



Government of **Western Australia**  
Department of **Health**

Responding to Interpersonal Violence: Are you safe?

Clinical Senate Meeting – 24 March 2017

Final Report

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## Introduction

The role of the Clinical Senate of Western Australia (WA) is to provide a forum where collective clinical knowledge is used to debate strategic health issues. Recommendations are made in the best interest of the health of all Western Australians and are subsequently provided to the Director General (DG), the Health Service Boards (HSBs) and through the DG to the Minister for Health.

The first meeting of the Clinical Senate of Western Australia for 2017 was held on 24 March at the University Club of WA. The topic for debate was “Responding to Interpersonal Violence: Are you safe?”

In Australia the combined effect of interpersonal violence presents a major public health issue. Research from the 2012 Australian Bureau of Statistics (ABS) Personal Safety Survey and Australian Institute of Criminology shows that both men and women in Australia experience substantial levels of violence. Domestic and sexual violence is overwhelmingly committed by men against women with 89 women killed by their current or former partner between 2008-2010. This equates to nearly one woman every week. Overall, 1 in 5 women and 1 in 22 men experience sexual violence; 1 in 6 women and 1 in 19 men experience physical or sexual violence from a current or former partner; 1 in 4 women and 1 in 7 men experience emotional abuse; and 1 in 3 women and 1 in 2 men experience physical violence<sup>1</sup>.

Key statistics regarding violence against women revealed Australian women are most likely to experience physical and sexual violence in their home, at the hands of a male current or ex-partner.

The focus for debate was to consider how clinicians can detect and manage interpersonal violence in patients attending WA Health facilities and to minimise future harm. Equally as important was for senators to consider how WA Health should support staff to manage Interpersonal Violence (IPV).

The Co-sponsors for the debate were Mr Wayne Salvage, Chief Executive, North Metropolitan Health Service and Ms Pip Brennan, Executive Director, Health Consumers' Council WA.

Present at the debate were a range of multiagency, cross jurisdictional experts with knowledge of health, research, law, child welfare, women's support services, social and community services including government and non-government agencies. Also in attendance were several victims of family and domestic violence.

Ms Tanya Basile, Deputy Chair of the Clinical Senate, introduced the topic for debate calling on senators to consider how clinicians at the coal face can detect, manage and provide care in the setting of IPV. How we can identify IPV within our healthcare facilities, respond to this sensitively and manage disclosures of interpersonal violence using evidence based approaches, whilst keeping our patients and our staff safe.

She provided the following definition of Interpersonal Violence according to the World Health Organizations:

“The intentional use of physical force or power, threatened or actual, against another person, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation.”

IPV can be categorized into:

- Youth violence - which is violence committed against young people;
- Child maltreatment - which included violence and neglect towards children by parents and caregivers;
- Intimate partner violence – which occurs within an intimate relationship;
- Elder abuse - which is violence and neglect towards older people by family, carers, or others where there is an expectation of trust;

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<sup>1</sup> Australia's National Research Organisation for Women's Safety (ANROWS) (2012). 'Violence against men and women: Key Statistics, 2012 ABS Personal Safety Survey and Australian Institute of Criminology.

- Sexual violence - which includes sexual assault, unwanted sexual attention, sexual coercion and sexual trafficking; and child maltreatment - which included violence and neglect towards children by parents and;
- Elder abuse - which is violence and neglect towards older people by family, carers, or others where there is an expectation of trust.

Three talks set the scene for debate. Superintendent Kim Massam, District Superintendent, Central Metropolitan Police District outlined the impact of IPV on WA Police and the opportunities for change. Ms Sherrilee Mitchell, Director, Family and Domestic Violence Unit and Ms Jane Simmons, Relieving District Director, Perth District, Department of Child Protection and Family Support (CPFS) offered perspective on the Child Protection and Family and Domestic Violence intersect. Ms Jenny O'Callaghan, Co-Director, Women's Health, Genetics and Mental Health, Women and Newborn Health Service presented on Health's responsibility in responding to IPV.

The plenary session was opened by Co-sponsor Ms Pip Brennan who provided the results from a pre-debate survey of not for profit services which support women and families affected by domestic violence. Ms Brennan was followed by Ms Roia Atmar who shared her lived experience.

## 1. Process

The Clinical Senate in Western Australia was established in 2003. Debates follow an agreed standard. The process ensures that senators have a clear understanding of the process and receive sufficient information to discuss the topic and develop recommendations for the Director General of Health (DG) as System Manager and Health Service Boards (HSBs) as operational managers (Appendix 1).

Prior to the debate, attendees receive pre-reading containing information in preparation for the debate. Speakers and additional expert witnesses provide additional information on the day (Appendix 2).

The full day Senate debate traditionally commences with a Welcome to Country, which for this debate was offered by Nyungar Elder, Ms Marie Taylor. Ms Taylor emphasised the need to understand “family violence” within Aboriginal culture and called on clinicians to consider the impact on the extended family and wider community.

Clinical Senate Deputy Chair, Tanya Basile welcomed senators and experts and provided a report on senate activities since the last meeting. She introduced the topic for debate, provided the WHO definition of IPV and called on senators and other experts to work towards development of policy recommendations designed to improve the detection of interpersonal violence within health care facilities, and to improve management outcomes for patients and for our staff.

Ms Basile outlined the program for the day and formally advised participants of how the Clinical Senate of WA operates stating we seek to:

- work collaboratively, setting aside individual and organisational agenda
- state your opinions freely, drawing on your clinical experience and expertise
- empower you to influence others in all your professional spheres with the new perspectives gained through the debate
- play a leadership role in health reform, developing strong, valid, priority recommendations in the best interests of the health of all Western Australians.

Professor Gary Geelhoed, Assistant Director General, Clinical Services and Research and Chief Medical Officer spoke on behalf of the Director General. He reported the DG had requested more time before reporting back on the recommendations from the debate on homelessness. In relation to the topic for debate, Professor Geelhoed stated that identifying and dealing with interpersonal violence is an increasingly reality of being a healthcare professional. Collectively, we have more of a chance of finding real solutions to both protect our staff and importantly our patients.

The next stage of the process was a series of presentations to set the scene for debate, offering the impact on WA Police, the child protection and family and domestic violence intersect and responding to family and domestic violence within WA Health.

The plenary session was opened by Co-sponsor, Ms Pip Brennan who provided the results from a pre-debate survey of not for profit services which support women and families affected by domestic violence. Ms Brennan was followed by Ms Roia Atmar who shared her lived experience. A plenary discussion and debate followed where senators were encouraged to share their experience and to draw on the expertise.

The afternoon workshops were focussed on developing recommendations:

1. to improve detection and management of IPV in patients attending WA Health facilities
2. to support our staff to manage IPV.

Recommendations from the workshops were presented in the final session of the day and ranked in order of importance by the Senate. Senators developed recommendations directed at both the System Manager and Health Service Boards (HSBs). The Clinical Senate Executive issued a request for a response by the Director General of Health to each recommendation at the next debate. Responses could be:

- a) endorsed,
- b) endorsed in principle,
- c) not endorsed, or
- d) refer to health service boards.

Information and resources were displayed and made available on the day. (Appendix 3)

## 2. Presentations

Mr Bevan Bessen, facilitator for the day, opened proceedings by welcoming participants, acknowledging the traditional owners both past and present, and introducing Ms Marie Taylor who offered the Welcome to Country.

Nyungar Elder Marie Taylor offered a Welcome to Country. Ms Taylor emphasised the need to understand “family violence” within Aboriginal culture and called on clinicians to consider the impact on the extended family and wider community.

Marie shared some personal stories involving family members who were subjected to family violence by their partners. In both cases the women were able to escape their abusers, but they required support from Marie and the community and personal determination to escape from their terrible situations.

Marie emphasised that violence was not a characteristic of Aboriginal families but of circumstances. The source of the problem had many origins including the removal of parent’s rights to discipline their children when they were removed to government care, increasingly poor attitudes in some children who answered back and disrespected their parents, and police and hospital staff who failed to see the broader picture. Even the court system needed to take more responsibility. Jurors were not provided with adequate information on family violence and aboriginal people. There had been a breaking down of traditional family respect, family teaching and responsibility, depleting the family unit to such a degree that families were lost. Grandparents were now being asked to leave the family unit.

Through her story telling the importance of “family” and what makes up the family became evident. As clinicians we were asked to consider who is involved in both protecting and supporting the perpetrator and the victim. Marie was also able to broaden our understanding of spread and impact of family violence and what impact it will have on the widened “family” unit.

Ms Tanya Basile opened the debate by providing an update on Clinical Senate activity since the last meeting. She reported on:

- (1) New Members
- (2) Audit of Clinical Senate recommendations (2013-2016)
- (3) Inaugural Clinical Senate Alumni
- (4) Senator survey of topics.

Ms Basile welcomed two new members from WA Country Health Service (WACHS): Ms Linda Curtain and Dr Roland Main whom she stated brought expertise and experience in mental health and care delivery in the rural setting.

With regard to the second item, she reported that the Clinical Senate requested WA Health perform a follow up audit of the recommendations from debates held 2013-2016, being those held prior to the introduction of the HSBs. The results will be made available upon completion of the audit.

Ms Basile reported the Clinical Senate Alumni was now established. The process is such that all retiring senators would be invited to join the Alumni. Alumni members would be kept informed of senate activity and be asked to contribute to each debate by submitting a short message or comment to inform senators. She stated, the process had been successfully tested with the inaugural members and their comments would be used throughout the day.

Lastly, Ms Basile stated the results of the Senator survey of potential debate topics had indicated that waste in healthcare, safety and quality, and aboriginal health remain priority topics. The senate executive aims to deliver debates on these topics within the next 18 months.

In turning her attention to the topic for debate, Ms Basile called on participants to consider how clinicians at the coalface detect, manage and provide care in the setting of interpersonal violence. How we can identify IPV within our healthcare facilities, respond to this sensitively and manage disclosures of interpersonal violence using evidence based approaches, whilst keeping our patients and our staff safe. The aim is to develop policy recommendations designed to improve the detection of

interpersonal violence within health care facilities, and to improve management outcomes for patients and for our staff.

She provided the following definition of IPV according to the World Health Organization:

“The intentional use of physical force or power, threatened or actual, against another person, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation.”

Ms Basile outlined that according to the World Health Organization (WHO) IPV can also be categorised into: youth violence; child maltreatment; intimate partner violence; elder abuse and sexual violence. She stated there are also strong links between alcohol and illicit substance use and interpersonal violence. She emphasised that where child maltreatment or intimate partner violence is identified, clinicians face challenges when they must address the needs of a patient who has been subjected to violence, yet the alleged perpetrator may also be present in the same room or immediate vicinity. Therefore, addressing violence in a safe way is vital for both the patient and the staff member.

Ms Basile stated there are also strong links between alcohol and illicit drug use and interpersonal violence. She reported it worth noting that aboriginal people generally prefer to use the term “family violence”. This concept describes a matrix of harmful, violent and aggressive behaviour and is considered to be more reflective of an Aboriginal world view of community and family healing. However, the use of this term should not obscure the fact that Aboriginal women and children also bear the brunt of family violence.

Citing statistics from the 2012 ABS Personal Safety Survey and Australian Institute of Criminology report that both men and women in Australia experience high levels of IPV. Domestic and sexual violence is overwhelmingly committed by men against women. Between 2008 and 2010, 89 women were killed by their current former partner. This equates to one death each week. In terms of experiencing violence, she reported that nearly 1 in 3 women and 1 in 2 men had experience physical violence<sup>2</sup>. Violence represents a significant burden of disease and represents a common indication for presentation to healthcare personnel. Of note, presentation to healthcare personnel may represent the only notification of violence, as only 58% of people subjected to violence report it to police.

Ms Basile outlined other reasons the topic had been chosen for debate as:

- People experiencing IPV use Emergency Department (ED) services 33% more than those that are violence free
- Health has a predominantly female workforce. With the ratio of 1:3 women having experienced some form of IPV therefore, it is extremely likely you will be working with staff who themselves have experienced IPV
- IPV is increasing in our society and our hospitals and health services. Health services are microcosms of our society

Furthermore, in the setting of partner violence, clinicians can be faced with challenges when they must address a patient who has been subjected to violence and when the perpetrator may also be present. Addressing violence in a safe way is vital for the patient and also for the staff member. Violence is increasingly spilling into our hospitals with the number of ‘Code Black’ calls rising across hospitals, especially those with emergency centres. In 2016, one tertiary site reported 2521 Code Blacks of which 45% were in the Emergency Department (ED).

She highlighted the timeliness of the debate and opportunity given the recent appointment of the Hon. Simone McGurk, MLA whose Ministerial portfolio includes Child Protection; Women's Interests; Prevention of Family and Domestic Violence; Community Services.

To set the scene and inform the debate Ms Basile stated there would be presentations by: Superintendent Kim Massam, Ms Jane Simmons and Ms Sherrilee Mitchell and Ms Jenny O'Callaghan.

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<sup>2</sup> Australia's National Research Organisation for Women's Safety (ANROWS) (2012). 'Violence against men and women: Key Statistics, 2012 ABS Personal Safety Survey and Australian Institute of Criminology.



Presentations would provide insights into how other agencies are responding to IPV such as WA Police and Child Protection and Family Support (CPFS) and what needs to happen in WA Health.

Ms Basile advised that during the morning break there would be posters on display showcasing current programs as well as samples of available tools/resources.

She informed the plenary session would include a report from Ms Pip Brennan on the results from a pre-debate survey conducted of not for profit services supporting women and families affected by domestic violence. Ms Roia Atmar who would then share her personal journey through domestic violence followed by a free flowing debate allowing for clinicians and a broad range of experts to debate the key issues.

Ms Basile welcomed senators and member representatives and formally reminded participants of how the Clinical Senate of WA operates stating we seek to:

- work collaboratively, setting aside individual and organisational agenda
- state your opinions freely, drawing on your clinical experience and expertise
- empower you to influence others in all your professional spheres with the new perspectives gained through the debate
- play a leadership role in health reform, developing strong, valid, priority recommendations in the best interests of the health of all Western Australians.

Ms Basile reported that the recommendations from the debate on Homelessness had been presented to the DG. She introduced Professor Gary Geelhoed, Executive Sponsor for the debate on homelessness who attended on behalf of the DG.

Professor Gary Geelhoed, Assistant Director General, Clinical Services and Research and Chief Medical Officer opened the debate on behalf of the DG. He reminded members that each senate debate includes feedback from the DG on the previous set of recommendations, which for this debate would be on the topic of Homelessness. Given the importance of the topic, and the breadth and nature of the recommendations provided, the DG had requested additional time and information in order to provide feedback on these recommendations. Therefore the feedback would be provided at a later date.

Professor Geelhoed expressed the DGs appreciation to the Clinical Senate for responding with such a comprehensive set of recommendations to address the challenges of access to appropriate health care for people experiencing homelessness. He stated that both he and the Director General looked forward to receiving this in further detail and providing a full report back to the Clinical Senate at a future debate.

Speaking as Executive Sponsor for the debate on Homelessness, Professor Geelhoed stated he felt that the recommendations produced were a great step forward for our health system, and would assist in making meaningful change to the way we address homelessness.

The Clinical Senate on Homelessness was only the second debate since the WA public health system began operating in a new, more devolved, governance environment. Through the debate, Senators responded holistically to the issue of homelessness in our health system, making recommendations appropriate for both the System Manager and Health Service Providers (HSPs) in areas of education, collaboration, policy and practice.

Going forward the clinical senate is even more important and has a greater role in ensuring we have a system wide view of key issues and not a siloed approach.

Professor Geelhoed stated that the DG looked forward to working with the Clinical Senate over the coming year to ensure this valuable group continues to support the new governance model in addressing some of the most pressing issues in our health system.

Professor Geelhoed next spoke on the topic of the day and thanked the co-sponsors, Mr Wayne Salvage and Ms Pip Brennan. He echoed Ms Basile stating that identifying, and addressing IPV is unfortunately an increasing reality of being a healthcare professional. He acknowledged the broad range of agencies and services in attendance and concluded "Collectively, we have more of a chance of finding real solutions to both protect our staff and importantly our patients".

The opening talk to set the scene was presented by Superintendent Kim Massam from WA Police. He shared his department's perspective on responding to IPV speaking to the impact of Interpersonal

Violence on WA Police and opportunities for change. Superintendent Massam stated he has oversight of 700 staff servicing one quarter of the metropolitan area. He reported IPV is core work for him as both an officer and as a leader of his staff. This debate truly is a call to action!

He reported that in 2015-2016 WA Police attended 59,408 (162.7/day) incidents of Domestic Violence (DV) and that DV makes up 30-40% of their work. He reported it a well-known fact that many women do not report this therefore; this is only the tip of the iceberg in relation to this issue. Many seek advice or support from family members, friends or community services. It is estimated that 74% of women have confided in someone about violence experienced while only 20% had reported it to police<sup>3</sup>.

He chose to dedicate his talk to one of the victims, Jane, in recognition of the opportunities lost, the terror she has been subjected to and the struggles she continues to face.

Jane's story: Jane is a woman in her early 30s, living in the central district and has been in a relationship for many years. She is completely estranged from her family and has a small child. Jane has been subjected to horrific abuse over many years. She has presented to emergency departments across the metropolitan area and once in rural area 8 times in 3 years. Her injuries were not limited to: broken kneecap, numerous broken bones in her hand, significant lacerations, bruising and scarring and on one occasion her partner would not let her go to hospital. None of the presentations were at the time of incident often 2-3 days after and in one instance she presented 3 weeks later with a towel on her head. To hide her injuries of abuse, Jane stated she knocked heads with a child on a trampoline, other explanations included: a hockey ball hit her in the face, she fell through a gyprock wall and she fell and hit her head on the ball of a tow bar.

Superintendent Massam stated Jane is the reason I get out of bed every day and the continual conversations I have with my staff about the importance of this issue. It is also why I am proud to be here today. In order to influence Jane's story in any way we must work together through service provision (community) and health provision. There are lessons for us all with regard to Jane. He stated the extent of Jane's injuries both mentally and physically is so severe and shocking that it has affected him personally. Many of us are desensitised, but I ask you not to be. He conveyed that what was particularly shocking about this case was that in all the incidents, not once did someone reach out to Jane. Therefore, he asked clinicians to consider what one positive interaction might have meant to Jane.

Superintendent Massam outlined what WA Police do to address IPV. They have a strong identification and response processes in place that requires mandatory attendance at all incidents; strict pro intervention policies including arrest; significant investment in quality assurance of attendance and multiagency triage and referral processes. Frontline police he stated are the gate keepers to help!

Superintendent Massam stressed the importance of the first contact and how management is critical to the victim's response. If as police officers and as health professionals we carry preconceived prejudices that all of the community have into our interactions with a victim, then our ability to assist them is diminished. It is the adaptive change and the challenge to change the hearts and minds of all our front line service delivery people to actually care and portray that on each and every contact that is the true challenge. He stated when we do increase victim safety we have an opportunity to stop the violence however, when we get it wrong the outcomes are often catastrophic, and our victims become voiceless. Superintendent Massam stated the challenge for you is when victims come through the front door of your health service; we simply cannot miss that opportunity.

Again returning to Jane's case he stated that one year ago he received a call from a doctor at Royal Perth Hospital who was crying on the phone. This doctor had finally realised what was happening to Jane. Superintendent Massam stated he was still very concerned for Jane and he worried that there would not be a positive outcome for her due to the cycle of abuse. I am here today to remind you that it is really important to take every opportunity at every occasion to put this together, to do some research,

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<sup>3</sup> Australian Bureau of Statistics (ABS), *Personal safety survey Australia 2012*, op. cit.

to read the play and to be the very best first responder. Make sure the people you work with and work for, as well as those who work under you, are doing the same so we never have another story like Jane.

Superintendent Massam restated that most victims do not report, yet might seek advice or support from family members, friends or community services so we all have a role to play both as a professional and as a member of society. In describing what could be done Superintendent Massam spoke of the “Community Frontline”. He stated that the community hospital emergency department staff and frontline officers are often dealing with the same issues from slightly different perspectives so there is always room for improvement and definitely opportunity to work together.

In describing what ‘good’ looks like Superintendent Massam described the need for a strategy with a holistic approach to the health and safety of the victim and that promotes positive intervention with the perpetrator. He reported there are massive gaps in government around perpetrators that can’t always be managed through the court system. He stated there must also be a structure whereby the system carries the load and individuals are not required to manage either the victim or the perpetrator alone. If it is mandated, then it happens. We cannot afford to have a single point of failure.

Lastly, there should be a system of communication and reporting that ensures relevant information is shared between agencies. Superintendent Massam stated this was particularly important at a time when some healthcare is being privatised and with the addition of Health Boards. It is important everyone is doing it the same. WA Police also rely heavily on training and processes to deliver services.

In the last part of his talk Superintendent Massam spoke of “Our people as victims or perpetrators”. He reported with 30-40% of the work related to family violence there is the need to get it right. Leadership is critical and must be underpinned by good processes and technical support in order to improve outcomes and service delivery standards. Prejudices remain the hardest area to crack. He stated their code of conduct includes what officers do both on and off duty and there are protocols for police involved in incidents that are often handled via internal investigation. Officers are offered counselling/support through the health and welfare division. Every effort is made to identify issues and intervene early.

In closing, he reminded participants of Jane’s story and stated that he dedicated his talk to her in recognition of the opportunities lost, the terror she has been subjected to and the struggle she currently faces.

Ms Sherrilee Mitchell, Director, Family and Domestic Violence Unit and Ms Jane Simmons, Relieving District Director, Perth District, Department of Child Protection and Family Support (CPFS) spoke on the intersect of Child Protections and Family Violence. Their talk was in two parts and included an overview of child protection and how they are working through the Family and Domestic Violence unit (FDVU) to integrate using improved policy and translation into better practices with families.

Ms Simmons opened stating that violence against women and their children takes a profound and long-term toll on the health and wellbeing of women and children, on families and communities, and on society as a whole.

The combined health, administration and social welfare costs of violence against women are estimated to be \$21.7 billion a year, with projections suggesting that if no further action is taken to prevent violence against women, costs will accumulate to \$323.4 billion over a thirty year period (2014-15 to 2044-45)<sup>4</sup>. Aboriginal women are 35 times more likely to be hospitalised due to family violence related assaults than non-Aboriginal women.

She overviewed the CPFS which operates 17 Districts across the state, and provides after hours responses through Crisis Care and the Men’s and Women’s Domestic Violence helplines. They are responsible for responding to referrals where FDVU is the presenting concern or is found to be present when investigating alleged neglect, sexual and/or physical abuse and emotional abuse. The FDVU is responsible for ‘internal’ child protection family and domestic violence policy, practice development and

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<sup>4</sup> Price Waterhouse Coopers (2015) ‘A high price to pay: the economic case for preventing violence against women’, report prepared for Our Watch and the Victorian Health Promotion Foundation (VicHealth).

guidance; and coordinating a central and regional across government approach to FDV strategic planning, policy development and implementation.

Ms Simmons shared a snapshot of 2015/16 activity which demonstrated a high demand for services to protect children and support families. She reported that of the 104,206 contacts (referrals) to the CPFS, almost 35,000 are incidents of family and domestic violence involving children. She reported a 27% increase compared to 2014-15. Furthermore there was 13,570 safety and wellbeing assessments that meant they used their powers to investigate on a multi-agency basis as well as using their legislative powers to get information, draw information from schools, health, police and other agencies. This resulted in 4335 substantiations of abuse resulting in 931 children in care and 931 lives disrupted as children are often displaced, can't go to the same school, live with family etc. Ms Simmons stated there is clearly more work to be done in this area.

In reporting on the growth in children in care Ms Simmons stated there is the need to understand the context of ongoing legislative, policy and practice reforms. Reform of the Department since the Ford Review has reduced the annual growth of children in care from 13% in 2008 to 3% in 2016 which suggested that something is working. However, the disproportionality is great and the total number of children in care has more than doubled since 2006. The rate of non-Aboriginal children in care grew by 0.6% in 2015/16 compared to 6% for Aboriginal children. Ms Simmons concluded that the response indicated that at a strategic level something needed to be done differently. We must build a system for collective impact.

Ms Simmons reported FDV featured in well over 90% of their work. They now take a position and assume that in all of their cases family and domestic violence may be present, regardless if indicated in the presenting issues. Co-factors are also often prevalent and include: drug addiction, mental health, homelessness etc. The Department is making better use of their data to understand the drivers of demand and measure outcomes for children who are in out of home care.

Ms Simons stated they have worked to realign the Department in order to focus on reforms aimed at reducing the number of Aboriginal children in care (Aboriginal Services and Practice Framework 2016-2018) and improve their practice around families and communities who come into contact with the child protection system in WA. In addressing comprehensive reform of child protection in WA she stated, included reforms to more effectively: divert families from the child protection system; prevent the need for children to enter the out of home care system; and support children in out of home care to thrive.

She spoke of the need for early intervention and explained that they are shifting the focus and investment rather than waiting for intervention. The Earlier Intervention and Family Support Strategy released in 2016 aims to divert families having contact with the child protection system and ultimately prevent the need for children to enter out of home care. This strategy focuses on four key areas and includes aspects of the spectrum of early intervention:

1. Delivering shared outcomes through collective effort - A system that is aligned and accountable to achieving shared outcomes for vulnerable families, with a focus on Aboriginal children and families.
2. A culturally competent service system - A system that is safe and responsive to the needs of Aboriginal families.
3. Diverting families from the child protection system - A system that identifies families that are vulnerable to involvement with the statutory child protection system, and provides early and intensive support.
4. Preventing children entering out of home care - A system that prioritises and aligns the Department's workforce and resources to prevent the most vulnerable children from entering out-of-home care.

In summarising her part of the presentation Ms Simmons reported that CPFS is working to better align research and services and separating the work they do with perpetrators from the work with mothers and children. She identified the challenges associated with a predominantly female workforce when dealing with male perpetrators and emphasised the need and importance of ongoing training and support for staff. <https://www.dcp.wa.gov.au/Pages/Home.aspx>

Ms Sherrilee Mitchell, Director, FDVU spoke next on the policies, strategic planning and State response to family and domestic violence. She outlined the many guidelines and policies that underpin practice and described the layers of complexity.

Ms Mitchell highlighted that a review and adjustment of the Department's FDV practice guidelines in 2015 was undertaken for the purpose of:

- more closely aligning the practice guidance to the Signs of Safety Framework and strengthening child protection processes
- bringing the practice guidelines in line with legislative changes
- addressing related recommendations from family and domestic violence investigation.

The five key messages of the current Internal FDV Policy, Practice Development and Guidance for Child Protection were highlighted in her presentation. She reflected on the second key message to emphasise the point that exposing a child to family and domestic violence is in fact, child abuse. The person responsible for 'exposure' is the perpetrator of violence. She stated much of child protection work is built on the assumption that a 'protective adult' can reduce or mitigate the risk posed by a perpetrator of abuse. However, when the perpetrator poses a risk to the child and the child's mother (the potential protector), protective actions can actually increase the danger rather than reduce it – for example, separation, seeking help from police, obtaining a violence restraining order etc. Ms Mitchell stated, when we put pressure on Mom we are putting her at risk; we should focus on the perpetrator. It is critical that we focus on the mother and the child as a unit. Screening and assessment is critical.

In speaking on the importance of service integration, Ms Mitchell reported there are 17 Family and Domestic Violence Response Teams (FDVRT) across the state comprised of members from the CPFS, WA Police and non-government agencies. Implementation of the FDVRT includes development of an interface between the CPFS and WA Police data systems to support more succinct information and sharing between agencies.

Ms Mitchell outlined the WA Common Risk Assessment and Risk Management Framework (CRARMF) which is: A standardised response to identifying, assessing, and responding to family and domestic violence. It is intended to provide a common practice framework for screening, risk assessment, risk management, referral and information sharing for all service providers in WA (mainstream, statutory and specialist). The second edition extends the original framework by updating policy context, incorporating evaluation to strengthen information sharing referral pathways and collaborative case management. It also strengthens practice guidelines about engaging and responding to perpetrators and provides and updates risk assessment tool.

She stated using the CRARMF assists us to work towards better identification of, and response to FDV regardless of what area of the service sector a victim or perpetrator come into contact with. This includes:

- Eliminating service gaps
- Keeping responses client and safety focused
- Supporting inter-agency responses to high risk cases so they are timely, streamlined and holistic.
- Using common language and common understandings

Ms Mitchell reminded of the importance of a wraparound multidisciplinary response and the importance of input into case management by all agencies.

In closing she stated the appointment of a dedicated Minister lifts the profile in WA and CPFS looks forward to working more closely with all agencies. "The demand is increasing but the capacity to respond is in dire straits, the more we do to encourage women to come forward, the more work there is to do."

Mr Bessen called a close to the morning session.

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During the morning break senators were able to view many of the resources available to them. A full list can be found at Appendix 3.

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The final presentation was delivered at the start of the plenary session by Ms Jenny O'Callaghan, Co-Director, Women's Health, Genetics and Mental Health, Women and Newborn Health Service who spoke on: Responding to Family and Domestic Violence in WA Health.

Ms O'Callaghan opened her talk by repeating the number of police responses to incidents in WA 2015-2016 (59,408). She described it as a shocking statistic and warned it was only the beginning. She thanked Ms Mitchell and Ms Simmons and reminded participants that it was critical to work together in order to understand each other's roles and responsibilities in this challenging space.

She described the debate as a call to action and suggested that IPV, like smoking, should be viewed as a public health issue. Ms O'Callaghan highlighted the unique opportunity in Australian history following 2015 Australian of the year Rosie Batty's story, to champion the rights and needs of victims of IPV. Commonwealth and State governments are starting to recognise the personal, social and economic costs of the consequences of the costs of IPV.

She outlined the Third National Action Plan (2016-2019) and called on participants to take note of the key parts of the priority areas as Health does have a role. These include:

- Prevention and early intervention of family and domestic violence
- Aboriginal and Torres Strait Islander women and their children are most at risk
- Greater support and choice for women and children
- Support for front line workers managing sexual violence
- Responding to children living with violence
- Keeping perpetrators accountable across all systems <sup>5</sup>

Ms O'Callaghan stated the definition of IPV aligns with the WA Health definition of Family and Domestic Violence, and encompasses child abuse and neglect, sexual assault and elder abuse. The Clinical Senate chose the term IPV to also address the widespread impact of FDV on our staff when dealing with victims and perpetrators. She quoted Prime Minister Malcom Turnbull who recently stated "not all disrespect of women ends in violence, but all violence begins with disrespect". This applies equally to the abuse of any person.

IPV is a critical health issue. It is a social problem with serious and far reaching health consequences:

- FDV contributes to more death, disability and illness in women aged 15 to 44 than any other preventable risk factor.
- Clients who have experienced FDV use health services significantly more frequently than clients who have not.
- Evidence suggests there is a direct causal relationships between interpersonal violence and depression, anxiety, homicide and injury, suicide and self-inflicted injuries, alcohol and drug use.

Ms O'Callaghan reported an overwhelming majority (90-95%) of people who experience FDV are women. There is strong evidence that intimate partner violence during pregnancy leading to low birth weight and increased risk of preterm birth and peri-natal deaths (still births/deaths of infants in first week of life) is more common among women who experience violence during pregnancy. There is a strong correlation between mental health problems, substance abuse and domestic violence. She reported that at King Edward Memorial Hospital (KEMH) patients identified as 'at risk' of child protection intervention has risen from 203 (2009/2010) to 366 (2015/2016) with FDV present in 43% (2009/2010) and 61% (2015/2016) of all cases. Finally, the total number of newborns in care rose from just 47 (2009/2010) to 76 (2015/2016).

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<sup>5</sup> Source: The Third Action Plan of the *The National Plan to Reduce Violence against Women and their Children 2010-2022*, October 2016, [www.dss.gov.au/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022](http://www.dss.gov.au/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022)

Ms O’Callaghan also reported on the prevalence in Aboriginal women stating Aboriginal women represent only 2% of the female population yet they are 45 times more likely to be victims of FDV and 35 times more likely than non-aboriginal women to be hospitalized due to family violence related to assaults.

Presenting on the costs of health care and FDV Ms O’Callaghan presented the following table<sup>6</sup>:

## Costs to WA Health

- The current system in place for WA Health data collection puts the total inpatient cost of FDV at **\$51,879,096** (2009-2015) across all WA Health regions.
- **48%** of this cost relates to spouse or domestic partner caused injuries.
- Increases to **71%** of the cost when assault by a family member is included.
- **56%** of the hospitalisation cost of injuries by a spouse or domestic partner related to Aboriginal women.

Total costs of FDV related hospitalisation by spouse or domestic partner and family member and health region, 2009-2015

HEALTH REGION	TOTAL COST 2009-2015
Kimberley	\$9,159,645
East Metro	\$7,279,915
North Metro	\$4,617,383
South Metro	\$4,110,385
Pilbara	\$3,922,269
Midwest	\$2,507,767
Goldfields	\$1,953,747
South West	\$1,255,796
Wheatbelt	\$1,205,131
Great Southern	\$ 545,150

Ref: WA Hospital Morbidity Data System. Epidemiology Branch, WA Department of Health. Costs of hospitalisations due to family and domestic violence by health region, year, gender, Aboriginality and type. 2017.

health.wa.gov.au

She reported that the current system of identification and coding captures the costs only when people are hospitalised for assault related injuries caused by a spouse or domestic partner, parent, other family member, carer, or acquaintance/friend. It puts the total cost at close to \$52 million over 7 years. Ms O’Callaghan reminded clinicians that if the story is not told then we are not getting the full picture.

Ms O’Callaghan further emphasised the importance for WA Health and shared FDV outputs of the Women’s Health Strategy and Programs. In addressing ‘Why Health’ she stated that with thousands of employees across Australia, hospitals have a significant and important role in the primary prevention of IPV. There is strong evidence that by building equal and respectful relationships between men and women in the workplace will contribute to a culture that actively challenges violence and the discrimination that attributes to interpersonal abuse. This is the responsibility of all of us!

Ms O’Callaghan stated, Health is often the first and ongoing contact for victims therefore, listening and acting to support people who make disclosures is very important and can make a big difference. Early intervention helps both the victim and the burden on the health system be informed and proactive in our capacity of a workforce building better outcomes for people exposed to violence. WA Health also has a duty of care to staff. FDV has a cumulative effect on staff due to the stories and impact of violence be it physical or otherwise.

In addressing solutions Ms O’Callaghan emphasised the importance of adopting the Principles of providing a trauma-informed service as an option for change. Another solution presented was that WA Health considers the evidence based, evaluated Victorian model: Strengthening Hospital Responses to Family Violence (SHRFV) which provides a whole of health system response. She touched briefly on the two overarching key principles:

- 1) Respect and gender equity

<sup>6</sup> WA Hospital Morbidity Data System. Epidemiology Branch, WA Department of Health. Costs of hospitalisations due to family and domestic violence by health region, year, gender, Aboriginality and type.2017.

By promoting respect and addressing gender inequity, hospitals can contribute to better health and social wellbeing, improved organisational performance, and prevention of family violence.

## 2) Sensitive practice

Sensitive inquiry is an aspect of sensitive practice involving a six steps approach to routinely asking patients about their experience(s) of family violence where specific risk factors are identified such as pregnancy, mental health, isolation, separation or plans for separation.

The six key elements of SHRFV supported internationally by Kaiser Permanente and Womens health services in WA include:

1. Creating cross hospital leadership and momentum
2. Laying a foundation through policy, procedures, and guidelines
3. Changing culture
4. Building capacity and capability
5. Building partnerships and connections with the wider community and the family violence sector
6. Building the evidence base- improving data collection, evaluation etc.

She reported that considerable progress had been made towards some of these elements however; there is the need for a whole of system approach directed at cultural and other change. Ms O'Callaghan stated it is time to support culture change. Health has a lot of influence both within our system and across the wider community. We should seize the opportunity starting within our systems and then working with our partners to go more broadly.

Ms O'Callaghan outlined future directions for WA Health. IPV has a significant impact on the health and wellbeing of victims and this is costing WA Health. Demand in mental health, drug and alcohol and responding to homelessness and IPV is a feature we must consider when providing care. In addition, supporting patients does have consequences on the health and wellbeing of our staff that care for these patients and their families. Consequently, we must also ensure that staff are supported and have access to training.

She called for implementation of routine screening particularly for high risk groups, working in a trauma informed and patient centred way, undertaking health promotion, introducing preventative strategies, and endorsing early identification. We must also collect data and undertake research to inform strategy.

Ms O'Callaghan closed, "We need to be the best responders, as first responders, we can be!"

During the morning tea break participants networked, viewed posters and were provided with information on current programs and the resources/tools available.

Presentations from the day can be found on the Clinical Senate website:

<http://ww2.health.wa.gov.au/Improving-WA-Health/Clinical-Senate-of-Western-Australia/Clinical-Senate-debates-and-publications>



### 3. Plenary debate

#### 3.1 Managing Interpersonal Violence at the coalface (in healthcare facilities)

Facilitator	➤ Mr Bevan Bessen
Presenter	➤ Ms Pip Brennan
Consumer	➤ Ms Roia Atmar
Expert witnesses	➤ Professor Colleen Fisher
	➤ Dr Alison Evans
	➤ Dr Ann O'Neill
	➤ Mr Mark Crake
	➤ Dr Debbie Smith
	➤ Ms Samantha Jenkinson
	➤ Ms Jade Lyons
	➤ Mr Michael Hovane
	➤ Ms Kathy Blitz-Cokis
	➤ Ms Vicki Butcher
	➤ Ms Gianna Renshaw
	➤ Ms Carla Francis
	➤ Ms Melissa Edwards
	➤ Dr Alice Johnson
	➤ Ms Kedy Kristal
	➤ Dr Cameron Burrows
	➤ Ms Jennifer Mace
	➤ Ms Jennifer Hoffman
	➤ Ms Corina Martin
	➤ Dr Amanda Frazer
	➤ Dr Maire Kelly
	➤ Ms Leah Bonson

Mr Bessen outlined the process for the session as one that would consist of a presentation on the results of a pre debate survey and consumer presentation followed by free flowing discussion/debate.

The plenary session “Managing Interpersonal Violence at the coalface (in healthcare facilities)” was opened with a presentation from Ms Pip Brennan, Executive Director, Health Consumers’ Council who shared her personal account of interpersonal violence which she stated, for her, has been about surviving an assault and the process of trying to create change in the sector”. She spoke of the incredible power to heal and create positive change. “I believe that not for profits, government, corporate and community together have the answers and the different expertise for all our wicked problems, including interpersonal violence. I challenge you to believe that too as you consider your recommendations today”. Ms Brennan spoke of the reality of the sector in terms of silos and called on participants to ‘Imagine’ a sector working together to create change... where health, women’s health, domestic violence, victim support and justice services connect and thrive on partnerships. It’s easy if you try!

Ms Brennan shared the results of a survey conducted prior to debate of the not for profit services supporting women and families affected by domestic violence. She reported the Clinical Senate Executive agreed to the survey as a strategy to bring the not for profit voice to the debate particularly given the fact that services for women and children affected by family violence span a number of government agencies with most services delivered in the not for profit sector.

The survey was developed by the Clinical Senate Executive in consultation with WA Health Womens and Newborn Health Service (WNHS). The survey consisted of 3 questions and was targeted at 41 different women's refuges and women's health centres. 24 responses were provided, and a short report compiled (Appendix 4).

The three questions posed were:

1. What is the one thing you would like our state's public health services to do better to support women and children affected by family and domestic violence?
2. Tell us which area you are providing feedback on? Tick all that apply.
  - Emergency Department (12/24)
  - Ward (10/24)
  - Outpatient clinic (7/24)
  - Mental health service (14/24)
  - Service provided by WA Health in the community (13/24)
  - Other (5/24)
3. Do you have any other comments?

In summarising the responses to the open ended questions Ms Brennan stated that both questions elicited quite similar feedback and responses were collated and themed together. The main themes were:

- Holistic care (9 mentions)
- Co-ordination of services (9 mentions)
- Staff Training (5 mentions)
- Funding (5 mentions)
- Culturally Competent Care (4 mentions)
- FDV as a health issue, routine screening (4 mentions)

Ms Brennan stated, "I urge you to stay connected to the humanity of the subject as you consider your recommendations. Keep the women and families at the centre. Keep thinking about the possibilities and consider the easy wins. Finally, look for opportunities through the use of existing committees where there is cross agency and sector collaboration and consider coordination through existing programs".

Next to speak was Ms Roia Atmar who shared her personal journey through domestic violence.

This is a summary of Roia's story:

I grew up in Afghanistan and at 14 years of age I got married and moved to Australia.

My husband was very controlling. He would accompany me to all of my appointments often speaking for me. When I became pregnant for the first time the GP, whom she had been seeing for six years spoke directly to her. He congratulated her and asked if she was happy, she replied no, however, instead of investigating her response he turned to her husband to ask why she had responded that way and he stated it as cultural. The GP did not ask again!

Things changed as soon as I had my first child. This is when he hit me for the first time. I was shocked and confused as I had never gotten hit before and didn't know how to react, so when he apologised and promised he didn't mean to or would never do it again, I accepted the apology and moved on. Unfortunately my life changed from that day onwards. He started getting angry over everything and anything and I would always be blamed. I was verbally; emotionally and physically abused and this would always be followed by remorse, apologies and the promise of it not happening again.

This happened again when I was 7 months pregnant and ended up in hospital sick because doctors thought I might go into early labour. The doctor came to see me and examine me. I asked what she was doing, I overheard the doctor her tell the nurse 'what will she do when the baby comes out'. In hospital again after a very long labour they asked my husband if I wanted

and epidural – he asked about the effects on the baby and decided I would not have an epidural. Nobody thought to ask me!

My husband was a very controlling and manipulative person- everywhere I was he was with me- he would always speak for me and would tell me what others were saying. There were many times I visited my GP and he was always standing next to me or behind the curtain. Health staff would not address me. I didn't know any better and just thought that was how it was. He repeatedly told me that he was the husband and he could do whatever he wanted, nobody cared about what was happening. I just thought that was life.

We came across many different people who I thought knew what was happening. The police were always in our house because he was constantly in trouble with the law and on all of the visits they made, not once did any of them to ask if we were okay, if we felt safe.

During six years of hell with him, I never asked for help, I never told anyone what he was doing because I thought everybody knew. The one time I did ask for help was after a horrible fight and I was really scared that he was going to kill me and my children. I came across a number, I think off the TV. I called and explained that I was really scared that he was going to kill us. A gentleman came straight away and was able to take me and my children somewhere. For years I thought it was a woman's refuge but now I think it was Child Protection and Family Support because we were taken to an office. They were trying to find a place for us however, his sister found out where we were and she came and picked us up and took us back home

I went home and waited, that day, the next day, the next week, waiting for someone to call to check to see if we were alive or dead. Nobody did, which made me believe what my husband had said was true, that nobody cared about us and he could do anything he wanted. I just thought that is how it is!

It was after he tried to kill me by setting me on fire while I was holding my 8 month old daughter and tending to my little boy that I ended up in hospital with burns to 35 percent of my body. I was lucky that I survived. I did not call the police, I called his family to come and take me to the hospital. While in hospital, he told everyone that I got burnt because my scarf caught on fire while I was warming milk for my child. Nobody questioned it and when I had to be transferred to RPH, he asked to come in the same ambulance I was in and the doctor agreed. I was in the burns unit for about 10 days and I could not say anything because my biggest fear was that if I spoke out then he or his family would take my children and I would never see them again. I knew he wouldn't kill me in front of everyone in there.

It was in RPH that I came in contact with staff and the police. It was explained to me that people actually cared about me and my children and what was happening to us. They explained there were ways that we could be protected from my husband's abuse.

So lucky me that my family and the hospital staff knew something was up. The hospital social worker was asked to speak with me. He came into the room and managed to get my husband out of the room so he could have a conversation with me alone. He asked me if I needed help. In six years, that was the first time someone had asked me. Even during the conversation the social worker realised that my husband had been observing our conversations and reading my lips so he shut the blind. When he asked me I replied, I do need help but it is not like anybody can help. He informed me that he would get a police officer to speak with me and explain exactly what I could do. The police officer explained I could get a Violence Restraining Order (VRO) and go to the family court and remove my children from his families care. I did not believe either one of them until the next day when my Mother rang to say she had my children.

That was the day I decided that somebody cared. The social worker and police asked me what happened. I told them, they trusted what I said; they didn't go back to my husband to verify I was telling the truth, they didn't go back to his family or my family, they trusted what I said and they did what they said they would do. That was my first step in getting myself and my children out of that relationship.

Roia stated she was eternally grateful for all of the staff in the burns unit. "That is when my journey into feeling what a human is started again. It was their kindness and compassion and how they made me feel safe and secure". She recalled that on the burns unit the nurse had to do alot of dressing changes which was apparently painful. I would just take it on and one day the nurse told me it is painful and that it

was okay to cry and be angry about it. I was confused and asked why do you want me to cry? For me, I was trained not to cry. For days she would come and hold my hand – she would tell me that even if it is not hurting you can squeeze my hand. That is one of the simplest things that helped me. “I thought I am a human being, I am allowed to feel pain; I am allowed to say that it hurts”. It went really well and I was lucky all the agencies worked together – the support network pulled us back up. The reason I am here is because of the staff, my family and others who picked up on what had happened to me. Although it was missed for 6 years when it was finally picked up it made all the difference in the world to me and my children.

Roia emphasised the need for clinicians to keep asking questions of the patient, to listen, act and advise them of the support and services available. Highlighted in her talk were the many missed opportunities but also the point at which someone did listen. She felt heard, protected, respected and supported. This was the moment that changed her life. She called on clinicians to remember the silent victims and to inform mothers of the effects on their children. Finally, victims must be made aware of the services available to them.

Roia’s story was followed by a plenary session where senators were reminded of the focus for debate which was on the detection and management of IPV for patients attending WA Health facilities and supporting staff to manage IPV. Participants worked through the challenges, shared their personal experiences and considered what should be done to support both patients and clinicians.

Senators were encouraged to share their own experience and to draw on the expertise. They worked to identify the challenges at the coal face. They considered what was required and explored resources that exist. They determined that IPV is a complex issue with many contributing factors and players involved.

The setting of first encounter for healthcare practitioners is often the emergency department which is not ideal but does pose opportunity for identification. This is an important first step.

Experts advised of some of the less known victims of IPV such as elderly people and people with disabilities. These they learnt bucked the trend in that abuse in the elderly is more likely to be against men, who are often more vulnerable than women. In addition, the perpetrators of violence, abuse and neglect against people with a disability are often carers/close family members or individual service providers. Reporting of these types of abuse is limited but where it occurs is often by service provider organisation and not necessarily the police or other channels.

Another issue raised was the impact on staff when they are subjected to abuse at work. They are often reluctant to prosecute or go to court and there should be support for them if they choose to proceed through the legal system. On the flip side, they considered how to manage staff who themselves are experiencing IPV. Senators agreed to the need for WA Health to audit/measure staff wellness and safety.

#### Key messages were:

- The question is the challenge! How do we raise it - clinicians need to have the skills around asking the question.
- Lack of universal screening.
- Consider targeting secondary points for detection - advertising to families etc.
- Limited mandatory reporting.
- Issues with partner presence when screening – allow for one on one time with patient.
- Specific concerns were raised for people with disabilities and older people.
- Early detection -Risk factors – must be identified by clinicians up front.
- Specific issues related to Aboriginals and family violence- there must be a different approach with understanding that it might impact the entire family.
- Treatment by responders (racism and victimisation).

### Specific issues related to staff:

- No policy around FDV for staff.
- Verbal abuse towards staff – difficulty managing this – what level is okay and how do we support staff.
- Education is important.
- There are issues of exposure for our staff to violent patients and although we have zero tolerance for this the difficulty is that within that medical issues often create the violence.
- We must be permanently mindful of the pressures staff are under and allow time and space for them to speak about it.

### Key summary points:

- Violence is a societal problem.
- Awareness is critical.
- FDV can have a high impact on kids as witnesses, or being caught in the cross fire.
- We need to ask the question! Non-negotiable. If not, we are failing in our duty of care
- Consider other pathways as opportunities to engage i.e. Child health services – when Mom has an appointment for child, ask the question.
- We need to find opportunities to ask the question – get patient alone.
- Need for respective engagement.
- Importance of screening.
- There is the need to build the capacity and capability of staff to manage IPV.
- Expressed on the day was the impact on staff and the capacity to respond. They are already overburdened.
- We need to build capacity for staff across our system to address issues of IPV.
- Consider where the opportunities are and interact much earlier on.
- Clinicians must not judge and should continue to ask the question(s).
- Health to self-regulate exposure and tolerance to IPV (people to people).
- Education – when staff are experiencing violence every day, it is difficult to provide education.

We must not forget the 'silent' victims of IPV – children and young people and the considerable psychological impacts on their health and wellbeing.

At the conclusion of the plenary session Mr Bessen confirmed many issues were raised. He advised that the key themes emerging from the full morning session had been captured using mind map software and would inform senators in the afternoon workshops.

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All participants then broke for lunch.

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Following the lunch break Senators participated in concurrent workshops to consider: detection and management of IPV for patients attending WA Health facilities and; supporting our staff to manage IPV.

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What follows are the working group notes and final senate recommendations.

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## 4. Workshop One

### 4.1 Workshop 1 – Improving detection and management of IPV in patients attending WA health facilities

Facilitator	Mr Bevan Bessen
Executive Committee Member(s)	Dr Jeanette Ward Ms Pip Brennan
Executive Sponsor	Dr Dan Xu
Expert Witness	Ms Kathy Blitz-Cokis
Support	Ms Kimberly Olson

Mr Bessen opened the workshop stating the focus as to consider strategies for improving detection and management of IPV in patients attending WA health facilities.

In the first part of the workshop groups worked to consider the key issues drawn from the morning session and identified additional issues. The facilitator led discussion around the key themes. Once determined senators self-selected to the group of their choice where they developed recommendations.

Participants worked in five groups to develop recommendations around the following themes:

- Cross agency collaboration
- Limited front line response systems
- Limited front line response systems (model) and limited support for women and children- around ongoing effects of IPV
- Data
- Public health, education and data

A summary of the discussions from each group is provided below.

#### Group 1 – Cross agency collaboration

Senators developed three recommendations aimed at building a strong foundation for cross agency collaboration.

Senators proposed use of the existing FDV advisory group as a mechanism to effectuate these changes. They called for extending the scope of the group to include greater representation from all area health services, the Aboriginal health division, consumers and non-government organisations.

They proposed that WA Health take a leadership role in promoting policy, procedures, and resources currently available. There is a need for consistency across all five health services.

Also recommended was the need for the inclusion of mandatory screening for high risk groups and it was recommended this be included in the next review of the existing policy. They identified some of the high risk groups/areas as: perinatal; mental health; patients with repeated visits to emergency departments; women with an intellectual disability; patients who have drug or alcohol dependency; CaLD and refugee groups; and Indigenous West Australians.

#### Group 2- Limited front line response system(s)

Two groups considered limited front line response systems with group two focussed on pathways for management and referral of individuals at risk of experiencing IPV or FDV. They agreed there needed to be a mechanism for all contributing parties to understand their role and do their part.

They also discussed patient consented communication whereby WA Health staff members could inform primary care providers about specific events of FDV on the same day of patient contact.

Recommendations from senators called for the System Manager to require each HSP produce an agreed regionalised flow pathway for management and referral of individuals at risk of or experiencing

IPV or FDV, based on the WA Health FDV guidelines and WAPHA Health Pathways. They agreed this should be updated every two years.

### Groups 3 – Limited front line response systems (models) and limited support for women and children

Clinicians in the second group on limited front line response discussed models specifically designed to support to women and children.

Clinician's acknowledged the complexity of the issues with regard to women and children and the need for a multi-agency approach, care coordination and follow up.

Senators called for HSPs to incorporate a multi-agency response service model to screen for FDV and that incorporated medical forensics.

The key recommendation was for the System Manager to direct a universal screening tool to be used across health, other government agencies and in general practice, screening for victims and perpetrators of FDV.

### Group 4 – Data

Clinicians discussed the importance of data.

They identified the need for workforce preparedness and education. Also discussed was the potential for access to statewide hubs.

Discussed was the option of including IPV services training as part of their induction training to WA Health (standardised) and then making it commensurate to their role and responsibilities.

Senators recommended the establishment of state-wide generic data collection systems including primary health with business rules and functionality around collection resulting in demand for services (trends) and support for resource allocation ( services, workforce, training/upskilling). This should include strategic occupation health and safety planning to raise the profile/attention of IPV.

### Group 4 – Public health, education and data

Clinicians identified IPV as an important public health issue. They highlighted the importance of education and identified there is a lack of support for education of clinicians across the health services.

Recommended was the need for HSPs to either create or formally allocate responsibility for the education and training of staff in IPV in order to: raise awareness; promote and effect cultural change; optimise screening and intervention strategies; and coordinate data collection and research activities.

With regard to data, clinicians recommended that the System Manger determines a methodology to collect data on IPV presentations to hospitals and mental health services in order to capture the true number of incidents and cost of FDV to the WA health system. They determined this is already done in relation to Body Mass Index (BMI) and therefore could also be done for FDV.

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A total of eleven recommendations were developed by participants in workshop one with the top six taken to the final session.

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## 5. Workshop Two

### 5.1 Workshop 2 – Supporting our staff to manage IPV

Facilitator	Mr Will Bessen
Executive Committee Member(s)	Ms Tanya Basile Dr Sharon Nowrojee Ms Marani Hutton
Executive Sponsor	Mr Wayne Salvage
Expert Witness	Dr Jenny O’Callaghan
Support	Ms Barbara O’Neill

Mr Will Bessen opened the workshop stating the focus as to consider strategies to support WA Health staff to manage IPV.

He then outlined the full process which was to:

- reflect on the key focus areas
- develop recommendations around them
- prioritise the recommendations
- vote on recommendations to be brought to the final session.

The facilitator led discussion around four key areas: support/tolerance levels for violence towards health staff; awareness and support for IPV amongst staff; building the capacity and capability of staff to manage IPV; and IPV as a societal public health issue. He called on senators to drill down on these and to identify others.

Clinicians agreed to the need for an overarching statement reflecting the final two areas: Recognition of IPV as a public health issue and the need for a ‘culture shift in health around respect and equity’.

Senators agreed on the following five key areas to focus on for development of recommendations:

1. Awareness of and support for IPV amongst staff.
2. Building cultural competency for Aboriginal experiences.
3. Staff skills to respond.
4. Violence towards health staff.
5. Building capacity and capability of staff to manage IPV.

A summary of the discussions from each group is provided below.

#### Group 1 – Awareness of and support for IPV among staff

Clinicians identified the need for health services to ensure that programs implemented to identify IPV are inclusive of strategies that target both patients and staff.

Health services must also implement culturally appropriate and relevant IPV programs that safely include strategies for patients and staff.

They called for health services to support a ‘trauma informed’ approach to both staff and patients who may be experiencing IPV.

The key recommendation from clinicians was for HSPs to implement guidelines and policies combined with training in the identification, management (safe conversations) and support for staff who themselves could be experiencing IPV.

It was agreed this recommendation be merged with the group considering how to build capacity and capability of staff to manage IPV.



## Group 2- Building cultural competency for Aboriginal experiences

A key focus of clinicians in group two was on Aboriginal safety and security and the need to build cultural competency amongst staff.

They identified the need for HSPs to partner and include Aboriginal leaders in the development and co-design of DV programs.

Also identified was the need for specific ongoing and sustained funding (permanent contracts) for aboriginal staff generally, aboriginal liaison officers.

## Groups 3 – Staff skills to respond

In addressing the skills required to respond, clinicians agreed that the HSPs should include a performance measure of staff's perception of safety. The System Manger should review current educational resources and programs related to staff preparedness to respond to violence and aggression (including debrief and post incident reports).

They determined that all sites and services must have access to an employee support program that includes support through the legal system/process.

## Group 4 – Violence towards health staff

In addressing the issue of violence towards health staff, senators recommended the need for HSBs to acknowledge IPV is an important issue impacting the health and wellbeing of staff and to respond accordingly.

They called for internal policies that enable reporting of instances of IPV occurring towards staff and patients and that records measures to document the impact of cumulative stress on staff due to abuse or aggression. The policy must also provide ongoing and opportunistic training in recognising and managing IPV through the use of communication and de-escalation skills and importantly, educates staff about understanding the causes for patient behaviours.

There must be commitment to proactive support mechanisms for staff that experience IPV in the workplace through such processes as: formal debriefings and team based support post event (immediate response teams- EAP based). Lastly, the policy must prioritise responses for staff and patients.

## Group 5 – Building capacity and capability of staff to manage IPV

In building capacity and capability of staff to manage IPV, senators identified three key areas: a consistent response to IPV/FDV; creating a culture of compassion; and the importance of managing IPV across the lifespan.

Recommendations called for a consistent approach across the system with regard to policy, education and training, resourcing (by local design) and interagency pathways. There must be support to staff with, data collection and performance measured.

In addressing the 'culture of compassion' clinicians identified the need for area health services to support them by adopting a trauma informed care approach to patients and staff utilising evidenced based training and resources. It was agreed this recommendation be merged with the group considering awareness and support for staff.

The key recommendation developed by clinicians emphasised the importance of managing IPV across the lifespan. Recommended was the need for a formal care pathway for vulnerable groups that gives staff clarity around tools and resources and that provide structure and a consistent format for staff. This should incorporate child abuse, FDV, elder abuse and sexual violence.

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A total of eleven recommendations were developed by participants in workshop two with the top five taken to the final session.

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## 6. Final Session

In the final session senators reviewed each of the recommendations presented from all working groups. A total of eleven recommendations were put forward for final voting with eight progressed after merging some recommendations.

The Clinical Senate recommendations provide the opportunity for both the Director General as System Manager and Health Service Provider Boards to ensure better detection and management of IPV in patients attending WA Health Facilities and strategies to support WA Health staff. It is critical there be a consistent response across the system to the issue of interpersonal violence.

A key message from the day was the need for recognition of IPV as a public health issue and the need for a ‘culture shift in health around respect and equity’.

This debate was described by many as rich, raw, potent and palpable. This debate revealed the ‘power of stories’ with both senators and consumers sharing theirs. These stories provided important insight into the complexity of the issue and the role Health and healthcare professionals must play in ensuring safe care and treatment of patients attending our facilities. Importantly, staff must also be supported.

The Clinical Senate agreed that WA Health should strongly consider implementing the evidence based, proven Victorian program ‘Strengthening Hospital Responses to Family Violence (SHRFV)’.

WA Health has a duty of care to protect staff. The safety of our staff is paramount and integral to the safety of our patients. However, we also have an obligation to our patients. As one alumnus stated:

“When interpersonal violence is no longer a taboo subject, when victims are able to gain disclosure before a critical stage, when we (community) are able to respond in meaningful ways to victim and perpetrator; then we will be heading towards a safer place, for all”.

In conclusion, hospitals are in a unique position to play a significant role in driving social change that reduces the occurrence of family violence. The hospital system is an early contact point for many people who have experienced family and domestic violence. Staff are able to make an early diagnosis. WA Health should ensure there are systems in place and that support front line clinicians to tackle this issue. WA Health should lead change.

The Clinical Senate recommendations align with the World Health Organizations Health Response. The recent appointment of The Hon Minister Simone McGurk, MLA to a family violence portfolio presents a unique opportunity to implement the key outcomes from the debate. The Health Consumers’ Council aims to convene a community forum to progress a consumer-centred approach to design.

A response from the Director General and Health Service Boards to recommendations is requested.

## 7. Clinical Senate Recommendations

### Responding to Interpersonal Violence: Are you safe?

#### That the System Manager:

1. Acknowledge that a consistent response is required across the system to address the issue of interpersonal violence and consider implementing the 'Strengthening Hospital Responses to Family Violence' (Vic Model) which standardises
  - Policy
  - Education and training reflecting a trauma informed model
  - Interagency pathways
  - Performance measurement and data collection
2. Advocate for implementation of the FDV screening tool across WA Health Services.
3. Identify a method to collect data on interpersonal violence presentations to hospitals and mental health services to capture the true incidence and cost to WA Health.
4. Commits to funding Aboriginal Liaison Officers within each Health service on a sustained and ongoing basis (permanent contracts).

#### That Health Service Boards:

1. Work in partnership with Aboriginal people and agencies within Area Health Services to develop and co-design FDV programs that are responsive to the health needs of Aboriginal clients.
2. Consider a policy in line with evidence based practice to implement mandated domestic violence screening for high risk patients such as pregnant women, people with disability, indigenous patients, mental health patients, frequent emergency department attenders, patients with significant drug and alcohol dependency, and patients with cultural and linguistic diversity.
3. Consider creating a new position or else formally allocate to an existing employee responsibility for education and training of staff in interpersonal violence in order to:
  - Raise awareness
  - Promote and effect cultural change
  - Optimise screening and intervention strategies
  - Coordinate data collation and research activities
4. Acknowledge interpersonal violence is an important issue impacting upon staff and develop internal policy that enables
  - Reporting of instances of interpersonal violence occurring towards staff members and patients and records measures to document the impact of cumulative stress on staff due to abuse or aggression
  - Provides ongoing training in recognising and managing interpersonal violence through the use of communication and de-escalation skills, and educates staff about understanding the causes for patient behaviours

- Provides proactive support mechanisms for staff who experience interpersonal violence in the workplace through such processes as formal debriefing process and team based supports post event (immediate response teams - EAP based)
  - Prioritises security responses for staff and patient safety.
5. Develop a care pathway for managing interpersonal violence across the patient lifespan that gives staff clarity about tools and resources available.
  6. Develop a local referral pathway for individuals at risk of, or experiencing interpersonal violence, based on WA Health guidelines and WAPHA Health Pathways, and ensure this pathway is updated every two years.

## Appendix 1: Program

# Responding to Interpersonal Violence: Are you safe?

Friday 24 March 2017

The University Club of Western Australia, Crawley, Western Australia

7.45am – 08.30am	Registration	Tea & coffee
<b>8:30am – 9:50am Presentations</b>		
<b>Executive sponsors:</b>	<b>Mr Wayne Salvage, Chief Executive, North Metropolitan Health Service Ms Pip Brennan, Executive Director, Health Consumers' Council WA</b>	
<b>Facilitator:</b>	<b>Mr Bevan Bessen</b>	
8.30am	Welcome to Country	Ms Marie Taylor
8.40am	Welcome and senate update	Ms Tanya Basile
8.50am	Director General's response to recommendations	Professor Gary Geelhoed
9.00am	Impact of IPV on WA Police and Opportunities for change	Superintendent Kim Massam
9:15am	Child Protection and Family and Domestic Violence Intersect	Ms Sherrilee Mitchell Ms Jane Simmons
9:30am	Health's Responsibility? Responding to Interpersonal Violence	Ms Jenny O'Callaghan
9.50am – 10:15am	Morning tea	Banquet Hall Foyer
<b>10:15am – 12:15pm Plenary - Managing Interpersonal Violence at the coalface (in healthcare facilities)</b>		
<b>10:15am</b>	<b>Survey results - Ms Pip Brennan</b>	
<b>10:25am</b>	<b>Introductory talk - A consumer perspective – Ms Roia Atmar</b>	
<b>Additional Expert Witnesses:</b>	Professor Colleen Fisher, Dr Alison Evans, Dr Ann O'Neill, Mr Mark Crake, Mr Greg Mahney, Dr Debbie Smith, Ms Samantha Jenkinson, Ms Jade Lyons, Mr Michael Hovane, Ms Kathy Blitz-Cokis, Ms Vicki Butcher, Ms Gianna Renshaw, Ms Carla Francis, Ms Kedy Kristal, Ms Melissa Edwards, Dr Alice Johnson, Dr Cameron Burrows, Ms Leah Bonson, Dr Maire Kelly, Ms Jennifer Mace, Ms Jennifer Hoffman, Ms Corina Martin and Dr Amanda Frazer.	
12.15pm – 1:00pm	Lunch	Banquet Hall Foyer
<b>1:00pm – 2.30pm Workshops</b>		
<b>Workshop 1 – Banquet Hall South Improving detection and management of IPV in patients attending WA Health facilities</b>		<b>Workshop 2 – Banquet Hall North Supporting our staff to manage IPV</b>
➤ Facilitator:	Mr Bevan Bessen	➤ Facilitator: Mr Will Bessen
➤ Expert:	Ms Kathy Blitz-Cokis	➤ Expert: Ms Jenny O'Callaghan
➤ Sponsor:	Ms Pip Brennan	➤ Sponsor: Mr Wayne Salvage
2.30pm- 2.50pm	Afternoon tea	Banquet Hall Foyer
<b>2.50pm - 3.45pm Final session</b>		
2.50pm	Presentation and prioritisation of recommendations	Mr Bevan Bessen Mr Will Bessen
3.30pm	Closing remarks – sponsor and senate	Mr Wayne Salvage Ms Marani Hutton
3.45pm	Close	

## Appendix 2: Executive Sponsors, Presenters & Expert Witnesses

- Mr Wayne Salvage, Chief Executive, North Metropolitan Health Service, WA
- Ms Pip Brennan, Executive Director, Health Consumers' Council Western Australia
- Ms Marie Taylor, Nyungar Elder
- Ms Tanya Basile, Deputy Chair, Clinical Senate of Western Australia
- Professor Gary Geelhoed, Assistant Director General, Clinical Services and Research and Chief Medical Officer, Department of Health
- Superintendent Kim Massam, District Superintendent, Central Metropolitan Police District, WA Police
- Ms Sherrilee Mitchell, Director, Family & Domestic Violence Unit, Department for Child Protection and Family Support, Western Australia
- Ms Jane Simmons, Relieving District Director, Perth District, Department for Child Protection and Family Support, Western Australia
- Ms Jenny O'Callaghan, Co-Director | Women's Health, Genetics and Mental Health, Women and Newborn Health Service, WA
- Ms Roia Atmar, Consumer
- Professor Colleen Fisher, Head of School, School of Population and Global Health, The University of Western Australia
- Dr Alison Evans, Executive Officer, Women's Community Health Network WA
- Dr Ann O'Neill, Complex Care Coordinator, HomeLink, Sir Charles Gairdner Hospital, WA
- Mr Mark Crake, A/Director, Special Projects & Statewide Protection of Children Coordination, Child and Adolescent Health Service, WA
- Mr Greg Mahney, Chief Executive, Advocare Incorporated
- Dr Debbie Smith, Senior Medical Officer, Sexual Assault Resource Centre, King Edward Memorial Hospital, WA
- Ms Samantha Jenkinson, Executive Director, People With Disabilities (WA) Inc
- Ms Jade Lyons, Policy and Projects Officer, Women's Health, Genetics and Mental Health Directorate, Women and Newborn Health Service, WA
- Mr Michael Hovane, Managing Solicitor, Family Violence Services, Legal Aid WA
- Ms Kathy Blitz-Cokis, Manager, Women's Health, Genetics and Mental Health Directorate, Women and Newborn Health Service, WA
- Ms Vicki Butcher, Head of Department Social Work, Women & Newborn Health Services, WA
- Ms Gianna Renshaw, Head of Department Social Work, Osborne Park Hospital, WA
- Ms Carla Francis, Head of Department, Social Work and Language Services, Royal Perth Bentley Group
- Ms Kedy Kristal, Policy Officer, Women's Council for Domestic and Family Violence Services (WA)
- Ms Melissa Edwards, Allied Health Professional Lead-Social Work, Fiona Stanley Hospital, WA
- Dr Alice Johnson, Consultant Paediatrician and Head of Department, Child Protection Unit, Princess Margaret Hospital, WA
- Dr Cameron Burrows, Director of Emergency Medicine, Emergency Department, Joondalup Health Campus, WA
- Ms Leah Bonson, Director Aboriginal Health, Child and Adolescent Health Service, WA
- Dr Maire Kelly, A/ Head of Clinical Forensic Medicine, Sexual Assault Resource Centre, Women and Newborn Health Service, WA
- Ms Jennifer Mace, Head of Department Social Work, Aboriginal Liaison and Language Services, Princess Margaret Hospital, WA
- Ms Jennifer Hoffman, Commissioner, Victims of Crime, Department of the Attorney General, WA
- Ms Corina Martin, Chief Executive Officer, Aboriginal Family Law Services, Western Australia
- Dr Amanda Frazer, Executive Director, Safety and Quality, North Metropolitan Health Service, WA

## Appendix 3: Information and Resources

Finding help before and after baby arrives (2012, formerly called “Where to Find Help”)

[http://www.health.wa.gov.au/docreg/Education/Population/womens\\_health/HP11881\\_HELP.pdf](http://www.health.wa.gov.au/docreg/Education/Population/womens_health/HP11881_HELP.pdf)

A Lanyard-size Screening Prompter that has the FDV Screening questions on one side, and some helpful hints and referral numbers on the back. This resource is designed to be printed, cut, and laminated, and fits conveniently in a lanyard.

[http://kemh.health.wa.gov.au/health\\_professionals/WHCSP/docs/Lanyard\\_Screening\\_Prompter.pdf](http://kemh.health.wa.gov.au/health_professionals/WHCSP/docs/Lanyard_Screening_Prompter.pdf)

Sexual Assault Resource Centre general information pamphlet

[http://www.kemh.health.wa.gov.au/services/sarc/documents/resources/SARC\\_services\\_brochure.pdf](http://www.kemh.health.wa.gov.au/services/sarc/documents/resources/SARC_services_brochure.pdf)

Family Domestic Violence Poster Toilet door

[http://kemh.health.wa.gov.au/health\\_professionals/WHCSP/docs/FDV\\_Maternity\\_Toilet\\_Door\\_Blue.pdf](http://kemh.health.wa.gov.au/health_professionals/WHCSP/docs/FDV_Maternity_Toilet_Door_Blue.pdf)

Family Domestic Violence Poster Child Health Setting

[http://kemh.health.wa.gov.au/health\\_professionals/WHCSP/docs/FDV\\_Child\\_Health\\_Setting\\_A3\\_Wall\\_Ochre.pdf](http://kemh.health.wa.gov.au/health_professionals/WHCSP/docs/FDV_Child_Health_Setting_A3_Wall_Ochre.pdf)

After a Sexual Assault pamphlet

<http://www.kemh.health.wa.gov.au/services/sarc/documents/resources/AfteraSexualAssaultforadultslivinginPerth.pdf>

Assessment Family and Domestic Violence (FDV 951) pamphlet

This form is to be used during a risk assessment of a client who has disclosed they are being abused (or have been recently) to assess their safety.

Fact Sheet 1: Are You in a Safe Relationship?

[http://kemh.health.wa.gov.au/health\\_professionals/WHCSP/docs/FS1\\_Are\\_you\\_in\\_a\\_Safe\\_Relationship.pdf](http://kemh.health.wa.gov.au/health_professionals/WHCSP/docs/FS1_Are_you_in_a_Safe_Relationship.pdf)

Fact Sheet 2: Being Safe

[http://kemh.health.wa.gov.au/health\\_professionals/WHCSP/docs/FS2\\_Being\\_Safe.pdf](http://kemh.health.wa.gov.au/health_professionals/WHCSP/docs/FS2_Being_Safe.pdf)

Fact Sheet 3: Being Safe with Technology

[http://kemh.health.wa.gov.au/health\\_professionals/WHCSP/docs/FS3\\_Being\\_Safe\\_with\\_Technology.pdf](http://kemh.health.wa.gov.au/health_professionals/WHCSP/docs/FS3_Being_Safe_with_Technology.pdf)

Screening for Family and Domestic Violence (FDV950)

This form is for routine screening of clients to identify if they are experiencing FDV. The WA Health Guidelines for Responding to Family and Domestic Violence recommends screening clients from vulnerable groups (i.e., pregnant women, women with mental health issues, Aboriginal women, CaLD women, women with a disability, and women with young children) and any client showing signs and symptoms.

The Women's Health Clinical Support Programs (WHCSP) has developed a customisable referral pathway for identifying and responding to disclosures of family and domestic violence.

[http://kemh.health.wa.gov.au/health\\_professionals/WHCSP/docs/FDVFlowchart.docx](http://kemh.health.wa.gov.au/health_professionals/WHCSP/docs/FDVFlowchart.docx)

Family and Domestic Violence newsletters:

December 2016

[http://kemh.health.wa.gov.au/health\\_professionals/WHCSP/newsletters/FDV\\_December\\_2016.pdf](http://kemh.health.wa.gov.au/health_professionals/WHCSP/newsletters/FDV_December_2016.pdf)

March 2017

[http://kemh.health.wa.gov.au/health\\_professionals/WHCSP/newsletters/FDV\\_April\\_2017.pdf](http://kemh.health.wa.gov.au/health_professionals/WHCSP/newsletters/FDV_April_2017.pdf)

Female Genital Cutting / Mutilation: A guide for health professionals

[http://kemh.health.wa.gov.au/health\\_professionals/WHCSP/docs/FGC\\_M\\_A\\_guide\\_for\\_health\\_professionals\\_booklet.pdf](http://kemh.health.wa.gov.au/health_professionals/WHCSP/docs/FGC_M_A_guide_for_health_professionals_booklet.pdf)

Child and Adolescent Community Health, Community Health Manual, Protocol-Family and Domestic Violence.

<http://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/CACH/CHM/CACH.CH.FamilyAndDomesticViolence.ashx>

Department of Health Western Australia. Reference Manual for Health Professionals - Responding to Family and Domestic Violence. Perth: Women's Health Clinical Care Unit, Women and Newborn Health Service, Department of Health Western Australia; 2014.

<http://www.health.wa.gov.au/circularsnew/attachments/895.pdf>

Department of Health Western Australia. Guidelines for responding to family and domestic violence. Perth: Women's Health Clinical Care Unit, Women and Newborn Health Service, Department of Health Western Australia; 2014.

<http://www.health.wa.gov.au/circularsnew/attachments/894.pdf>



**Appendix 4: Health Consumers' Council WA – Results of survey of the Not for Profit services which support women and families affected by domestic violence**



**HEALTH CONSUMERS'  
COUNCIL**  
YOUR VOICE ON HEALTH

**Clinical Senate Debate  
Responding to Interpersonal Violence**

**Results of survey of the Not for Profit services which support women and families affected by domestic violence**

Ms Pip Brennan, Executive Director, Health Consumers' Council, WA

Ms Jenny O'Callaghan, Co-Director, Co-Director,  
Women's Health, Genetics, and Mental Health, Women and Newborn Health Service

## Background

The topic of the March 2017 Clinical Senate Debate is “Responding to Interpersonal Violence- Are you safe?” During the planning the Clinical Senate Executive Advisory Group discussed the fact that most family and domestic violence services are delivered from the not for profit sector.

A survey was therefore developed by the Executive Advisory Group in consultation with and WA Health’s Women’s and Newborns Health Service and was sent to women’s refuges and women’s health services. In total the survey was sent to 41 different organisations. Survey responses were solicited by direct email, and through phone calls made by WA Health staff.

## Survey Questions:

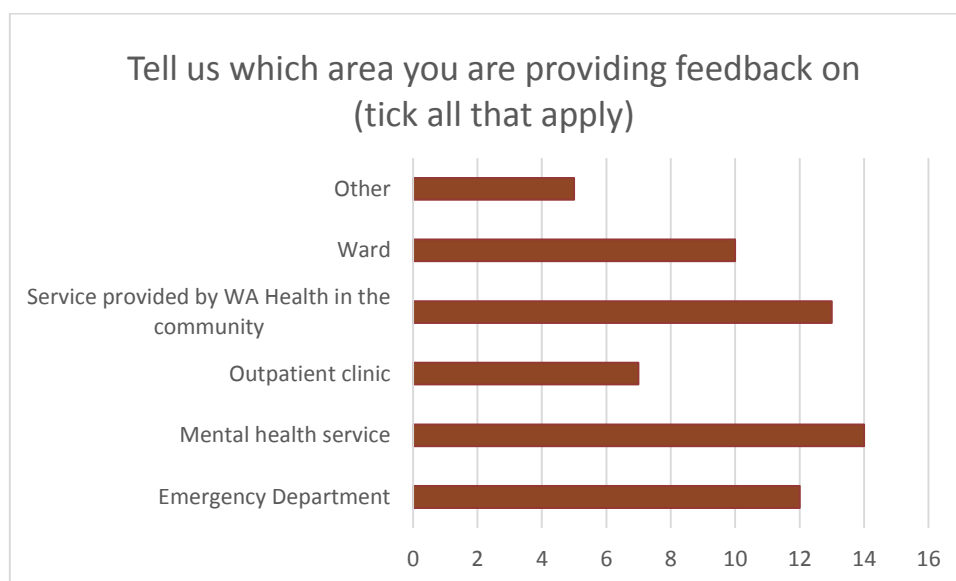
There were three survey questions:

1. What is the one thing you would like our state’s public health services to do better to support women and children affected by family and domestic violence?
2. Tell us which area you are providing feedback on? Tick all that apply.
  - Emergency Department
  - Ward
  - Outpatient clinic
  - Mental health service
  - Service provided by WA Health in the community
  - Other
3. Do you have any other comments?

## Responses

There were 24 responses received from the 41 organisations targeted. Responses to Question 1 and Question 3 were open ended and yielded similar feedback. These have therefore been themed and summarised on page 3. The open-ended responses have been extrapolated into themes and on occasions split where there are two key themes explored. They are included in this report in alphabetical order by themes to assist Senators in informing Recommendations in the afternoon workshops.

## Quantitative Data - Question 2



Emergency Department	12
Mental health service	14
Outpatient clinic	7
Service provided by WA Health in the community	13
Ward	10
Other	5
<b>TOTAL RESPONSES</b>	<b>61</b>

There were five responses with “Other”. Two mentioned women’s refuges, one mentioned community women's health services, and one mentioned domestic and family violence services.

### Key Themes

A review of the open-ended responses both to question one and to the “any other comments” question has been themed. The ones most relevant to the Clinical Senate have been summarised here.

#### Holistic care

There were 9 separate mentions of holistic, woman and family centred care. Concern about unmet physical health needs, including untreated Acquired Brain Injury, were noted in the comments.

#### Co-ordination of services

This was mentioned 9 times in the data, and related both to co-ordination of front line services, and co-ordination across the sector. The call for a one-stop shop which allowed for a woman to access all the relevant services was noted. While this is the most client-centred approach it is acknowledged that it would be a significant reform to the sector. Other suggestions to improve co-ordination included a co-ordinated inter-governmental and inter-agency team such as that in Albany. Also the use of Memorandums of Understanding to facilitate a quicker referral and co-ordination process. Other quick wins included the suggestion for health services to have access to the Bed Count Website maintained by Department of Child Protection and Family Services.

The establishment of a more inclusive reference group was also discussed as a simple mechanism for better high-level co-ordination.

### **Staff Training**

Suggestions for staff training were mentioned five times, and highlighted the importance for Emergency Department staff in particular to be well-supported in uncovering and responding to family and domestic violence.

### **Funding, Data Collection**

Given the vulnerability of the sector to funding cuts, this was a key theme, mentioned five times. There were two suggestions for the use of data to better plan services. The Clinical Senate may wish to engage with WA's inter-governmental Partnership Forum to support more innovative approaches to addressing family and domestic violence.

### **Culturally Competent Care**

This was mentioned four times and highlighted the importance of listening to and working with community.

### **FDV as a health issue, routine screening**

Three suggestions appeared in the data to support the implementation of routine screening for family and domestic violence, in Emergency Departments definitely, and elsewhere if possible.

### **Access to mental health services**

The gap for young people affected by family and domestic violence was particularly discussed.

### **More timely response**

One response highlighted the importance of early involvement of Social Workers, where possible.

### **Awareness Raising**

There was mention of how little the public know about the services that are available, and that more could be done to highlight WA Health's stance against violence against women and children.

## Open Ended Responses in full, themed.

### Access to Mental Health Services

- Better access to acute, sub-acute, and community-based services, for mental health, drug and alcohol, and acquired brain injury. Mental health services for minors.
- Better mental health support for younger clients - our service supports girls of 14-18 years of age and they are suffering from mental health issues due to FDV they've witnessed and they are a homeless because of this FDV. Our service is not a mental health service, and there are no vacancies and long waiting lists for mental health supported accommodation for this age group.

### Accommodation

- Accommodation - homelessness is a big problem - people need to be discharged into appropriate transitional accommodation and accommodation for people who have to travel from remote areas to receive treatment - some have to stay in homeless hostels which is inappropriate.

### Awareness raising

- Advertise to the general public that you are looking to support victims of abuse. Use television ads to do this on a regular basis and link in with the White Ribbon Campaign. Victims often lose their teeth from beatings. Many can't afford to pay for the dental costs. It would be good for victims of abuse to know where they can go to receive free treatment. I'm sure that there are dentists out there who will supply this service to one or two victims per year. Women won't go looking for jobs when they have had their teeth badly damaged.
- The general public need to know that the State's Public Health Services abhor violence and abuse towards women and children. Services like ours know that you are intending to do what you can - but the victims themselves need to know. Use the Media at your disposal to do this and link in with White Ribbon who may be able to supply some good ideas.

### Co-ordination of services – front line

- In Albany they have an FDV Response team - which includes staff from CPFS, an NGO (in Albany Anglicare) and police, who come together to triage police incidents. If Health could become a partner to this kind of arrangement, it would be helpful to gather and provide information to do improve risk assessments. Information can be missed when agencies act in isolation and women can be re-traumatized having to retell their story, or they can simply fall through the gaps. An MOU with Health would be more efficient and help to provide earlier intervention.
- The siloed approach to FaDV is not working for women and children who are affected by FaDV, there is a lot of talk about client centred practice but we are not seeing evidence of that and we need the state public health system to remember that these are people not merely a combination of isolated experiences and problems that can be separated from the whole
- Women are very confused by the number of services that they have to attend and this can be very overwhelming. Having everyone in one building will be beneficial for clients and will allow more prompt response and better case management.
- Provide a 'one stop' where women and children to go to attend counselling, see police, meet with CPFS or visit with a doctor.

- It would be helpful if the Hospital / social workers had access to the Bed count website run by CPFS to improve efficiency and to reduce time wasting. Then they can access immediately which refuges have availability and don't waste time calling around.
- Referral pathways - hospitals and health professionals are in a good position to get that first disclosure and from there need to be able to provide access to safe accommodation for the woman upon discharge.

### **Co-ordination of services – strategic**

- I believe an independent reference group that is inclusive and well informed about better integration (similar to the East Coast) instead of a focus on Child Protection and high risk thresholds will provide scope for innovative practice, better workforce development and high level trust between the invisible (and fantastic) work being done that is never recognised or known about.
- The one thing that would considerably assist is to for Health to develop better relationships with the FDV sector beyond the Women's Council as there are a huge number of agencies and services that the Women's Council do not represent. This creates invisibility and a perception of a broader peak body that is not meaningfully inclusive and does not represent the sector in terms of on the ground practice.

### **Culturally competent care**

- Not be racist and ignorant to Aboriginal clients' culture and identity. Be given and provided with basic human rights to better services rather than band aid solutions such as, ensuring clients leaving the medical services, well looked after and treated such as provision of wheel chair to help mobility rather than given excuse that wheel chair will be wrecked when not considering client is being housed at the women's refuge.
- Clients accessing medical services without further disrespect for culture when being hospitalised by placing female clients in rooms where male clients are bed for medical treatment. Most importantly, be culturally appropriate and culturally aware especially with various cultures being housed under the one room and of another community. Mental Health facility not bedding clients who are diagnosed with high risk psychosis rather than refer to Refuge without medical and professional support.
- Need more Aboriginal health workers in regional hospitals and emergency departments in particular, to encourage aboriginal people to attend and receive treatment. Saying you have a culturally secure or appropriate facility is not enough, you need to actually practice it. And better facilities in general, Aboriginal people are disadvantaged and it's not getting any better. Having people travel far distances across the state and to Perth has a massive cost for the government, so more dialysis units in regional facilities would be helpful. Especially in EDs, culturally secure care - not just words DO IT. Even transient staff - culturally trained but stay long enough.
- [Women's Refuge need to have ongoing funding and ability to help clients throughout their wellbeing and life changes.] Without these simple and basic requirements, it only adds to current pressures of dietary, mentality and natural ability to seek outside support which then becomes a 'family conflict' situation that leads to suicide, sexual abuse with children seeking alternative family and parental love and guidance. The mental state in lack of cultural and identity values become a part of oppression and disrespect towards one's own family or individual and often guided to that of another culture of drugs, drinking and violence. It is not always and often the most appropriate value in life to look after your health and many Aboriginal families and individual do not value their life to succeed in today's society with so many imbalances such as money and mainstream and urban living standards. To make any

pathways to 'close the gap' or improve individual families, it needs more than money and micro management from the top level down. It requires local input from clients themselves, ground level workers and families who are dealing with issues affecting health and wellbeing and heads of department to acknowledge support being given through 'cultural guidance' and empathy.

### **Data Collection**

- Health departments not collecting enough consistent data regarding family and domestic violence. Data needs more consistency and awareness in the private health sector as well due to some health campuses being split public and private i.e. Joondalup & Peel.
- Greater sharing of information across the sector to allow for the targeting of resources to where they can have the biggest effect.

### **FDV as a health issue, routine Screening**

- See it as a health issue, so that hospitals and health professionals have an integrated response. Make FDV screening routine, that way if disclosures are made, there are processes in place to respond to them.
- Routine screening of all women for FDV at Emergency Departments - priority at EDs, and would be great to see in all other health care settings.
- Mandatory family & domestic violence screening in all health care settings but particularly when women present to an emergency department in a hospital. If this becomes the norm and the treating health care professionals ask it like a normal every day conversation with the woman it would be really helpful.
- Family and domestic violence is considered by Health to be a 'health issue' rather than a community issue.

### **Funding**

- Provide more funding to women's health services and other not-for-profit community services to meet the increased demand for family and domestic violence support, advocacy and counselling.
- Increase access (i.e. increase funding) to services that support women and children affected by FaDV instead of just raising awareness around the issue.
- Fund and use gender specific and trauma informed services and use the evidence gained to supply FDV training for all agencies.
- Demand has increased substantially over recent years and this is an area where a timely response is essential. With limited resources, wait times for counselling appointments are inevitable and not helpful in these circumstances.
- Women's Refuge need to have ongoing funding and ability to help clients throughout their wellbeing and life changes.

### **Holistic Approach**

- Work holistically with women rather than seeing women as a set of isolated issues and problems, recognise that those issues and problems are interwoven.
- To offer more specialist support services to families in crisis e.g. trauma counselling, emergency support etc.
- There is a gap in services for women, usually presenting alone, with mental health and/or drug and alcohol disorders. Many have had repetitive head/face trauma and may have ABI.

They generally have either not been diagnosed or treated, are currently not receiving treatment, or are sporadic in their treatment. They are typically homeless, and are exceptionally vulnerable to sexual assault, and family and domestic violence. They may be abused by multiple or successive perpetrators. There do not seem to be the resources available for women to be adequately engaged with services for proper diagnosis, treatment and ongoing support. As community service organisations, we assist when these women are in crisis, but this does not address clinical issues which may be contributing to the cycle.

- Hospital referrals - from a duty of care perspective, refuges are receiving a high number of referrals for women with significant injuries. Some women are being discharged to refuges with significant injuries and refuges don't have capacity to monitor 24 hours a day. It is inappropriate to discharge a woman with significant injuries - particularly head injuries and an inappropriate referral for the refuge to have to manage. In a recent incident, refuge staff had to accompany a seriously injured woman to hospital along with her children and it was unknown if they had also been injured. When refuge staff asked the hospital to check the children as well, they were advised they would need to go to PMH. This brought up issues of consent, as the mother couldn't accompany her children and also further trauma to the children in having to be separated from their mother. Acknowledging in an assault incident, if the woman and her children could be treated as one unit so they don't have to go elsewhere for the treatment for the children would be helpful.
- It's time for a client centred approach to supporting women and families.
- Health services too clinical. Not practical. Remain distant from actually helping our clients not available for on the spot help needed (need help today not next week!!!)
- Be honest with the women, provide choices and information, listen and let them make own their decisions.
- Communication and referral processes needs to have the best interest of the clients at the foremost point of entry into women's refuge in addition respect and acknowledgement of ground rules applying to services in support of clients being diagnosed appropriately rather than released to refuge without further complications.
- We continue to see health professionals across all areas of the health sector with very poor understanding of coercive control and the broader dynamics of a service system that works with higher and higher thresholds.

### **Legal issues**

- VRO are not enforced enough to protect the person

### **More timely response**

- To work more closely with front line services. Act quicker on requests from front line services.
- Referrals into an appropriate Domestic Violence service and a timely referral particularly from Emergency Department - so call the refuge not just provide information or a pamphlet.
- Have social workers involved at earliest possibility.

### **Perpetrator**

- Perpetrator accountability



## Staff training

- I believe the public health service is effective in response to interpersonal violence via referrals or queries to DFV specific services - however, ongoing education will benefit women and children and build confidence amongst staff.
- Some training around FDV for health staff. To reduce re-traumatisation.
- Ongoing education of health professionals on how to respond to disclosures of FDV. How to make environment comfortable so women feel comfortable to disclose.
- Specific FDV training as well from appropriate organisations like the Women's Council for Domestic and Family Violence Services for health staff. Awareness for health staff around when to contact police if a woman presents injured and get police involvement so evidence can be collected in timely manner, a delay in police involvement can serve to minimise the event.
- Would be helpful for Emergency Departments to have staff that are more supported so there is time to build rapport with women to try and be able to screen more successfully for FDV.

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