Royal Commission into Family Violence

WITNESS STATEMENT OF MEGHAN JANE O'BRIEN

I, Meghan Jane O'Brien, social worker, of 59 Victoria Parade, Fitzroy in the State of Victoria, say as follows:

1. I am authorised by St Vincent's Hospital Melbourne and St Vincent's Health Australia to make this statement on their behalf.

2. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

3. I have been asked to comment on several matters.

Current role

4. I am currently employed as the Social Work Team Leader and Senior Clinician at St Vincent's Hospital Melbourne. I have held this position since February 2009.

5. As part of my role in relation to elder abuse I am responsible for targeted staff training on how to identify and respond to elder abuse; I conduct assessments and provide clinical consultation; I contribute to policy development and collection of data.

Background and qualifications

6. Between November 1992 and October 1995, I worked as a Social Worker at the Austin and Repatriation Medical Centre.

7. Between October 1995 and May 1999, I worked as a Social Worker at the Caulfield Aged Care Assessment Service which sits within the Caulfield General Medical Centre. During this time, I worked for a one month period in 1997 at Bethlehem Hospital in Caulfield.

8. Between May 1999 and July 2007, I worked at St Vincent's as the Deputy Chief Social Worker and Senior Clinician in Aged Care and Discharge Planning in the Social Work Department within Acute and Palliative Care. During 2005 and

2006, I worked at St Vincent's Melbourne as the Project Officer Transition Care Program in the Social Work Department.

9. Between August 2007 and January 2009, I was the Manager Care Coordination & Discharge Team at Austin Health. During that time, I was the Chair of Austin Long Stay Committee.

10. I have the following qualifications:

10.1. In 1992, I obtained a Bachelor of Social Work from the Royal Melbourne Institute of Technology;

10.2. In 1998, I obtained a Certificate of Gerontology from La Trobe University;

10.3. In 2004, I achieved a Master of Social Work in Human Service Management from the University of Melbourne. The Advanced Practice Portfolio contemplated Demonstrating Best Practice in Residential Care; and

10.4. Since 2009, I have been a PhD Candidate at the Department of Social Work in the Melbourne School of Health Sciences at the University of Melbourne. The topic of my PhD is 'From Suspicion to Intervention: Improving Responsiveness to Abuse of the Elderly in Acute and Sub-Acute Health Care'. This research is due to be completed in 2015.

St Vincent's Hospital Melbourne (SVHM) and St Vincent's Health Australia (SVHA)

11. St Vincent's Hospital Melbourne (**SVHM**) provides a comprehensive suite of medical and surgical services, sub-acute care, allied health, specialist clinics, diagnostics, and community and outreach services. Our specialist aged care, palliative care, mental health services, and correctional healthcare is widely recognised. We have three main campuses — St Vincent's Hospital in Fitzroy, and St George's Health Service and Caritas Christi Hospice in Kew — and offer services from another dozen sites across greater Melbourne. St Vincent's Hospital Melbourne is part of the St Vincent's Health Australia group (**SVHA**), a Catholic not-for-profit healthcare provider which is Australia's 12th largest privately held company.

12. St Vincent's Melbourne operate across 15 locations in metropolitan Melbourne including St George's Health Service and Caritas Christi Hospice in Kew and our main campus in Fitzroy.

13. St Vincent's Melbourne serves a diverse community. Geographically, our primary catchment takes in the municipalities of Yarra, Boroondara, Darebin and Moreland, yet only 43% of patients live in these municipalities. A further 40% are from other parts of Melbourne or are homeless, with 12.5% from rural and regional Victoria and 3% from interstate or overseas. Our patient population includes:

    13.1. people from culturally and linguistically diverse communities;

    13.2. Indigenous Australians;

    13.3. people who are socially and financially disadvantaged, including people with a background of homelessness;

    13.4. prisoners, in respect of their health needs;

    13.5. people who are deaf or hard of hearing; and

    13.6. refugees and asylum seekers.

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

15. We believe that hospitals can and should play a role in not only identifying family violence, but assessing risk and providing interventions and support to prevent violence from escalating and aim to improve a patient at risk of further harm.

Elder abuse

16. Elder abuse is any act of family violence which causes harm to an older person and is carried out by someone they know and trust such as a family member or friend. The abuse may be physical, social, financial, psychological or sexual and can include mistreatment and neglect. Elder abuse is a particularly pervasive kind of family violence, as it often occurs behind closed doors and tends to be unreported.

17. St Vincent's are at a unique nexus in the identification and ongoing treatment of elder abuse by health professionals. The model created by the St Vincent's Hospital Melbourne (as outlined below) could assist with further identification of older people at risk of elder abuse presenting to a wider range of Victorian hospitals.

Challenges for health professionals

18. Unless family violence has already been disclosed to a health professional, the first stage of responding to family violence is identification. Health professionals may not immediately identify elder abuse, as it is rare that a health professional would be present while the abuse is occurring. The challenge becomes identifying the abuse when the older person presents at the hospital, and for health professionals to support the patient to access assistance, both internally within the hospital, and through further referral and follow up.

19. A study we carried out at St Vincent's Hospital Melbourne 10 years ago showed that health professionals were unlikely to act upon suspicion of elder abuse. This reflected a lack of understanding of elder abuse in the broader community, with health professionals frequently lacking the confidence to respond appropriately when elder abuse is suspected. Literature suggests that older people are reluctant to report elder abuse. Perpetrators are frequently family members. The older person may be dependent on these family members and there may be issues of family loyalty and fear of the consequences of reporting. There may also be issues associated with the older person's cognitive/decision making capacity, or their capacity to talk about and describe the abuse.

Developing the elder abuse framework

Pilot Phase (2005)

20. In 2005, staff from St Vincent's Hospital Melbourne and identified that patients who may have been experiencing elder abuse were attending the hospital yet not reporting their family abuse. There were varying degrees of identification and support provided by hospital staff, and improvement was required to increase awareness of these issues. Even if staff were correctly identifying elder abuse, there was a lack of both shared knowledge and training moving from suspicion to intervention. We identified that we could not train staff until there was framework or policy in place, and that we needed to develop a hospital based education framework for hospital staff.

21. In 2005, the St Vincent's Social Work Department in association with the School of Nursing at the University of Melbourne conducted a pilot study into the detection and management of elder abuse within an health care setting. The aim of the study was to explore the recognition of aged abuse in an acute and subacute hospital setting. The study included a survey of hospital staff who as interviews with staff to explore their response to aged abuse over a retrospective twelve-month period.

22. A comprehensive article was written detailing the evidence and recommendations from the study. Attached to this statement and marked '**MO-1**' is a copy of the article 'Responding to a "Window of Opportunity": The Detection and Management of Aged Abuse in an Acute and Subacute Health Care Setting'.

23. At the time the study was conducted, elder abuse did not have a public profile, and St Vincent's Melbourne had identified the hospital as a window of opportunity through which to examine the identification and response to elder abuse. The instigator for the pilot study stemmed from the ethos behind St Vincent's, which is to engender compassion, dignity and respect for all people within our catchment area who may have to attend the hospital. Our vision is to target disadvantaged and vulnerable people within the community, which extends to those suffering from family and elder abuse violence. Additionally, the cohort of patients that the St Vincent's treat include a large intake of older people, as the reality is that the majority of older people will at some point require hospital attention and support. We had a captive audience of patients who were potentially victims of elder abuse, and we needed to act.

24. Initially, the study obtained baseline data from staff in focus groups to ascertain their confidence, competence and knowledge of identifying and treating patients suffering from elder abuse. 166 staff anonymously completed a questionnaire on their professional experiences of abuse of the elderly. The baseline data collected from the St Vincent's staff indicated:

    24.1. 53% of staff had reported suspicion of aged abuse in the previous 12 months;

    24.2. 17.7% had attempted to explored the situation further; and

    24.3. 7% had attempted a further intervention.

25. The results of the study revealed the need for the following services or measures:

25.1. A screening tool for the detection of aged abuse in acute and subacute care;

25.2. Ensuring health professionals have to time to implement an intervention in a neutral, protected environment;

25.3. Educational and professional development programs designed to increase awareness of aged abuse;

25.4. Guidelines to facilitate pathways of referral within the health service for health care professionals where they feel there are issues for concern; and

25.5. A program for carer education and community support.

Research Phase

26. Following the Pilot Study (2005) an Australian Research Council Linkage Project in conjunction with the University of Melbourne provided funding to begin a research project in 2009 to develop and evaluate an education package for hospital clinicians who suspect elder abuse. The research was designed to provide information to assist in the improvement of knowledge, competence and confidence for staff in identifying and responding to suspected elder abuse. This research included a Victorian Department of Health study tour: 'Improving Care for older people and people with complex needs' was awarded to Meghan O'Brien. The focus of the scholarship was to review the United Kingdom's (UK) response to EA where the family response within hospitals is very similar to the Victorian system. The UK system seeks to provide contemporary evidence across cross-jurisdictional areas of both jurisdictional key barriers to effective practice, and best practice from other areas.

27. The PhD research was designed to develop:

27.1. An agreed pathway to respond to elder abuse in a health services setting;

27.2. Development and evaluation of a hospital based training package for staff to improve recognition of suspected elder abuse; and

27.3. Development of an education strategy and competency framework.

28. The research methodology included a number of different phases: phase 1 included St Vincent's staff responding to a survey as to their learned experiences,

by way of an online survey (275 participants), focus groups (24 participants) and individual interviews (6 participants).

29. The online survey results found that 38% of participants had suspected elder abuse amongst their patients within the last 12 months. An additional 44% believed that they would have managed the case differently if they had received informed training and education about elder abuse.

30. Phase 2 included staff participating in focus groups and individual interviews. Staff were asked to explore the barriers to responding to the suspected elder abuse. Participants in the focus groups stated that they had a lack of understanding of what constitutes elder abuse, compounded by the lack of confidence and skills in conducting potential elder abuse assessments. Some of the suggested strategies provided by the focus group included the provision of training and education for first response staff at the hospital, as well as the opportunity for case discussions and access to expert consultation with experienced clinicians.

31. Phase 3 was the development and evaluation of a hospital based education package.

32. During this time, I began my research on my PhD thesis which comprehensively covers the identification and response to elder abuse within the health system, and how to support health professionals to identify and support an older person at risk of abuse. My PhD will be finalised in late 2015, and is entitled 'From suspicion to intervention: improving responsiveness to abuse of the elderly in an acute and sub-acute hospital setting'. My PhD seeks to build on the foundations of our earlier elder abuse research (2005) and data as outlined above. The recommendations has already informed a model at SVHM which responds to elder abuse identification for hospital staff and which can be considered for a roll out state-wide with hospital and community services. The studies, assessment and research which St Vincent's have undertaken to date provide an evidenced based governance framework within which the sector can work.

Identification of elder abuse in hospitals

33. We have found that where an vulnerable older person (**VOP**) at risk of abuse is able and willing to disclose their situation, this tends to occur just prior to the point of discharge from hospital. Often this is a time when the person of concern (alleged perpetrator) is not present, and the older person begins to realise that when they are discharged, they will be returning to a situation of difficulty and/or harm. When an older person who is at risk is in hospital, they are in a safe

holding environment. If we have received a disclosure of family violence from a patient, we are able to assess the situation further including discussions with the person of concern. There may be issues of carer stress, lack of knowledge, a need for education and we aim to work towards putting services in place (safety net) to ensure that support, treatment and further monitoring are provided. The patient's medical record contains essential information which allows us to create a care plan which addresses their specific needs, so that planning is tailored to their situation.

34. An older person's cognition (ability to make informed decisions) is pivotal in how they are able to respond to elder abuse. At St Vincent's Hospital Melbourne, we have neuropsychologists and geriatricians to provide expert assessment and guidance if there are concerns about the capacity of the older person. If there is an issue with the communication of the abuse to hospital staff, we have speech therapists and other specialist staff on site so we can offer a specialist, advanced clinical response. Hospitals can play a key role in identifying elder abuse. Helpfully, there is a full suite of medical services which can be provided to the victim in cases of suspected elder abuse. We have complex care and transition care programs, which include ongoing case management and funded services to assist potential victims in creating new and empowering pathways for their lives. Hospital are uniquely placed to provide these services as we have access to on-site specialist medical support and can make rapid and effective referrals to other departments.

35. Whilst important, having a policy about elder abuse is not enough. Due to the complexity of issues and conditions treated at hospitals, there can be no assumption that all staff will know how to react/respond when identifying or responding to suspected elder abuse, so training of health professionals is essential.

36. An older person's capacity is pivotal in how they are able to respond to elder abuse.

37. Clinical leadership and executive level support within the hospital are critical, as are the range of services which can be drawn on to assess and work through issues. St Vincent's Hospital Melbourne is in a strong position to provide a model of care people suffering elder abuse as a form of family violence that is based on the best available evidence.

38. As outlined in the material attached to this statement, the United Kingdom has implemented an approach called 'Safeguarding' to address elder abuse which includes an overarching governance structure. Within that structure, there is a dedicated worker at each hospital to consult/receive referrals regarding elder abuse, and all hospital staff are mandated to undertake elder abuse training. St Vincent's Hospital Melbourne has based its approach on key components of the UK framework.

Overview of Competency Framework

39. My PhD has informed the need for a competency framework with a three step process to assist staff education as follows:

    39.1. ***Level 1 - Awareness raising*** – this level assists staff in identifying signs and risk factors to support vulnerable older people presenting to hospital.

    39.2. ***Level 2 - Core competencies for managers*** – this level supports managers in understanding the governance framework to assist staff in acting on suspected elder abuse.

    39.3. ***Level 3 - Core competencies for staff undertaking assessment*** – education for clinicians undertaking assessments and providing interventions for vulnerable older people. All social work and emergency department care coordinators have received this training.

40. As a next step, Social Work at St Vincent's Hospital Melbourne is considering a possible submission for the consideration by of one of the key programs in the Victorian Department of Health and Human Services to regarding a pilot project with two other Victorian health services to test the effectiveness of the St Vincent's Hospital Melbourne model in other settings. The submission would recommend delivery (level 1 awareness raising training) to key clinical staff who have direct contact with vulnerable older people, as well as the provision of further comprehensive training (levels 2 & 3) to staff and managers in community and ambulatory care programs.

St Vincent's Education Package

41. The Education Package for the care of vulnerable older people includes a PowerPoint training presentation for staff, which provides information about the clinical pathway to assess situations of suspected abuse. During the presentation

and training sessions, we provide information on appropriate assessment and intervention guidelines as well as holding case study discussions with staff.

42. We developed a training DVD which includes five validated case scenarios which reflect the issues which can present in the hospital setting. The DVD forms part of the six hours (in total) training session. We also run two x three hour sessions which are compulsory within the Social Work Department and which are also offered for Care Coordinators in the Complex Care Team at St Vincent's Hospital Melbourne.

43. The training has now been delivered for all St Vincent's Hospital Melbourne Social Work staff who care for inpatients, and additionally all new Social Work staff complete the training.

44. In terms of evaluating the impact of the training, we have been collecting data since 2012 on situations of suspected elder abuse as reported by staff. This informs us about types of abuse, patterns of issues and risk factors involved. Using a Pre and Post Test design my PhD identified that once staff have been trained, their confidence and competence levels in identifying and responding to elder abuse has increased by 20%.

Implementation phase

45. In 2012, SVHM embarked on the development of a policy for the Protection of Vulnerable Older People (**VOP**) based on Victorian Government directions in relation to EA - *With Respect to Age: Victorian Government practice guidelines for health services and community agencies for the prevention of elder abuse (2009).* The Protection of Vulnerable Older People Working Party led by Social Work involved a range of key stakeholders including the Director of Aged Care, Managers of Aged Care Assessment Team (**ACAS**), Aged Psychiatry Assessment and Treatment team (**APATT**), ALERT and representatives from Nursing Education, Sub acute Nursing and Social Work. Consumer representation was included and consultation also occurred with the Victorian Department of Health Elder Abuse Prevention Unit. This Policy was closely followed by the establishment of St Vincent's Vulnerable Older Persons' Coordination and Response Group (March 2013) and a Clinical Working Group.

46. Based on the ARC Linkage project and the findings of the UK study tour outlined above, SVHM's policy work also focused on developing an effective and comprehensive clinical governance approach in responding to suspected EA. We

were informed by the UK 'safeguarding' approach - *No Secrets legislation (2000)*, which is about the protection of people who may be in vulnerable circumstances.

47. The SVHM Protection of VOP framework was established in March 2013. It includes:

47.1. Organisational systems and processes;

47.2. Education and Training;

47.3. Effective Clinical Care;

47.4. Risk Management;

47.5. Culture and Leadership; and

47.6. Performance Measurement.

48. The St Vincent's Vulnerable Older Persons' Model of Care outlines a required set of steps when dealing with a suspected case of elder abuse, as follows:

48.1. Identification of the trigger for the suspected elder abuse;

48.2. Consultation and risk assessment;

48.3. Line manager notification

48.4. Notification to the Vulnerable Older Persons' Coordination and Response Group using template form. This suspected Vulnerable Older Person notification encapsulates a range of contributing factors to the abuse, including the type and location of the alleged abuse and the details of the person of concern. It also requires the clinician making the early notification to record the current care plan that is in place, and what further action may be required;

48.5. Elder abuse assessment by two clinicians to ensure a collectively informed decision is made;

48.6. Documentation of regarding the abuse issues;

48.7. Planning an appropriate response for the older person suffering the abuse, as well as ongoing monitoring and support; and

48.8. Review of the case.

49. A new system was introduced of routine confidential notifications of cases of suspected Elder Abuse to the Chair of the VOP C&RG. SVHM Quality Assurance

(**QA**) ethics approval was obtained for retrospective auditing of a consecutive sample (n = 102) of suspected EA notifications and related episodes of care. A data mining approach (Epstein, 2001) using existing medical record documentation was undertaken by Social Work staff trained in the audit process. This process was based on both the Ritchie & Spencer Framework (1994) which enables analysis of descriptive categories and themes, and also the Canadian Centre for Health and Social Services Cavendish Checklist (2010) which enables evaluation of EA risk. An initial audit of the Vulnerable Older Persons' notifications was conducted from December 2012 - March 2014 (n = 102).

50. Once the new model of care and response framework for Vulnerable Older People was introduced across the health service, we noticed a trend in the rate of notifications. Initially, notifications were primarily from social workers and ALERT clinicians in our Emergency Department. As education and information sessions progressively occurred during 2014 to SVHM community programs, we noticed an increase in the notification rates from clinicians in these programs, as staff become more aware of the policy. The data shows the following:

50.1. Percentage of patient population that were female was 75%.

50.2. The highest notification rate was patients aged between 76 and 84 years (48%).

50.3. 71% of sample were born in another country and 45% required an interpreter.

50.4. The person of concern was a son (47%), spouse/partner (22%) or daughter (21%).

50.5. Types of abuse were financial 54%, physical 36%, psychological/emotional 44% and neglect 29%.

50.6. 64% of sample lived with the person of concern.

50.7. Multiple types of abuse suspected - two types 28%, three or more 18%.

50.8. Risk factors in the case - mental health issues (39%), dementia/cognitive impairment (27%), substance abuse (25%) and history of family violence (24%).

50.9. In 60% of our notifications, the older person disclosed the information directly to the health professional.

50.10. In 70% of cases, the suspicion of elder abuse was confirmed, suggesting that in the vast majority of cases were correctly identified.

50.11. In 11% of cases, the auditor determined there was an immediate risk to the older person, and in 49% of cases, the auditor determined there was an impending risk to the older person.

50.12. This data collection will inform updating of the SVHM policy and staff training with a view to strengthening practice.

Case study

51. The case study below illustrates how St Vincent's Hospital Melbourne current elder abuse governance framework assists staff to identify and respond to suspected elder abuse.

52. Mrs B[1] is an 83 year old female from a CALD background. She is widowed. She lives in her own home with her 52 year old son who is in receipt of a disability pension due to mental health issues.

53. Mrs B has a medical history that includes heart disease and diabetes.

54. Mrs B presented to the Emergency Department due to severe back pain following a fall at home. She was diagnosed with a fractured hip. Her son presented in emergency department as stressed and said in passing that he left his mother alone most of the day. Mrs B had limited contact her with local doctor and there were no community services in place.

55. Following her surgery Mrs B was transferred to the Rehabilitation Unit for ongoing assessment and therapy. The treating team were concerned about Mrs B's reluctance to participate in therapy. The unit Social Worker met with Mrs B at the time of her admission and she identified no issues relating to her hospital admission, family or ongoing care. Two days before her expected discharge she disclosed to the Social Worker that she was worried about her son's ability to care for her at home. She raised issues relating to her son's emotional demands for money and his violent outbursts at home.

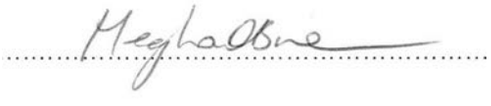
56. A notification was made to the Vulnerable Older Persons Coordination and Response Group by Social Work based on information disclosed by Mrs B.

57. At the time of her discharge from the Rehabilitation Unit, Mrs B required supervision and support with some tasks such as showering and dressing. Mrs B was insistent on returning home. A cognitive assessment was completed during

[1] Not her real name or initial. This case study has been de-identified.

her admission and there were no issues identified with her memory or ability to make decisions relating to her care. In line with the organisation's Vulnerable Older Persons Policy of empowerment and self-determination, the team supported Mrs B's right to make her own decision and recommended that community services be organised to assist on her discharge. Mrs B's son was upset about the services being organised on financial grounds saying "that would affect my inheritance." Following a family meeting, the treating team recommended a comprehensive community care plan at discharge given the patient's requirement for supervision and a range of social risk factors including her son's mental health condition. Following consent from Mrs B, a referral was made to the Aged Care Assessment Team at the hospital for assessment for a home based Transition Care Package to assist with case management, community services and ongoing therapy at home.

58. Mrs B was discharged home with ongoing support and case management to assist with her transition back into the community.



Meghan Jane O'Brien

Dated: 12 August 2015