ST VINCENT'S HEALTH AUSTRALIA

UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

Submission to Royal Commission into Family Violence

1 June 2015

St Vincent's Health Australia Ltd

ABN: 75 073 503 536

Level 1, 75 Grafton Street
Bondi Junction NSW 2022
Tel: 02 9367 1100

www.svha.org.au

1. Introduction to our submission

This submission from St Vincent's Health Australia focusses on strategies that have the potential to maximise the 'window of opportunity' that hospital presentations provide in identifying and responding to family violence. This includes overcoming key barriers to effective responses from health services.

Given the likely high levels of family violence experienced by people who present to hospitals in Victoria (which we estimate is currently under-identified), St Vincent's Health Australia believes that hospitals can play a key role in delivering systemic improvements to Victoria's response to family violence.

In addition to addressing the immediate health needs of a victim or person at risk, improved identification of family violence in hospital settings with appropriate follow-up and referral to specialist services can significantly increase the number of victims or people at risk who receive support.

We also know from our experience that a hospital may be the only service in the family violence system that a victim or person at risk is accessing, or chooses to access (usually as a result of their health needs). We believe that hospitals can and should play a role in not only identifying family violence, but assessing risk and providing interventions and support to prevent violence from escalating and improve a victim's ongoing safety post-discharge.

Of course, although public hospitals are a key part of the family violence service system they are a mainstream service. Delivering effective support to victims of family violence that use hospital services depends on effective partnerships with specialist family violence services. This submission provides a hospital perspective on strengthening integration and coordination in the Victorian family violence system.

There are lessons that can be learnt from evidence-based practices and programs at St Vincent's Hospital Melbourne, and from other jurisdictions including from our public hospital in Darlinghurst, Sydney. Our submission also draws on evidence-based clinical guidance from other jurisdictions, and research evidence on health service interventions to respond to family violence.

With the support of the Victorian Government, best practice approaches could be expanded both within St Vincent's Hospital Melbourne, and to other Victorian health services.

Note on language and definitions

This submission uses the term 'family violence' as defined by the *Family Violence Protection Act 2008* and adopted by the Royal Commission.

'Elder abuse' is one form of family violence. Elder abuse is defined by the Australian Network for the Prevention of Elder Abuse as "any act occurring within a relationship where there is an implication of trust, which results in harm to an older person". Elder abuse may include physical, emotional, financial or sexual abuse, and neglect.

While recognising that child abuse and neglect is a form of family violence, this submission does not directly address child protection issues given the major inquiries already undertaken into this issue in the past decade.

Finally, for simplicity this submission generally uses ‘victims’ to describe people who have experienced family violence but it is not our intention to victimise people. In some areas, the submission refers to ‘women’ who comprise the majority of people who experience family violence.

2. Overview of recommendations

Recommendation 1:

That the Royal Commission consider supporting a trial of enhanced responses to family violence in hospital settings, including:

- *routine screening of all women in mental health and drug and alcohol services; and*
- *targeted screening in the ED based on systematic identification of risk factors.*

The trial of expanded screening would require additional government funding, and should be supported by:

- *the development / adoption of a validated screening tool;*
- *training for frontline staff on screening methods, and appropriate follow-up and referral processes;*
- *additional social work capacity for more comprehensive risk assessment and follow-up where family violence is identified (including in the ED); and*
- *governance, documentation and data collection processes to support case review, continuous improvement and evaluation (see also recommendation 4).*

We believe that St Vincent's Hospital Melbourne would provide an ideal trial site.

Recommendation 2:

That the role of hospitals in responding to family violence (beyond identification) including providing risk assessment, safety planning and first line responses is recognised and supported in government policy and practice guides.

Recommendation 3:

That the Royal Commission consider supporting the development of an effective practice model for Victorian hospital Emergency Departments to inform a best practice response to victims of family violence.

St Vincent's Health Australia suggests that the ALERT model at St Vincent's Hospital Melbourne represents a possible model that could be further developed for use in other hospitals.

Recommendation 4:

That the best practice elder abuse framework at St Vincent's Hospital Melbourne be adopted more broadly for responding to family violence.

Key features of the framework could form part of the proposed trial of enhanced responses to family violence in hospital settings (see recommendation 1):

- *a tiered education and training model;*
- *senior governance arrangements for case review, performance monitoring and continuous improvement; and*
- *data collection and reporting arrangements.*

Recommendation 5:

That guidance be developed for mainstream services on best practice in responding to disclosures or suspicions of abuse perpetrated by a client.

Recommendation 6:

That the Royal Commission consider mechanisms for strengthening frontline coordination between health services, Police and specialist family violence services.

St Vincent's Health Australia suggests that safety action meetings, currently being trialled in NSW, provide a useful model for further consideration in the Victorian context. The Elder Abuse interagency protocol is also a useful mechanism.

Recommendation 7:

That the Royal Commission support further work with Aboriginal and Torres Strait Islander communities to develop guidance for health services in how to appropriately support Aboriginal people to access either Indigenous-specific or mainstream support services, dependent upon the Aboriginal person's choice.

Recommendation 8:

That the Royal Commission support a review of resourcing, training and cultural competency within support services to meet the needs of Aboriginal people experiencing family violence.

3. Context: health services are a critical part of the response to family violence

Family violence is now widely recognised as a major public health problem.

It is prevalent….

- In Australia, around 17% of women, and 5% of men have experienced violence (physical and/or sexual) by a current or former partner since the age of 15.
- A quarter of women, and 15% of men, have experienced emotional abuse by a current or former partner.[1]
- Indigenous women and children are more likely to experience violence than any group in the community. Indigenous women are five times more likely to be victims of domestic homicide than non-Indigenous women, and six times more likely to be victims of domestic assault reported to police.[2]

…and it has serious health impacts including premature death

- Intimate partner violence was found to be the leading contributor to death, disability and ill-health in Australian women aged 15-44 in Victoria.[3]
- Based on recent crime data, around a third of rape offences, 45% of assaults and 30% of homicides in Victoria are related to family violence.[4]
- Victims of family violence experience wide-ranging and persistent health impacts that increase with severity and length of exposure to abuse. For example, studies in Australia and internationally have found that health impacts include:
    - lower physical and mental health functioning scores;
    - greater risk of self-harm, depression and anxiety;
    - higher rates of chronic pain, gastrointestinal and gynaecological problems; and
    - reduced access to contraception, increased rates of miscarriage, pre-term deliveries and lower birth weight babies, and increased sexually transmitted diseases.[5]
- Children who are exposed to family violence are at risk of poorer learning, developmental and behavioural outcomes, as well as poorer physical and mental health.[6]

Victims of family violence are high users of health services…..

[1] Australian Bureau of Statistics (2013), *Cat 4906.0 Personal Safety Australia, 2012*, Commonwealth of Australia.
[2] Parliamentary Library (2015), *Domestic violence in Australia: a guide to the issues*, Parliament of Australia, Canberra.
[3] VicHealth (2004), *The Health Costs of Violence: measuring the burden of disease caused by intimate partner violence*, Victorian Government.
[4] Victoria Police (2014), *Crime Statistics Official Release 2013-14*, Victorian Government; Bryant, W & Cussen, T (2015), *Homicide in Australia: 2010-11 and 2011-12 National Homicide Monitoring Program Report*, Australian Institute of Criminology.
[5] Spangaro, J & Ruane, J (2014), *Health Interventions for Family and Domestic Violence: A Literature Review*, NSW Kids and Families.
[6] Department of Human Services (2012), *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3*, Victorian Government.

In light of the health impacts of family violence, it is not surprising that people experiencing family violence (mostly women) also have frequent interactions with the health system, in both primary and acute care settings.

For example, studies have found:

- A higher than average long-term GP attendance rate among victims of family violence.[7]
- Higher prevalence of family violence among women who present to hospitals than the general population.
- An estimated 38% of women who present to Emergency Departments (EDs) have experienced physical abuse in their lifetime (based on analysis of 18 different studies). Another study found that between 65 and 85% of women attending EDs experienced emotional abuse.[8]

There are also a range of factors that increase a women's vulnerability to family violence and for which she may access health services, including in hospital settings. In particular:

- Pregnancy – the prevalence and intensity of violence has been shown to escalate during pregnancy, and many women report violence occurring for the first time during pregnancy.
- Mental health issues – there is a strong association between mental illness and experiencing family violence, and prevalence of lifetime physical and sexual abuse among women attending mental health services has been found to be higher than in any other health setting.
- Alcohol and other drug use – women who are victims of family violence are more likely to have a drug or alcohol problem, and women with a partner with a substance abuse problem are also more likely to experience abuse.[9]

….which means that health system interactions provide a key window of opportunity for intervention with victims that should be maximised

It is clear that health services, and hospital services in particular, provide a key 'window of opportunity' to support victims of family violence.

Despite this, a synthesis of research from Australia, the UK and the US found that victims of domestic violence can experience difficulties when accessing health services including:

- discomfort with disclosing violence in the healthcare environment; and
- inappropriate responses by health professionals and a lack of patient confidence in the outcomes following a disclosure.

It is also likely that victims of family violence remain significantly under-identified in health services. For example, one study from the US found that 72% of women who attended an ED after an incident of family violence were not identified as victims of abuse.[10] Clearly, under-identification can be attributed in part to an unwillingness of victims to disclose. However, there is also international evidence of common barriers to effective response by healthcare professionals. These include:

- inadequate skills and competence in identifying signs of family violence; and

[7] Evans, I (2007), *Battle scars: long-term effects of prior domestic violence*, Centre for Gender Studies and Women's Research, Monash University.
[8] Spangaro & Ruane (2014).
[9] Ibid.
[10] Ibid.

- a lack of confidence asking patients about family violence and a fear of offending patients.[11]

Health services also serve many perpetrators of family violence…..

As a mainstream service, hospitals care for all members of the community which will include perpetrators. However, drug and alcohol and mental health services in particular are more likely to work with clients who perpetrate abuse:

- There is evidence that among men in treatment for substance abuse there are high levels of perpetration of family violence.[12]
- Staff working in SVHA mental health and drug and alcohol services report that a reasonably significant number of their clients have been identified as alleged perpetrators of abuse, either by clinical staff, or through inter-agency case management forums.

Health services need to be equipped to respond to alleged or disclosed abuse perpetrated by clients, including considerations of duty of care to the victim (who may not be a patient of the service).

[11] McGarry, J et al (2014), *Responding to domestic violence in acute hospital settings*, Nursing Standard vol. 28, no. 34, pp.47-50.
[12] Spangaro & Ruane (2014).

4. Best practice in health service interventions for family violence

3.1 Identifying family violence – screening

The first stage of a response to family violence is identification (unless family violence has already been disclosed). Screening is an evidence-based process of directly asking questions about current or previous abuse and/or safety concerns at home. In health settings, screening can either be:

- *routine* (or universal) – where all women presenting to a particular service are asked a standardised set of questions (regardless of indicators of violence); or
- *targeted* – where women are selected for screening based on a professional's judgement where there are indicators of family violence present.

In Victoria, current practice guidance for mainstream services (including health services) on identification of family violence support targeted screening where a professional suspects violence has occurred based on key indicators.[13] The exceptions are public antenatal care, and child and family health services where routine screening is recommended.

However, in a number of other jurisdictions routine screening is conducted more broadly in health services, for example:

- In NSW, routine screening is mandated in public antenatal, early childhood, mental health and drug and alcohol services.
- In most states in the US, routine screening is conducted in emergency departments (EDs).

Clinical guidelines from the World Health Organisation (WHO) and the UK National Institute for Health and Care Excellence (NICE) both recommend routine screening for selected groups of patients at elevated risk of family violence, namely:

- women with mental health symptoms or disorders;
- women attending antenatal care;
- women experiencing substance abuse problems; and
- women presenting for sexual health or HIV testing.

The NICE guidelines further recommend routine screening of adults in postnatal and reproductive health settings, and children's services.

A recent literature review of the evidence on screening in health services concluded that:

> *There is clear evidence that screening by a skilled health worker directly asking questions increases the identification of women experiencing abuse, has little or no adverse effect on women, is supported by most women who have experienced both abuse and screening, and can bring benefits to women particularly when associated with referral to counselling.*[14]

Further, the evidence suggests that the benefits of screening are maximised when:

- a validated, standardised tool is used, rather than general questions;
- staff are appropriately trained;
- for services with ongoing contact with a patient, screening is conducted at the second visit and patients are rescreened after some time once trust is established; and

[13] Department of Human Services (2012).
[14] Spangaro & Ruane (2014), pp. 20-21.

- an on-site social work response is available immediately where abuse is disclosed to ensure appropriate risk assessment and follow-up.[15]

Our current practice

Current practice at St Vincent's Hospital Melbourne is to conduct targeted screening – consistent with Victorian Government practice guidance.[16] Where any staff member suspects family violence they will generally refer to a specialist for screening and more detailed assessment:

- a hospital social worker – if the patient is in acute, palliative or sub-acute care;
- the Assessment, Liaison & Early Referral Team (ALERT)[17] – if in the ED; and
- a treating psychiatrist or identified clinician / case manager – if in Mental Health.

In addition, ALERT are physically present in the ED and conduct proactive, targeted screening of patients based on their observations of patients presenting (without referral from another clinician).

All ALERT and Social Work Department staff are trained and skilled in identifying and responding to family violence as a core competency. Non-social work staff in ALERT can also draw on the expertise of senior social workers within the team.

Embedding best practice in hospitals

St Vincent's Health Australia considers that there is strong evidence to support routine screening in health services where significant numbers of women at higher risk of family violence are seen.

In line with WHO and NICE guidelines, we consider that routine screening for family violence to mental health and drug and alcohol services, as well as sexual health clinics should be considered. Our experience from St Vincent's Hospital Sydney where routine screening is mandated in these services is that screening by skilled staff can increase identification.

Further, we consider there is scope to expand screening in hospital EDs based on systematic identification of risk factors (targeted screening), with screening to be conducted by a broader range of medical and clinical staff.

To support enhanced screening (both routine and targeted), more hospital staff need to be educated to improve their competence and confidence in responding to family violence, and trained in using screening tools / questions. Further, if more cases of family violence are identified additional social work (or other specialist) capacity would be required to undertake more comprehensive risk assessment and safety planning, and provide appropriate follow-up and referral to specialist family violence services.

This would have resource implications that would need to be funded by the Victorian Government.

The Victorian Government may wish to support a trial of enhanced responses to family violence in hospital settings, including enhanced screening. A trial would allow new screening processes to be rigorously evaluated before consideration of rolling out new arrangements to all Victorian hospitals. This would build the Australian evidence-base and allow the costs and benefits to be assessed.

[15] Ibid.

[16] St Vincent's Hospital Melbourne does not provide antenatal, or child and family services.

[17] ALERT is a multidisciplinary team (including social workers), that operates within the ED 7 days a week 8.30am to 9pm. They provide assessment, allied health, care coordination and/or ED discharge planning for people with a range of complex psychosocial and medical needs.

We believe St Vincent's Hospital Melbourne would be an ideal trial site given:

- a particularly vulnerable patient demographic, and clinical and medical staff that are experienced working with highly vulnerable populations;
- St Vincent's Hospital Melbourne's significant mental health and drug and alcohol service offering would provide the scale required to test routine screening in these settings;
- strong organisational commitment in line with Catholic values of compassion and social justice for the most vulnerable including victims of family violence;
- experienced social work department and ALERT staff to support implementation and the evaluation of new processes; and
- St Vincent's Hospital Melbourne's experience with developing, introducing and evaluating an evidence-based and best practice elder abuse framework that could be applied to family violence more broadly (described in more detail below).

A trial should also incorporate other elements of St Vincent's Hospital Melbourne's framework for the Protection of Vulnerable Older People (described in more detail below) including senior governance arrangements for case review and continuous improvement, data collection and documentation, and a structured education framework.

Recommendation 1:

That the Royal Commission consider supporting a trial of enhanced responses to family violence in hospital settings, including:

- *routine screening of all women in mental health and drug and alcohol services; and*
- *targeted screening in the ED based on systematic identification of risk factors.*

The trial of expanded screening would require additional government funding, and should be supported by:

- *the development / adoption of a validated screening tool;*
- *training for frontline staff on screening methods, and appropriate follow-up and referral processes;*
- *additional social work capacity for more comprehensive risk assessment and follow-up where family violence is identified (including in the ED); and*
- *governance, documentation and data collection processes to support case review, continuous improvement and evaluation (see also recommendation 4).*

We believe that St Vincent's Hospital Melbourne would provide an ideal trial site.

3.2 Responding to family violence – risk assessment & safety planning, first line responses, care coordination

The Department of Human Services' *Risk Assessment and Risk Management Framework and Practice Guides 1 to 3* (2012) provide comprehensive guidance on responding to family violence in different settings.

However, St Vincent's Health Australia believes that this guidance does not appropriately reflect the role of hospitals and other health services beyond identification of abuse. The guidance assumes that once identified, victims of abuse will be referred to specialist family violence services for risk assessment and safety planning. As such, there is no guidance on appropriate responses to

disclosures in health services other than referral. However, risk assessment and safety planning in health services can be highly effective when conducted by skilled staff such as social workers.[18]

In practice, St Vincent's Health Australia's hospitals deliver a range of interventions to respond to violence once it is disclosed. Based on our experience, there are many cases where the hospital is the only service a victim is accessing, or chooses to access. In these circumstances, the presentation to hospital is a key window of opportunity for intervention that should not be lost.

Further, where violence has been identified hospital staff need to understand the level of immediate risk facing the victim, and whether it is safe for them to be discharged. This is particularly important for an ED presentation, where the presentation itself increases a victim's vulnerability and their risk of death.

Our current practice

St Vincent's Health Australia's public hospitals have highly trained social work staff on-site that deliver a range of interventions reflecting the victim's choices:

- *risk assessment* – evaluating the likelihood and severity of future violence, including whether it is safe for the patient to be discharged;
- *safety planning* – assisting a person who wishes to return home to identify the risk factors and likelihood of harm and develop a future plan for action (including for any children living with them); and
- *first line responses* (or supportive advocacy) – providing information and support to empower victims and assist them to access community resources such as legal, housing and financial advice, including through referrals.

In addition, St Vincent's Hospital Melbourne has a unique care coordination service in the ED to work with patients with complex needs – the Assessment, Liaison & Early Referral Team (ALERT). ALERT has some particular features that allow the hospital to provide tailored and more intensive support to victims of family violence who present to the ED – outlined in the box below.

Social workers and the ALERT service aim to work in close partnership with other agencies including specialist family violence service 'Safe Steps', the Women's Information and Referral Exchange (WIRE), Victorian Centres Against Sexual Assault and Victorian Police Family Violence response units. More information about integration and coordination is in Section 4.

[18] Spangaro & Ruane (2014).

Box 1: The Assessment, Liaison & Early Referral Team (ALERT)

The ALERT model has the following strengths:

- *Multidisciplinary* – all team members work as generic care coordinators but also have a discipline specific role (for family violence, social workers are the specialists and support other members of the team where violence is identified).
- *Continuity of care* – a primary aim of the ALERT service is to establish linkages for clients in the community so their care can be sustained after they leave the ED. ALERT staff can engage with a client in ED and continue to support them in the community in the short to medium term.
- *Care or service coordination* – ALERT can take the role of service coordination if a client is already engaged with multiple services. Alternately, ALERT can coordinate care by linking clients with appropriate services in the community. A key supporting mechanism is weekly clinical review and coordination meetings held by ALERT to review selected care plans with other areas of the hospital and external providers (eg. NGOs / GPs).
    - In many family violence cases, the coordination role will be undertaken by a specialist family violence service. However, where a victim of family violence has ongoing health needs (physical or mental) or a range of complex needs, the ALERT team may be best placed to coordinate.
- *Access to brokerage funds* – ALERT staff can purchase crisis accommodation (eg. hotels) for victims of family violence, and meet immediate needs such as transport and clothes if a victim does not want to return home.
- *Supportive culture* – the ALERT service enjoys strong organisational support given the strong social justice values of SVHM, as well as professional support from the nursing and medical ED staff who recognise the expertise and skills of ALERT in working with highly vulnerable groups.

<u>Embedding best practice in hospitals</u>

The ALERT model is unique among Victorian hospitals. It developed due to combination of factors – St Vincent's Hospital Melbourne's inner city location and demographic, the hospital's history as a charitable service, and the organisation's culture and values grounded in the Catholic faith to serve the poor and vulnerable. Victorian Government funding (originally from the Hospital Demand Management Strategy and now the Hospital Admissions Risk Program) supports the program.

The ALERT service works with ED patients who present with a range of complex psychosocial and medical needs – including mental health, homelessness, substance use, victims of assault and violence including family violence, vulnerable older persons, people with acquired brain injuries and Aboriginal clients.

SVHA believes the ALERT model is an example of excellent clinical practice in responding to patients with complex needs, including victims of family violence. However, there remains scope to strengthen the model including by formalising pathways and partnerships with specialist family violence services outside of the health system.

Recommendation 2:

That the role of hospitals in responding to family violence (beyond identification) including providing risk assessment, safety planning and first line responses is recognised and supported in government policy and practice guides.

Recommendation 3:

That the Royal Commission consider supporting the development of an effective practice model for Victorian hospital Emergency Departments to inform a best practice response to victims of family violence.

St Vincent's Health Australia suggests that the ALERT model at St Vincent's Hospital Melbourne represents a possible model that could be further developed for use in other hospitals.

3.3 Improving effectiveness – education & training, governance, data & continuous improvement

There is clear evidence that the effectiveness of responses to family violence in health settings can be improved through organisational or system level changes.

Firstly, education and training is a critical success factor. A lack of knowledge, competence and confidence among staff is the key barrier to effective responses to family violence[19]. Many medical staff in particular have no formal family violence training. Conversely, training is a key enabler in identifying violence (including through screening) and has been found to improve the standard of clinical practice[20].

An education and training model for health workers that is supported both in the literature and by St Vincent's Health Australia social workers is the tiered competency framework introduced in the UK, as part of their *Framework for Safeguarding Vulnerable People in the National Health Service*.

Within the safeguarding model, specific guidance from the NICE in relation to domestic violence recommends four levels of training – see Box 2. This guidance recognises that health workers need different levels of education and training commensurate with their role in identifying, assessing and responding to abuse.

The second critical success factor is institutional support including supportive organisational processes and structures. From various studies, senior management support, 'clinical champions', systems for information sharing and processes and tools for documenting and monitoring / auditing cases have all been found to improve identification of family violence and clinical outcomes for women who disclose family violence[21].

[19] McGarry et al (2014).
[20] Spangaro & Ruane (2014).
[21] Ibid.

Box 2: NICE guidance on domestic violence training for health and community service workers

Training to provide a **universal response** should give staff a basic understanding of the dynamics of domestic violence and its links to mental health and alcohol and drug misuse:

- **Level 1** Staff should be trained to respond to a disclosure of domestic violence and abuse sensitively and in a way that ensures people's safety. They should also be able to direct people to specialist services.
    - This level of training is for: physiotherapists, speech therapists, dentists, youth workers, care assistants, receptionists, interpreters and non-specialist voluntary and community sector workers.
- **Level 2** Staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. Staff should also be able to respond with empathy and understanding, assess someone's immediate safety and offer referral to specialist services.
    - Typically this level of training is for: nurses, accident and emergency doctors, ambulance staff, GPs, mental health professionals and alcohol and drug misuse workers.

Training to provide a **specialist response** should equip staff with a more detailed understanding of domestic violence and abuse and more specialist skills:

- **Level 3** Staff should be trained to provide an initial response that includes risk identification and assessment, safety planning and continued liaison with specialist support services.
    - Typically this is for: social workers, unit level champions and those involved in multi-agency risk assessment processes.
- **Level 4** Staff should be trained to give expert advice and support to people experiencing domestic violence and abuse. This is for specialists in domestic violence and abuse.
    - For example, domestic violence advocates or support workers, refuge staff, domestic violence and abuse and sexual violence counsellors and therapists.

Other training to raise awareness of, and address misconceptions about, domestic violence and abuse issues and the skills, specialist services and training needed to provide people with effective support. This is for: commissioners, managers and others in strategic roles within health and social care services.

<u>Our current practice</u>

In 2013, St Vincent's Hospital Melbourne implemented a new hospital-wide policy, model of care and education framework to respond to elder abuse (one form of family violence), in line with the Victorian Government's *Elder Abuse Prevention Strategy (2010)* and *With respect to age: practice guidelines for health and community agencies for the prevention of elder abuse (2009)*.

The new framework was developed in response to clear evidence that:

- Hospitals are a key window of opportunity for intervention in elder abuse – people experiencing elder abuse are at greater risk of hospitalisation than other seniors[22].

[22] Joubert, L & Posenelli, S (2009*), Responding to a Window of Opportunity: the detection and management of aged abuse in an acute and subacute health care setting,* Social Work in Health Care 48, pp.702-714.

- Health professionals lack specific understanding, education and training in recognising abuse and intervening.[23]
- Education and training of health professionals in elder abuse is regarded as an important means of ensuring the early identification, prevention and effective management of elder abuse.[24]
- High levels of suspicion of abuse, but low levels of intervention before the new framework was introduced. An anonymous survey of staff at St Vincent's Hospital Melbourne found 53% had suspected abuse in the last 12 months, but only 17.7% attempted to explore the situation further and 7% attempted an intervention[25].

The new framework was developed as part of the PhD research of St Vincent's Hospital Melbourne Senior Social Worker, Meghan O'Brien and supported by an Australian Research Council Linkage grant in collaboration with the University of Melbourne. As such, the model is based on contemporary evidence of both key barriers to effective practice, and best practice from other jurisdictions including evidence gathered from a study tour of the UK.

Box 3: The St Vincent's Hospital Melbourne Elder Abuse Framework

The key features of the model are:

- *High-level governance arrangements* – a senior Vulnerable Older People Coordination and Response Group has been established. Members of the group review all data relating to suspected cases, and also advises on policy and continuous improvement.
- *A model of care* which supports staff to identify pathways for intervention and escalation based on risk, patient choice and safety planning.
- *Data collection and notification* – All cases of confirmed, witnessed or suspected elder abuse are notified to the coordination and response group. The data informs process improvement and workforce training.
- *Education* – the framework is underpinned by three tiers of competency training for hospital staff:
    - **Level 1** – Awareness raising for all hospital staff who do not receive Level 2 and 3 training. Not yet rolled out at SVHM.
    - **Level 2** – Education for managers. So far delivered to key managers in community programs only (ie. the Aged Care Assessment Service, the Aged Psychiatry Assessment and Treatment Team, and residential aged care). There are many other relevant senior staff and managers yet to receive this training.
    - **Level 3** – Education for clinicians undertaking assessments and providing interventions for vulnerable older people. All social work and ED care coordinators (ALERT) have received this training. Staff working in community programs are yet to receive it.

[23] Cooper, C., Selwood, A. and Livingston, G. (2009), *Knowledge, detection, and reporting of abuse by health and social care professionals: A systematic review*, The American Journal of Geriatric Psychiatry, 17 (10): 826–838.
[24] Day, M.R., Bantry-White, E. and Glavin, P. (2010), *Protection of vulnerable adults: An interdisciplinary workshop,* Community Practitioner, 83 (9): 29–32.
[25] Joubert & Posenelli (2009).

The elder abuse framework has already delivered significant practice improvements, even though the training framework was only delivered to social work and ALERT staff as part of the PhD research funding. Outcomes delivered so far include:

- Better identification of abuse through improved knowledge, competence and confidence of hospital staff.
    - Over a two year period 102 notifications were received – considerably higher than before the new policy[26]. The vast majority of notifications came from staff who had received training.
    - Staff who received training improved their confidence, knowledge and competence to act on suspicion of elder abuse by 20%.[27]
- Data collected for the first time through the notification process including on types of abuse, risk factors, level of ongoing risk, interventions delivered and case outcomes. This data has supported performance measurement and continuous improvement, including an audit of 100 notifications.
- Audit results show that effective clinical care was provided and the policy was adhered to in most cases.
- Strong organisational commitment embedded through the governance arrangements.

As a next step, St Vincent's Hospital Melbourne is currently preparing a submission to the Victorian Department of Health seeking funding to:

- Undertake a pilot project with two other Victorian health services to test the effectiveness of the St Vincent's Hospital Melbourne governance model in other settings.
- Deliver level 1 awareness raising training to key clinical staff who have direct contact with vulnerable older people.
- Provide more comprehensive training (levels 2 & 3) to staff and managers in community and ambulatory care programs.

Further, St Vincent's Hospital Melbourne is currently negotiating with Justice Connect (a legal services NGO) to establish a new 'Health-Justice Partnership' at St Vincent's to improve outcomes for older patients with a focus on the prevention of, and response to, elder abuse.

For other forms of family violence (largely intimate partner violence), social work and ALERT staff at St Vincent's Hospital Melbourne receive specialist training and have required competencies in this area. Other clinical and medical staff receive no or limited formal training in family violence.

This is in line with other hospitals in Victoria and our public hospital in Sydney. However, structured education and training is the key mechanism to overcome barriers to effective health service responses and as such can deliver major improvements. For example, St Vincent's Hospital Melbourne staff report that training provided by the Domestic Violence Resource Centre and funded by the Department of Health for key frontline workers was highly valued and improved staff competence.

Further, data on the prevalence of family violence in Victorian hospital services is not currently collected, which limits monitoring and performance measurement. To this end, St Vincent's Health Australia welcomes the recent announcement by the Victorian Government to develop a Victorian

[26] Based on staff observation. There were no data collected previously to allow a concrete comparison.
[27] From an evaluation of the education package as part of the PhD research.

Family Violence Index and we look forward to working with the Government as this project progresses.

Embedding best practice in hospitals

St Vincent's Health Australia considers that the St Vincent's Hospital Melbourne elder abuse framework is current best practice in safeguarding those at risk – not only for vulnerable older people, but for all victims of family violence.

We believe that a similar framework – involving tiered training, senior governance arrangements and data collection and documentation processes – could be applied to other forms of family violence including domestic violence and child protection. There is currently a lack of data collected in health services about family violence which makes performance measurement and service improvement difficult.

The evidence shows that the barriers and success factors for effective practice are the same for elder abuse as domestic violence. Further, experience in the UK shows that an integrated approach to safeguarding vulnerable people can be effective, noting that key aspects of that framework are tailored for children and adults.

St Vincent's Health Australia considers that a trial of enhanced responses to family violence in hospital settings (see recommendation 1) should incorporate the key features of the St Vincent's Hospital Melbourne elder abuse framework. We believe that embedding these arrangements more broadly has the potential to deliver significant improvements in the detection and management of family violence in health care settings.

Recommendation 4:

That the best practice elder abuse framework at St Vincent's Hospital Melbourne be adopted more broadly for responding to family violence.

Key features of the framework could form part of the proposed trial of enhanced responses to family violence in hospital settings (see recommendation 1):

- *a tiered education and training model;*
- *senior governance arrangements for case review, performance monitoring and continuous improvement; and*
- *data collection and reporting arrangements.*

3.4 Working with perpetrators

There is a lack of evidence about how health services should respond to disclosures or suspicions of abuse perpetrated by patients. Reflecting this, there is also a lack of guidance available to services.

Perpetrator treatment or behavioural change programs have received much interest in recent years, however there is little current evidence of effectiveness:

- A European systematic review of 12 studies found some modest changes but that high drop-out rates, the use of self-reported measures and short follow up periods limited the conclusions that could be drawn[28].

[28] Akoensi et al (2013), in Spangaro and Ruane (2014).

- Another systematic review from US concluded that there had been a relatively small number of studies and many had methodological limitations which meant that conclusions could not be drawn on effectiveness[29].
- NICE guidelines for health services in the UK conclude there is a lack of consistent evidence on both effectiveness and cost-effectiveness.

Our current practice

St Vincent's Health Australia hospitals do not provide any behavioural change programs for perpetrators.

Our services will continue to work with alleged perpetrators, for example in mental health and drug and alcohol services. Other actions that our services may take in relation to alleged perpetrators are:

- report disclosures or suspicions of serious violence to Police or child protection authorities (if a child is at risk); and
- provide information about perpetrators to other agencies (including through inter-agency forums in NSW) where there is a risk of harm to the victim or others (for example, workers entering the home).

Embedding best practice in hospitals

St Vincent's Health Australia considers that responding to perpetrators, including how to manage duty of care to their family members who may not be a client of the hospital's services, is an area where further guidance should be developed. This is likely to be an issue for a range of mainstream services.

Recommendation 5:

That guidance be developed for mainstream services on best practice in responding to disclosures or suspicions of abuse perpetrated by clients or by family members of a client.

[29] Eckhardt et al (2013) in Spangaro and Ruane (2014).

5. Integration and coordination in the Victorian family violence system – a hospital perspective

In the context of responding to family violence, effective service integration can be defined as 'coordinated, appropriate, consistent responses aimed at enhancing victim safety, reducing secondary victimisation and holding abusers accountable for their violence'.[30]

A major review of integrated responses to family violence from various jurisdictions conducted by the Australian Domestic and Family Violence Clearinghouse found:

- A range of positive outcomes from integration including: increased reporting, charges and convictions; reduced reports of violence over time; reduced duplication of services for some women; and increased access to services for more vulnerable women who face highest barriers to access.
- No clear evidence on which particular model of integration is most effective.
- However, some key success factors do emerge, namely:
    - active leadership within participating services;
    - robust governance arrangements, plus clearly defined outcome and accountability arrangements; and
    - the inclusion of a range of agencies including justice, health, housing and victim support services.[31]

5.1 Current integration and coordination mechanisms in Victoria

There are a number of current integration mechanisms that hospitals participate for elder abuse:

- St Vincent's Hospital Melbourne is a member of an interagency protocol led by City of Yarra. The development of an interagency protocol was a requirement for all local areas under the Victorian Government's policy: *With respect to age: practice guidelines for health and community agencies for the prevention of elder abuse (2009)*.
    - The protocol covers processes for responding to elder abuse and defines the roles and responsibilities of respective parties, and was developed by a funded position at Senior Rights Victoria.
    - Feedback from St Vincent's Hospital Melbourne staff is that the protocol has been useful at encouraging coordination between agencies.
- St Vincent's Hospital Melbourne also participates in the Eastern Elder Abuse Network coordinated by Eastern Community Legal Centre which has representatives from government, legal services, community services and hospitals.

Currently, there are not similar mechanisms for other forms of family violence in Victoria (involving St Vincent's Hospital Melbourne at least). As a comparison, our public hospital in Sydney is involved in a number of inter-agency processes to respond to family violence in a coordinated way. These include:

- A NSW Government trial of 'safety action meetings' for the Waverley local area command as part of *It Stops Here: Standing Together to End Domestic and Family Violence,* the NSW Government's Domestic and Family Violence Framework for Reform.

[30] Mulroney, J. (2003), *Trends in interagency work*, Australian Domestic and Family Violence Clearinghouse, Sydney.
[31] Australian Domestic and Family Violence Clearinghouse (2010), *Understanding domestic violence and integration in the NSW context: a literature review*, Sydney.

    - Safety action meetings are facilitated by the Police, and involve file review and integrated case management of victims of family violence (or those at risk) by a range of government agencies and NGOs working in the area.
    - Another part of the reforms was information sharing legislation (supported by protocols) that allows service providers to share information about victims and perpetrators so that victims do not have to retell their story multiple times, to hold perpetrators accountable and to promote an integrated response for victims at serious threat.
    - Feedback from our staff involved in this trial is that the meetings are resource-intensive, but highly valuable. In addition to victims to present to our hospital, our many cases, our hospital can also share information about perpetrators using our services when requested by other agencies (eg Police).
- A Domestic Violence inter-agency group set up by agencies in the local area (Police, Health, NGO refuges) to coordinate planning and service delivery.
- The NSW Health Statewide Domestic Violence Network with representation from range of health services.

5.2 Areas for improvement

Frontline St Vincent's Hospital Melbourne staff consider that enhanced coordination mechanisms between hospitals, Police and specialist family violence services would improve the overall system response to family violence in Victoria.

However, there are some barriers to effective coordination. Firstly, effective coordination involves a time commitment. This obviously has resource implications but delivering on National Emergency Access Targets can also be barrier for ED staff.

Secondly, training and resources are essential so that staff understand what information can be shared within legislative requirements and under what circumstances. For example, as part of the NSW reforms a range of resources were developed for service providers across various parts of the system on the new information sharing protocols and legislation.

Recommendation 6:

That the Royal Commission consider mechanisms for strengthening frontline coordination between health services, Police and specialist family violence services.

St Vincent's Health Australia suggests that safety action meetings, currently being trialled in NSW, provide a useful model for further consideration in the Victorian context. The Elder Abuse interagency protocol is also a useful mechanism.

6. Responses for particular groups and communities

While St Vincent's Health Australia recognises the specific needs of a wide range of groups and communities, at St Vincent's Hospital Melbourne we particularly focus on the needs of Aboriginal and Torres Strait Islander communities in Victoria. As such, we have limited our comments to this vulnerable group.

5.1 Aboriginal and Torres Strait Islander communities

The disproportionate levels of family violence experienced by Aboriginal people, particularly women is well documented.

St Vincent's Hospital Melbourne has a team of three Aboriginal Hospital Liaison Officers (AHLOs) who work with Aboriginal patients and hospital staff to support cultural safety, and integrated and holistic care including responding to family violence.

Our Senior AHLO acknowledges that Aboriginal staff can have a reluctance to engage with family violence and child protection issues that present in hospital settings. This reluctance is based on low levels of trust in welfare / social work services and police in the local community due to historical events from colonialisation and the Stolen Generations. There are also concerns from staff for their own safety if they report or investigate suspicions. At times, Aboriginal staff that are involved in such cases have experienced repercussions from the community because of their role in reporting.

In response, the Senior AHLO and the St Vincent's Hospital Melbourne Social Work Department have developed a model that supports AHLOs and ensures their safety. The model involves:

- Team-based decision-making and case management to share responsibility – AHLOs work with mainstream teams (eg. with ALERT or Social Work teams) where required rather than Aboriginal clients being referred to AHLOs. All cases are discussed with a clinical supervisor.
- Two-way learning – the AHLOs play a role in educating social workers, ALERT and mental health staff, and vice versa.
- AHLOs acting as brokers between social work and the local communities to build trust, including facilitating community visits for clinical staff.

Our AHLOs consider that Aboriginal staff in other organisations would benefit from similar support to allow them to meet their responsibilities to victims in a safe way.

Our AHLO staff report a number of suggestions for improvement in how the family violence system more broadly in Victoria supports Aboriginal victims:

- Victims should be given a choice in referrals between mainstream and indigenous-specific services to support their choices and ensure their safety. For example, there is only one Aboriginal refuge in Melbourne which is highly visible in the community and anonymity for victims who use the service cannot always be assured.
- This means that mainstream services must be culturally appropriate for Aboriginal people, and staff must receive appropriate cultural competency training.
- Currently, the Safe Steps program is not generally working for Aboriginal women and it can be very difficult to get Aboriginal women into mainstream family violence services.
- There is a lack of justice services for Aboriginal victims. Aboriginal Legal services support alleged perpetrators in legal matters but there is no dedicated service for Aboriginal women.

Recommendation 7:

That the Royal Commission support further work with Aboriginal and Torres Strait Islander communities to develop guidance for health services in how to appropriately support Aboriginal people to access either Indigenous-specific or mainstream support services, dependent upon the Aboriginal person's choice.

Recommendation 8:

That the Royal Commission support a review of resourcing, training and cultural competency within support services to meet the needs of Aboriginal people experiencing family violence.

About St Vincent's Health Australia

St Vincent's Health Australia is the nation's largest Catholic not-for-profit health and aged care provider. We are a clinical, research and education leader working in private hospitals, public hospitals and aged care services in New South Wales, Victoria and Queensland.

Our services comprise 27 facilities including six public hospitals, eight private hospitals, 13 aged care facilities and four co-located research institutes (Victor Chang Cardiac Research Institute, Garvan Institute of Medical Research, O'Brien Institute, and St Vincent's Institute of Medical Research).

From the health services established by the Sisters of Charity in 1857 at Woolloomooloo in Sydney, St Vincent's Health Australia has grown to operate more than 2,500 hospital beds, 1,100 aged care places, employs over 17,000 staff, works with over 2,500 medical practitioners and draws on the talents of over 1,300 generous volunteers. Each year we provide care to more than 250,000 inpatients and over 1 million episodes of care through our outpatient services.

We are a clinical and education leader and have a national and international reputation in various fields of medical research. Our areas of expertise crosses a large domain including: heart lung transplantation; bone marrow transplantation; cardiology; neurosurgery; cancer; HIV medicine; respiratory medicine; mental health; drug and alcohol services; aged psychiatry; homeless health care and urban Aboriginal health.

Grounded in our history and Catholic values, we are leaders in delivering healthcare to the most vulnerable Australians including people with mental illness and drug and alcohol addictions, the homeless, urban Indigenous communities and prisoners. We believe that a society is only as healthy as the least healthy among us. Our shared responsibility for the society which privileges most, but cripples some, calls us to act.