Royal Commission into Family Violence

WITNESS STATEMENT OF DR BRIGID REGINA MCCAW

I, Dr Brigid Regina McCaw, Medical Director of 1950 Franklin St, Oakland California, in the State of California, United States of America say as follows:

1. I am authorised by Kaiser Permanente to make this statement on its 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.

Current role

3. I am currently employed as the Medical Director of the Family Violence Prevention Program for Kaiser Permanente, Northern California Region.
4. I oversee the implementation of a comprehensive, coordinated approach for improving screening, identification, and services for intimate partner violence (**IPV**) and lead the national efforts of Kaiser Permanente to improve IPV services for over 10 million members.
5. My teaching, research, and publications that I engage in while undertaking this role, focus on developing a health systems response to IPV and the impact of IPV on mental and physical health.

Background and qualifications

6. I received my medical degree from the University of California, San Francisco in 1986.
7. I also hold a Masters Degree in Public Health (specialization in Epidemiology) and a Masters Degree in Science (specialization in Health and Medical Sciences) from the University of California, Berkeley both of which I attained in 1984 respectively.
8. I have been a Fellow of the American College of Physicians since 2003, and certified in the specialty of Internal Medicine since 1989.
9. I was the 2014 Chair of the National Health Collaborative on Violence and Abuse,
10. Finally, I am a member of the Institute of Medicine's Forum on Global Violence Prevention.

About Kaiser Permanente, Northern California

11. Founded in 1945, Kaiser Permanente is one of the largest not-for-profit, integrated health care delivery systems in the United States of America, serving more than 10 million members in eight regions through 39 Hospitals and 619 Medical Centres. The Kaiser Permanente workforce comprises more than 18,000 physicians, 50,000 nurses and 178,000 employees.

12. Kaiser Permanente offers a network of health care centres in 8 US States and the District of Colombia. These facilities are available to members of Kaiser Permanente Health Insurance Plans. Plans can be purchased by employers or individuals, and represent health care insurance options available under the United States' *Patient Protection and Affordable Care Act 2010*.

13. Kaiser Permanente provides the communities in which it operates an integrated health service offering. Centres offer outpatient, inpatient, emergency and behavioural-health services including mental health services as well as pharmacies, diagnostics and laboratory services. This extended suite of services sets Kaiser Permanente apart from many other types of health services in America, for example those that are for-profit, fee for service, or those that only offer a limited range of services

14. In addition, Kaiser Permanente has a fully integrated and centralised electronic medical record system, extensive experience in management of chronic conditions, a team-based approach to care, recognized research expertise, and a strong commitment to prevention and health education — all grounded in a mission to improve the health and wellbeing of the communities in which each centre operates.

15. It is because Kaiser Permanente offers all of these types of health care services, together with these capabilities and a commitment to community health and wellbeing that it presents a unique opportunity for implementing family violence services.

16. This unique environment led to the development of the Kaiser Permanente systems-model approach. Over time, Kaiser Permanente have progressively brought more and more individual centres on board with this approach, which has now been in place at some centres for 15 years. The systems-model approach represents a sustained program of systems change that has shown itself capable of generating significant and replicable results within integrated health care systems.

17. Such results include a dramatic increase in the identification of family violence at the ambulatory care stage, when women are receiving check-ups at clinics. This is compared to the previous trend of identification occurring at the later in-patient care stage such as when a woman arrived at an emergency room with an injury. At this

later stage, a lot of the damage would have already occurred to the women and her children. As a result of these increased levels of identification at the early ambulatory care stage and in turn because of the effects of the systems-models approach, there have also been sustained increases in the rates of referral to Community Advocacy Services and associated community based specialist family violence services that support women and children subjected to family violence. Such community specialist services might include legal advice or women's shelters for example. Because of this, we have seen increased levels of engagement with specialist family violence at an earlier stage, allowing women to better address the various issues that they are facing via early intervention options.

Background to the Kaiser Permanente systems-model approach

18. Prior to the development of the systems-model approach in 1997, there was already an established specialist family violence service network that was able to assist women at the point where they sought out the help of those services in California. However, we came to recognise that by the time a woman was actively seeking out help from a specialist service, whether for emergency shelter services or legal help, a lot of the damage had already been suffered by her and her children. We grew to realise that we needed to uncover and address instances of family violence much earlier on, because women were not accessing the services that were available, or they were accessing them too late for them to be the most helpful. We saw that to be more valuable to these women, they needed access to these services earlier.

19. It became clear to us, having recognised this, that the health care system had a really important and unique role to play in identifying women experiencing family violence earlier, and helping them to access and engage with the services that would be able to improve their lives, their health and wellbeing, and that of their children. We see that the opportunity available in the health care system isn't really available in other sectors so it's really important that we work to maximise this opportunity as best we can. This is particularly true because women are especially likely to engage with a health centre multiple times over her life. Where she has children this also occurs via pre-natal, antenatal and paediatric appointments, providing us with multiple opportunities to engage with a woman.

20. By the mid 1990's there had been a strong level of engagement from US law enforcement and criminal justice, and community advocacy groups. However, despite recommendations for routine domestic violence (**DV**) screening in health care settings by multiple US medical professional organizations, very few health care

settings, including Kaiser Permanente, were doing this. There was of course action taken by these clinics when a person attended with a physical injury, in that the clinic would treat that injury. However, often the next step wasn't taken in terms of connecting the woman to additional life-saving services and resources that were already in the community.

21. In formulating a response to this issue, we understood early on that simply training clinicians in new early identification processes, for example, was not going to result in long term, systemic changes that would result in better identification outcomes. We knew this because there was quite a bit of literature on what happens when you train clinicians. This research clearly showed that a purely training-based approach might raise awareness of family violence but it would not result in a long term change in the behaviour of clinic staff, which is what we wanted.

22. As a result, when we designed our response to the problem, we ensured that we included all of the opportunities which are present in the health care setting in our model along with methods to embed the changes using quality improvement methods. We did this so that the approach to be implemented was a multi-pronged, enduring health care based response to family violence.

23. The systems-model approach was initially implemented in 1998 as a pilot in one clinic. The results of the pilot were significant - a 3 fold increase in screening and identification of intimate partner violence, and increased referral rates to mental-health clinicians and community DV specialists. It was also found that the clinicians themselves rated the systems-model approach well and so were more supportive of the changes that it required from them.

24. As a result of the success of the pilot, Kaiser Permanente's systems-model approach was chosen by the American Association of Health Plans/Wyeth as the 2003 Gold winner of its HERA award, presented each year to an exemplary program that advances quality in women's and children's health care.

25. Over the next 10 years, the systems-model approach was adopted by all 46 Kaiser Permanente clinics in Northern California (which provided health care for approximately 3.6 million people, of which about 1.2 million are women aged 18-65. This uptake in the approach has been associated with a 13-fold increase in the identification of Kaiser Permanente members experiencing family violence.

26. The systems-model is also being implemented in the Kaiser Permanente regions outside of Northern California.

The Kaiser Permanente systems-model approach

27. The systems-model approach utilises the entire health care environment to address the problem of family violence. As the name suggests, the approach is focused on changing the way in which the system operates so that practices which support family violence identification, treatment and management are embedded in the health system. The systematic approach ensures that there is not simply a short term peak in understanding of family violence that is then lost over time. This is safeguarded against by embedding practise into the workplace. The systems-model approach ensures long-term change as well as the built-in capacity for the network to grow and evolve over time as new practises and knowledge are identified. In this way, the family violence response is both reliable and agile. Attached to this statement and marked "[**BM 1**]**"** is a copy of "Preventing Violence Against Women and Children: Workshop Summary" dated 2015 which details this response.

28. The systems-model approach has five components:

    28.1. a supportive environment;

    28.2. clinician inquiry and referral;

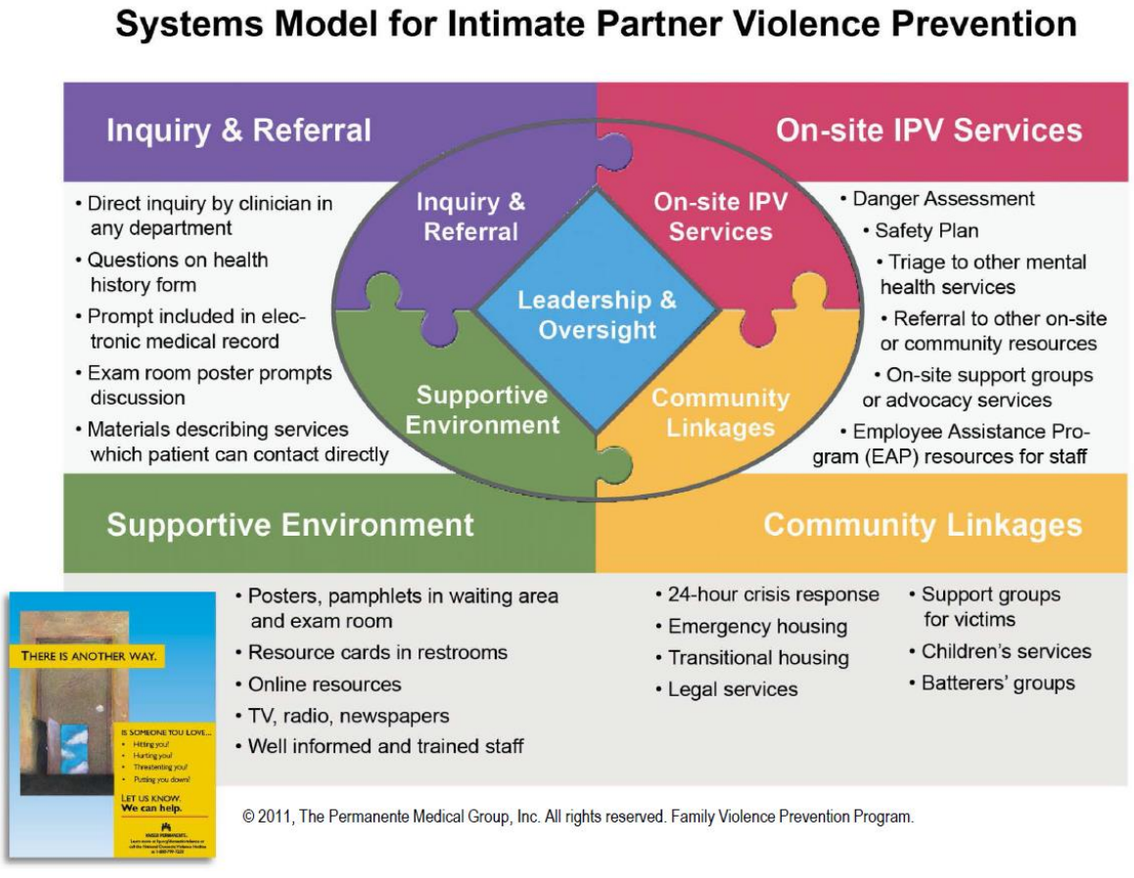
    28.3. on-site family violence services;

    28.4. linkages to community resources; and

    28.5. leadership and oversight.

    These are summarised in **Figure 1:** *Systems Model for Intimate Partner Violence Prevention*, shown below.

Figure 1: *Systems Model for Intimate Partner Violence Prevention*



Providing a supportive environment

29. This aspect of the systems-model approach involves creating a supportive and comfortable environment in the clinic so that women feel that it is a place in which they can disclose to their medical practitioner that they are experiencing family violence and that that disclosure would be welcome.

30. It is also a place that they can receive information about community resources so that if they are not yet ready to disclose, they can observe posters or they can take away material that outlines that what is happening to them is not right and tells them how they can get help, when they are ready to do so.

31. To create this type of environment, our clinics have posters on the walls of the examination rooms, pamphlets that provide greater detail, information sheets on the back of toilet doors and tear off sheets. The posters display a hopeful image and basic language "There is another way. Is someone you love hitting you, hurting you, threatening you, or putting you down? Let us know, we can help". The goal is to let a women know that what is happening to her is not right and encourage her to talk with the clinician.

32. By placing posters in the examination rooms, it also serves to provide language that the clinicians can use and remind them to ask.

33. We have also expanded our messaging to the Kaiser Permanente on-line information, because we know that many of our members will access information about their health concerns via the internet. We therefore try and place friendly and engaging messages about family violence at the places where they get this information online. In addition to materials in other languages, we have developed messages in a more pictorial form so that those with lower literacy skills can receive the message and understand where they can get help. One example of this that we have used recently is the "foto nota" which uses graphics to offer information about family violence and accessing help for our Spanish speaking members.

34. We also embed a lot of messages around family violence in our health education materials, particularly those for prenatal, maternity, and "well baby" care, that go out to member's homes. Finally, we have recorded messages about family violence and how to get help that members hear if they are on hold on the phone.

Clinician inquiry, referral and documentation

35. In addition to providing a physical environment which is supportive for patients, it is also very important to provide training and support to clinicians so they know how to inquire about family violence in a caring and effective manner. It is both the asking of the questions and the clinician's response to a disclosure that are the subject of this training and support.

36. The goal is to help clinicians become more knowledgeable about family violence, and to develop an approach to screening that is comfortable and natural for them. This aspect is important as research has shown that if the process seems unnatural or uncomfortable for clinicians, they often won't engage in the screening process.

37. Once a disclosure is made, the response that the clinician makes to that women is really important. Clinician training includes models for empathetic listening, supportive and empowering responses to disclosure as well as how to offer a referral to community specialty services or, if indicated, to mental health services.

38. An important element of clinician training is how to use tools that are in-built into the electronic health record. These tools provide reminders and questions to clinicians that can be used for screening. They also assist clinicians in complying with their documentation requirements for patient progress notes and medical records specifically around family violence. This documentation is important for coordination

of care between health care providers. It is also part of the quality improvement efforts that make use of automated data.

39. In addition to embedded screening tools as part of the medical record system, our centres also have paper based screening tools. At present, we have not attempted to standardise these across the centres, and we have not worked to identify which questionnaire that is in use is the most preferable. Really, they are being used as a tool to promote conversation in a way that is effective in that particular clinical setting.

On-site IPV (family violence) services

40. The next element is providing an on-site support service that can connect women to other services within that health clinic. This might involve connecting women to social services or to a mental health service, though the scope for direct referrals depends on what is available in that particular clinic.

41. Part of ensuring that a patient has access to as many services as possible, is ensuring that clinicians know that they can offer the clinic as place for a women to use the phone to call the community service directly.

Linkages to community resources

42. The next element is ensuring that the clinical staff have really good relationships with and knowledge about the specialist services that are available in the community, for example homelessness services and women's legal services.

43. Over time, we have seen better relationships develop between clinical staff and community services.

44. In the beginning, the relationship only extended as far as the clinician having paper material about particular services that would include a contact phone number. The clinician would give that material to the patient when family violence was identified. It was a very arms-length, one-way, type of relationship, where clinicians only knew of the services and not much more.

45. Over time, we progressed to make sure that staff members from the community services became part of the multi-discipline teams that we use as part of the systems-models approach. These staff members would come to the medical centre and attend meetings so that our teams could learn more about what services they provided to women in the community, what their challenges were and what their needs were. It was quite revealing to many clinicians exactly what services were available, as over time the types of services offered has increased greatly. In the past, services offered might only have included contact hotlines and emergency

housing. Today, many of the services are much more robust and offer counselling, court accompaniment, services for children, job resources and so on. As a result, when clinicians speak to patients, they can offer a more knowledgeable referral.

46. The next stage of partnership model that some of our clinics are progressing towards is having clinicians become involved in the community specialist services themselves, such as being a member of the Board. This has meant there is more communication and understanding between the two, and a heightened understanding within the clinic about exactly what happens within those services.

47. More recently, some clinics have begun having an on-site advocate available so that if a patient is identified as being at risk, they can walk over and engage with the advocate and discuss what referral services might be available. The advocate can then provide a "warm" referral to a particular service. This might involving saying to the women "I would like to refer you to someone that I know who works at Family Violence Service X, let us call them together now and I can introduce you to them". We believe that this kind of warm referral is more likely to "take" in that it is more likely to result in the women actually using that service. We are still in the process of learning how to do this, but making the referral process more effective is a really important aspect of what we are trying to do, particularly as part of our mission is trying to prevent future harm via early intervention.

48. We have also found that there have been benefits for our community partners as a result of the clinic's partnership with them. I think it has been a two way street in this regard. We have noticed that these benefits have accrued most noticeably around the area of training. In the early days, when we would invite the advocates to come in and do training they would do an excellent Domestic Violence "101" for clinicians. However, the training periods that are available for clinicians are very brief, often less than an hour and it was difficult for the advocates to provide the full version as they had intended it. So what the community services have learnt to do is to distil the key messages and use language that is really meaningful and compelling for the clinicians, to get across a message that is clearer and so resonates more strongly with those clinicians.

49. Those community services providers have also learned to communicate using "doctor speak" in that it is brief, to the point and very task focused. They have also taken back to their services an ability to include health based messages in their normal communications with women. We know that if a women is debilitated by mental illness or a medical condition, then she is unlikely to be able to take the steps she needs to pursue an intervention order through the courts. Similarly, clinicians have

come to realise that they will not be able to make good progress with a patient's diabetes if that person is living in an unsafe home.

Leadership and oversight

50. Finally, an important aspect of the systems-model approach are strong local and regional health centre leadership structures to ensure that activities are coordinated among departments and across medical centres, that new research data is disseminated and that revised and innovative approaches are embedded into everyday practise so that these remain current and in line with best practise thinking.
51. Health centre physician-champions and team leaders meet regularly to review quality improvement metrics, identify promising practices, and identify new initiatives which might be incorporated into every-day practise. These metrics also provide information about poor performing clinics or departments so that further inquiry can be conducted.
52. Executive sponsorship in the health care centre is also essential as sponsors can increase the program's visibility, assist with goal setting, identify and procure resources, and when necessary, participate in problem solving.
53. These steps together provide oversight of the whole network and ensures that the outcomes of improving family violence identification, management and referrals are moving in the right direction, and allows any systemic issues to be identified and rectified.

The role of the "champion"

54. The systems-model approach also requires the presence of a "champion" and a multi-disciplinary team.
55. The multi-disciplinary team is responsible for making sure that all of the elements of the model are present in their clinic. It should be noted that these are not the people who are necessarily going to be responding to people with family violence. Rather, their job is to make sure that the clinicians have been trained, the materials for that supportive environment are widely available, that there is a clear referral protocol for mental health services and also a clear referral protocol to community resources. These are the people that make sure that all of the key components are in place.
56. Physician-champions are equipped with the necessary tools and materials to implement the model at their local centre. These might include an outline of what the first step is to implementing the systems-model approach, what the second step is

and so forth. It will also instruct them on what needs to be done next, once the model is established.

57. Champions play an important role, as they are highly visible experts within the organisation in terms of the systems-model approach and are able to motivate the workforce to come on board with changes, to support them during the change process and to provide ongoing education to them as the system matures. They help to hold everything together and to keep things on track.

Multi-discipline teams: make-up and purpose

58. The overall makeup of the multi-discipline team can be varied, and it will depend on the types of services that are available in the area in which the centre operates.

59. However, the composure of the core members of the team, those that are essential, would certainly include a clinician, usually being a physician. If the team is led by a clinician champion, then usually the "team-lead" would be drawn from one of several different groups including clinic managers, mental health services or the centre's health education department. This person would work on the operational aspects of getting the new approach in place.

60. There would also need to be people drawn from each of mental health services, social services, health education and management services.

61. After that the team is made up of a number of people that are interested in the area, which might include nurses and other clinicians.

62. We have had multi-disciplinary teams which have included members from law enforcement and solicitors drawn from local "family justice centres". Making this link has proved very useful as it helps clinicians really understand the value of a protective order, to understand the importance of the notes that they take and why it is vital to be very specific in what they see, so that a judge can later make a more informed decision about a women's case.

63. In the end, it is difficult to provide an exact formula for a multi-disciplinary team, as each one will vary based on the needs of that particular centre.

Training is essential but it will not result in enduring behaviour change without more

64. Although training is not the focus of the systems-model approach, it does play an essential role in supporting the systems-model approach.

65. To maximize the effectiveness of the systems-model approach, training is offered in multiple ways and venues, so as to be as convenient and valuable as possible to clinic staff. We do this applying adult learning principles, which show that shorter

sessions and visual demonstrations of the behaviour being modelled tend to be most effective in building long term memory, we usually use short seven- ten minute videos that show a clinician interacting with a patient.

66. In addition, lunch-time lectures continue to play an important part of continuing medical education as do brief departmental updates, case presentations, online-training tools, broachers and reports on quality-improvement data. These different learning options allow clinicians to choose the format which is the most effective for them, using repetitive messaging, delivered by someone who is credible (meaning that they are usually a specialist in that faculty).

67. Clinicians are offered multiple options for incorporating family violence screening into their practices in a way that is comfortable and natural for them. Cultural considerations are also incorporated into all training as this is essential to getting disclosures from a diverse range of communities.

68. Such training also comes with credit towards their continuing medical education.

69. As part of the learning program, we dedicate quite a bit of time to "training the trainer" in that we provide training to identified "champions". We give the champions materials and resources such as presentations and videos and they are then able to tailor that material, if they wish, and deliver multiple training sessions to the workforce within their particular clinic in a way that is the most relevant and practical for those particular workers.

70. Training then can be seen to be multi-faceted in that it comes in many different formats, it covers different approaches and different groups are targeted. The most important aspect however is really embedding that learning into the workflows to drive long term behaviour change to support better patient outcomes.

Innovation sharing for cumulative network evolution

71. Identifying innovation or particular approaches that are working especially well in individual centres, and disseminating that to other centres within the network is particularly important to ensure that the whole of network remains at the forefront of best practise, so that practices and behaviours do not stagnate. This approach is based on standard health system quality improvement methodologies.

Implementation of the systems-model approach

72. The systems-model approach is not difficult to roll out and scale up to many different centres. It is really just an approach that seeks to change systems to make more effective and efficient use of already existing resources, both within the clinic and in

the community. So in terms of cost, it is rather cost effective. The difficulty really comes in being clear conceptually about what is trying to be achieved with the systems-model approach and ensuring that that the transformation process stays on track.

73. The pieces of the systems-model approach are really quite easy to implement when they are broken down in to parts and implemented carefully. There is a phased approach to implementation and tools to guide the champions and team. This type of approach is frequently used for quality improvement efforts for other health issues so it's not an unfamiliar process to take a health issue and embed its identification and management in the work flows of a clinic.

74. What is really important to the success of the systems-model approach is ensuring that there is sponsorship and buy-in from the people who run the clinics and the people that work there, who will have to adjust their practises to the new approach.

75. Leadership also needs to support the staff and work to make managerial level changes that will result in the necessary high level systems changes.

76. Additionally, by establishing a multi-disciplinary team and a workplace champion, change can be established quite quickly within in the clinical workflows.

77. In our experience, it has also been important to show that we are making progress, in terms of disclosure and referral metrics to staff, which re-enforces the benefits of the system and in so doing motivates further systems and behaviour change.

78. Finally success in implementation also comes from being able to evolve the system by disseminating new innovation and embedding new research into the work practises at each centre, to ensure that the service that are being delivered act to further improve outcomes.

79. A lot of the tools that the systems-model approach relies upon are already being used by other parts of the health system, for example quality and standard processes. We are just implementing the research and knowledge that is already out there is a family violence identification and prevention context.

Outcomes and insights of the systems-model approach

80. When we implemented the systems-model approach, we also included some more robust ways of measuring whether this change was having an effect. Initially we developed some process-related quality metrics: basic requirements that every health centre needed to have: a physician-champion, a multi-disciplinary on-site team, and a clearly defined referral protocol to mental health or social services. Later we added quantitative metrics that utilize the automated databases that are available

as part of the electronic health records system. This allows us to pull out data about the number of our members who have been given an identification of domestic violence and then also what percent receive follow up. These metrics are similar to quality improvement measures that are used for other health conditions which are familiar to clinicians and health administrators.

81. Attached to this statement and marked "[**BM 2**]**"** is a copy of "Integrating Intimate Partner Violence Assessment and Intervention into Healthcare in the United States: A Systems Approach" dated 2011 which explores the systems-model approach and the family violence identification rates among Kaiser Permanente members since the year 2000.

82. The data that we have collected has provided us with strong and evidence that the systems-model approach is effective in increasing rates of identification of family violence. The data show that most of the identification now occurs in ambulatory care or mental health departments. This contrasts with data before implementation of the systems-model, in which the majority of identification took place in the emergency department when a patient was seen for a family violence related injury.

83. Over the past 10 years there has been a steady and continued increase in the number of members who are identified within our clinics as having experienced partner violence and also the percentage that receive a referral to mental health. Over this 10 year period, more than 50,000 members have been identified and offered services in Northern California Kaiser Permanente. Last year alone, 13,000 members were newly identified as experiencing family violence.

84. It is important to note that this improvement is a result of better processes of identification, not an increase in the prevalence of domestic violence. We know this because the data shows that rates of domestic violence in the United States are actually stable or possibly even slightly decreasing.

85. While our data shows that the majority of members identified as experiencing family violence have a follow up visit with a mental health or social service clinician, we don't have data on the percentage of our members that receive referrals to speciality services outside the Kaiser Permanente network actually receive care from those community services. This data gap exists because once our members go outside of the network, the Kaiser Permanente electronic record system is no longer used, so we cannot access those records for obvious confidentiality reasons.

86. However, we do know that more than half of our members that are identified as having intimate partner violence do get follow up evaluation in mental health. We also know from our own data that when they are identified, doctors consistently give them pamphlets, refer them to community resources and provide them with phone

numbers. We just don't know how many of those people actually get to those services.

Expanding the system to other types of violence and promoting healthy relationships

87. At Kaiser Permanente, we started our work with a focus on intimate partner violence. However, over the years we have expanded the types of abuse that we are trying to address, including child and elder abuse, sexual assault and human trafficking, and now exposure to adverse childhood experiences (**ACE**).

88. Finally, we are trying to balance our messaging with not just about what we want to prevent, being family violence, but also what we do we want to promote, being caring, healthy and respectful relationships and families.

Brigid Regina McCaw

Dated: 11 August 2015