomes.

The strategies suggested above can contribute to addressing the needs of these population groups. Sir Michael Marmot also argues for the approach of 'proportionate universalism' where 'to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.[11]

As an example this might involve universal policies that prevent smoking, universal Quit programs that assist people to quit combined with specific and enhanced programs and services that involve Aboriginal health services, health workers and communities to better understand the reasons for smoking, to implement community-supported services and campaigns, and to promote Aboriginal friendly quit services.

In relation to Asthma and COPD for example, the Northern Respiratory Partnership project used hospital data to show that residents of the most disadvantaged locations disproportionately attended Emergency Departments and were admitted to hospital for respiratory conditions. This data led to a focus on higher need locations in terms of prioritising support and training for primary health care service providers and strategies to ensure service responses were enhanced for this population group.

In relation to diabetes, Australia has comparatively high rates of diabetes-related amputations that are preventable, both by preventing diabetes in the first place, as well as early

identification of the condition and effective management. Countries overseas such as Scotland and Scandinavia have reduced amputations by having a concerted approach to the issue through primary care services using a standardised screening tool and clarifying the roles of different professionals. Health promotion professionals would play a role in such an approach by working with the community to explain the need, the changes to services, bringing service providers and community organisations together to develop different strategies and build personal foot care skills.

As an example, cardiovascular disease evidence based approaches focus on:

- Prevention of cardiovascular disease particularly among populations most at risk
- Improving mechanisms for detection of people who are already at increased risk of vascular and related disease
- Improved management of risk for people with existing conditions.
- Early detection of modifiable risk factors through a comprehensive assessment program can identify those people who would most benefit from targeted management through lifestyle changes and where needed, pharmacological therapy.
- Effective prevention and management of one condition can lead to a reduction of risk of the related diseases.
- Relatively few GPs routinely conduct integrated (Absolute Risk) checks with eligible patients. Given the clustering of risk factors, evidence indicates that calculating absolute rather than relative risk is more accurate in determining those patients who are most at risk and can benefit from timely intervention. Thousands of Australians are at high risk of having a heart attack or stroke within the next 5 years but are unaware of this risk.
- Better screening of those most at risk can ensure the most vulnerable are successfully managed and those at moderate to low risk are successfully supported with prevention and health promotion programs.
- Triaging will ensure cost effective and timely interventions to save lives, ensure effective self-management and to reduce hospital readmissions.
- Including the integrated health check (heart, stroke health, and kidney and diabetes risk) as part of GP software will facilitate uptake in primary care settings.
- Processes are needed to support routine monitoring and evaluation as part of quality improvement processes.
- Incentivising the uptake of integrated health checks as part of a quality-focussed Practice Incentive Program will identify high risk patients and save lives.
- PHNs are well placed to promote this, to facilitate links with relevant prevention services and support data collection and reporting systems.

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