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VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE

MELBOURNE

WEDNESDAY, 12 AUGUST 2015

(18th day of hearing)

BEFORE:

THE HONOURABLE M. NEAVE AO - Commissioner

MS P. FAULKNER AO - Deputy Commissioner

MR T. NICHOLSON - Deputy Commissioner

COMMISSIONER NEAVE: As I have said on a number of previous occasions, the functions of the Commission can be performed by one or more Commissioners separately. Today I'm sitting with Deputy Commissioner Faulkner. Deputy Commissioner Nicholson will not be here today. I think Deputy Commissioner Faulkner has a statement she wishes to make.

DEPUTY COMMISSIONER FAULKNER: I want to state that I'm the Deputy Chairman of St Vincent Health Care Australia. There is a witness today appearing to give evidence about programs of St Vincent Health Care Australia, and I believe that that causes me no conflict of interest.

MS DAVIDSON: Thank you, Commissioners. The theme for today is the role of the health care system. What we know is that family violence services are able to provide a specialist response to family violence but they are not usually sought out or contacted by women until they are in crisis. Women, children and other victims are more likely to disclose and to disclose earlier to a person or a professional with whom they already have a relationship.

Medical professionals such as general practitioners, antenatal services, and maternal and child health care workers have been identified by many women and victims with whom the Commission has consulted as having had the opportunity to identify family violence and associated risk factors and to intervene early.

Hospital staff and other health professionals have also been identified as having opportunities to identify and address family violence. However, many of the submissions have identified a number of impediments to health professionals taking a more active role in

addressing family violence, including lack of knowledge and training about family violence, including how to ask and what to do if family violence is disclosed; challenges in terms of time and resources to be able to ask about family violence and lack of capacity to address the issues; adequacy of referral pathways and knowledge of appropriate services. Other submissions have identified issues about gaps in patient health information and record keeping; and a lack of recognition of family violence as the public health issue that it is.

We are going to hear from a number of witnesses today. Firstly we will be hearing from Professor Frank Oberklaid from the Royal Children's Hospital. We will then have a panel of a number of experts from New Zealand, California and Victoria in relation to the way in which health professionals are able to be resourced, trained and assisted in addressing family violence issues.

We will then hear from a panel of witnesses who can talk about the role of health workers at the Royal Women's Hospital and the sort of work that is being done at the Royal Women's in order to address family violence.

After lunch we will hear from a maternal and child health nurse professional who can talk about the role that maternal and child health nurses play in this area and opportunities for improvement in that area. We will hear from Meghan O'Brien from the St Vincent's Hospital about some of the work that is being done in St Vincent's Hospital in relation to elder abuse.

We then have a witness from New South Wales, Lorna McNamara from the Education Centre Against Violence, who will be able to talk about the role of a government

agency in providing training to health professionals and to departmental staff, and the benefits of having a government agency with a family violence focus and involvement in policy development.

Then finally we will hear from a witness from the Department of Health and Human Services, Frances Diver. I should also note that the Commission will have a witness statement by Sue West from the Murdoch Children's Research Institute, but we will not be calling evidence from them today.

COMMISSIONER NEAVE: Thank you, Ms Davidson.

MR MOSHINSKY: Commissioners, the first witness is Professor Oberklaid. If he could please come forward.

<FRANK OBERKLAID, affirmed and examined:

MR MOSHINSKY: Professor Oberklaid, could you please tell the Commission what your current position is and give an overview of your professional background?

PROFESSOR OBERKLAID: I'm a paediatrician. I'm trained in what's called developmental and behavioural paediatrics, child development and behaviour. I am the Director of an academic centre at the Children's Hospital, the Murdoch Children's Research Institute, called the Centre for Community Child Health. We have about 130 full-time equivalent professionals, and our formal mission statement is supporting communities to improve children's health.

So we have major research streams, we see patients with problems of development and behaviour, and we have a large role in what we call research translation; that is, we have a major interest in translating the research that we do and our colleagues around the world do so that it informs public policy, service delivery,

clinical practice and parenting.

MR MOSHINSKY: In terms of your main areas of academic research and expertise, could you just outline briefly what those areas are?

PROFESSOR OBERKLAID: We are particularly interested in the pathways to children's problems. The sort of clinical issues we see affect most families in Australia. So we are particularly interested in the pathways, why do children have these problems in the first place, and especially interested in what we do about them.

We are cognisant of the fact that there's a limit to resources, and so we are very interested in doing research using the present service system - how can we work with our current service system to prevent these problems in the first place or, when they occur, to manage them in a way that's appropriate to the evidence.

MR MOSHINSKY: Have you prepared a witness statement for the Royal Commission?

PROFESSOR OBERKLAID: I have.

MR MOSHINSKY: Are the contents of your statement true and correct?

PROFESSOR OBERKLAID: They are.

MR MOSHINSKY: Can I first take up an issue that we heard evidence about on Days 2 and 3 of this public hearing relating to the impact of family violence on children. I was just wondering whether you might be able to comment on that topic. What do we know about the impact, particularly of stress levels on the development of children?

PROFESSOR OBERKLAID: Sure. I think the last 20 years we have a much more detailed and finely tuned appreciation of the

way that the brain develops in those early years. So this starts at conception and continues right through life, of course, but we know that the brain in those early years of life is exquisitely sensitive to environmental effects.

So the way we develop, the way children develop is the result of a transaction between the genes that we are born with and our life experiences and life events. So the genes provide the manual, but the way development unfolds is almost entirely dependent on the environment. So that's why we immunise children, to make sure they don't get acute infections that can compromise their development. We make sure we pay a lot of attention to nutrition. But the most important thing is the quality of the relationship that a baby, then a young child has with care givers, with parents, with extended family, with professionals and out-of-home care.

So where that relationship is positive - that is, it's consistent, it's warm, it's predictable, there are routines - then development unfolds as it should and the child has every chance of fulfilling his or her potential. When that is compromised in some way - poor nutrition, infection, trauma and stress, and I'll come back and talk about that in a moment - then that significantly interferes with brain development.

So what is happening in the early years is the brain is busy developing circuits, connections between different parts of the brain. The way those circuits develop is almost entirely dependent on getting necessary inputs from the environment at particular times - for example, vision, hearing, et cetera, et cetera. That depends on a relatively stress-free environment. So, when

stress is experienced by the child, stress hormones go up in that child's body, cortisol, and persistently high levels of stress interfere with brain development.

You can't get rid of stress completely. So young children feel stress all of the time - when they fall over and hurt themselves, when they feel the pain of immunisation - but it's transient and it is short lived and, very importantly, it's mediated by an adult who makes it okay. So when a child falls over and starts to cry an adult picks them up and cuddles them, et cetera. So there is no evidence that causes any long-term deleterious effects.

But we have this notion of toxic stress, where there is persistently high levels of stress in a child's family. We see that in child abuse, sexual abuse, extreme poverty, where there is substance abuse, where parenting is interfered with, where there is dysfunctional parenting, and particularly there is no parent who makes it okay. Sometimes the parent is the cause of that stress in the first place.

So where that happens there is abundant evidence now that that interferes with optimal brain development and has long-term consequences. So what's emerged in the last 10 years is what we call the life course literature. So if we project for a moment issues and problems we see in adult life - mental health problems, criminality, illiteracy, welfare dependency, family violence, cardiac disease, diabetes - there's increasingly robust evidence that they begin in pathways in those very early years, and that is mediated by this stress response.

Where there is persistent stress, it affects the

body's physiological systems and resets them at a higher level, at a different level. So that child, who becomes a young person, becomes an adult, then becomes more vulnerable to getting all those illnesses and problems that we saw.

MR MOSHINSKY: In your statement at paragraph 11 you refer to an elephant in the room. What's the elephant in the room from your perspective?

PROFESSOR OBERKLAID: I think there is still a failure to appreciate just how important the research evidence is about these three years.

MR MOSHINSKY: Sorry, these three years?

PROFESSOR OBERKLAID: Sorry, in the first three years.

MR MOSHINSKY: The first three years of a child's development.

PROFESSOR OBERKLAID: Correct, just what I mentioned. So we are still having debates, for example, about can we afford quality child care, we are still ordering more ambulances to try and treat problems that we know we can prevent early on. I think from a public policy view we really haven't embraced the fact that if we fix up those first three years, if we can provide the sort of support that families need, parents need, if we can have high-quality early learning environments, that's the best economic investment that any country can make. There are long-term gains in productivity. So the real productivity issue is in building social infrastructure. It's not only on getting women back into the workforce, for example.

So that's the elephant in the room. The academics appreciate that, the media are starting to understand that. We haven't seen a consistent, sustained public policy response to that research evidence yet.

MR MOSHINSKY: Can I take you to some slides which relate to the themes you have been talking about. The first one is a bell curve. Could you use this slide to explain what is our traditional approach in terms of public health and what you think should happen?

PROFESSOR OBERKLAID: Sure. Traditionally not only in this country but in every other country we are focused on the hard end where those arrows are. The metaphor for that is we keep on ordering more and more ambulances. People get into trouble, children get into trouble, whether it's family violence, whether it's mental health, whether it's child abuse, whether it's a whole range of problems. We wait until problems become entrenched and then we focus on that hard end, relatively small numbers of people, when many of these conditions, many of these problems exist on a continuum - whether it is stress, whether it is mental health, whether it's wellness, whether it is obesity, whether it is hypertension.

The research suggests and we think very strongly that there will never be enough resources to pay for enough ambulances at the bottom of the cliff. The real question to ask is: what went wrong in our service system that these children, families, young people got to that tertiary end? It really is a failure of the service system. It's not as if we don't have services out there. Something goes wrong if that child or that parent or that person gets to that hard end where they need an ambulance. That's the first thing.

The second thing is that the evidence at a population level that you can fix entrenched problems is very slim. That's not to say we shouldn't try to help

people and treat people et cetera. But at a population level there's not much evidence. They tend to be political solutions, not scientific solutions.

So all the research is telling us very, very strongly we need to start much earlier in the life course, much earlier in the cycle. We need to understand that all these conditions exist on a continuum and we need to make sure that all families and all children have the support that they need. If they do and if the service system is responsive so they do get the support they need at critical junctures that whole distribution curve will move over to the left and therefore reduce the number of children who need ambulances.

MR MOSHINSKY: Is what you are saying if we apply measures on a universal basis to the whole of the population the aim would be to move that bell curve to the left?

PROFESSOR OBERKLAID: Correct.

MR MOSHINSKY: Can I then show the next slide. It is headed "Rates of return to human development investment across all ages". Picking up some of the points you were making before, can you explain what this slide demonstrates?

PROFESSOR OBERKLAID: This is a slide that all of us use all of the time from James Heckman. James Heckman is an economist. When we talk about James Heckman we always preface it by "that Nobel Prize-winning economist". He won a Nobel Prize many, many years ago for something that I can't recall, very obscure. But he has looked at the data about children and problems and early intervention, et cetera. Simply on the basis of looking at data he now goes around the world - and he has a web site, and he's published books and articles - arguing that the best

economic investment that any country can make is in early child development.

So you wouldn't expect him necessarily to take a position on that, whereas I have a conflict of interest because I look after kids, you would expect me to. So this is simply on the basis of economic data. We have to be a little cautious interpreting American data to an Australian context, but I think it's a theme in every country in the world now that, even if you don't want to invest in children, the future prosperity of a country depends on increased investment in children, not just to prevent those problems that I mentioned earlier on but in terms of making sure that children grow up and become productive citizens and contribute taxes. It really speaks to the future prosperity and democratic institutions of any country.

MR MOSHINSKY: If we go to the next slide, then, could you explain what this slide depicts?

PROFESSOR OBERKLAID: This is a slide using English figures. Again, we have to be very careful transposing those to an Australian context. But if you look at the right-hand side of that graph, and you can do one bar even further, to keep one person in prison is - I don't know what it is in Australian terms, quarter of a million dollars a year; to keep a young person in trouble in secure accommodation; and as we go back in time the cost of intervention becomes so much less.

So providing intensive - we call it intensive care support to a family in crisis might be $10,000 or $20,000 or $30,000 or $50,000, and we have these arguments, "Well, we can't afford that. We don't have

enough services," and we will talk about services in a few minutes, but it is still infinitely cheaper than not doing anything and then trying to pay for the consequences.

The consequences for many of these children for many of these families are unemployment, welfare dependency, and many unfortunately do end up in prison. This starts early on. So we have Australian data. Across Australia, one in four children arrives at school vulnerable in one or more areas of development. In some communities it is every second child arrives at school developmentally delayed or vulnerable in one aspect of development. So these are children who are at significant risk of not fulfilling their potential.

What we are expecting schools to do is to compensate for what's happened in those first five years, and it is an extremely challenging task to do that, no matter how good the school system is. So when we talk about education and trying to improve educational outcomes, we are pretty silent about those first five years. We are still having debates about can we afford accessible high-quality child care, and that's what I meant by the elephant in the room. It really starts in those first five years of life.

MR MOSHINSKY: We can take down that slide, and can I now ask you about a topic of the role of universal services. Could you just give us an overview of what do we mean when we refer to universal platforms?

PROFESSOR OBERKLAID: Universal platforms are the sort of services that every child and every family has access to. Australia and Victoria are lucky that we have an

accessible high-quality system. So we are talking about maternal and child health nurses, child care, preschools, schools, GPs. These are non-stigmatising universal platforms that everybody has access to. Nobody, theoretically, is barred from access to any of these services by virtue of money or any other reason. That's what I mean by universal services.

MR MOSHINSKY: In terms of what the challenges are in terms of big public health issues, and I include here the issue of family violence, what observations do you have about how those types of issues ought to be approached given that we have a universal system but also some particular issues?

PROFESSOR OBERKLAID: I think it's the question that I posed before that by the time somebody ends up in needing family violence counselling, and I should declare I'm not a family violence expert, we could ask the question, "What happened?" It's not as if these children and families don't make contact with the service system. So young children, particularly in Victoria, where we have maternal and child health nurses, they make contact on numerous occasions with some of those universal services. Somebody sees these kids and families, and children don't go by themselves. A parent goes with them usually.

So I think we are missing opportunities early on in that sequence to notice that things aren't going right and to intervene then, and instead we are waiting until problems become so acute that they need these specialist services. The point that I made before is there will never be enough resources for ambulances at the bottom of the cliff. We could double or treble or quadruple the number of specialists, whether it's child protection,

whether it is mental health, whether it is family violence, and there still probably won't be enough.

So we really have to move that whole curve. We call it population - shifting the curve. At a population level we need to find out what happened to these kids and these families early on when problems perhaps weren't so intractable, weren't so entrenched, where intervention would have been simpler - not in all cases - and cheaper and more effective.

MR MOSHINSKY: In paragraphs 17 and 18 you indicate that the big challenge then is how to reconfigure the universal platforms to be able to identify risk factors and emerging problems and intervene early. You refer to extensive retraining and professional development so that every nurse and doctor is sensitive to signs, and you refer to service mapping. Could you indicate how do you think one should approach solutions to this problem? What do solutions look like?

PROFESSOR OBERKLAID: It's challenging. I guess we have come to the conclusion we have been working on these sorts of things for about 15 years in the centre, trying to look at ways of preventing and early intervention. Prevention is a very hard sell because it is invisible. You are really trying to glue up existing services.

But let me try to summarise that. Yes, there is a training and retraining agenda. I think that all universal providers - nurses, GPs, child-care workers, teachers - need to have some training in recognising family stress and the signs of stress and violence as well. But we can't expect everybody to become an expert. What we can expect, what we should expect, is each of

these providers to recognise that things aren't going particularly well and to refer early and know who to refer to.

So in every community there are lots of services. Victoria is really blessed compared to some of the other jurisdictions both in Australia and overseas. We have an existing service system. It's not as if we need more services. There's lots and lots of services. The problem is that support tends to be delivered in small silos. These services have grown up over a long period of time with very good intentions to address issues of the day, whether it is family violence, whether it is child protection, whether it is alcohol, whether it is drug dependence, mental health, et cetera, et cetera. That's good, and these are good people working in usually good programs.

The issue is that risk factors cluster together. If you have alcohol problems you may well have child abuse problems, you may well have other issues. So for many of the issues that families present to these professionals for they are outside the expertise of any one single professional. But, secondly, they are - we call them wicked problems because they are very, very complex. If a service has been developed to deal only with alcohol abuse or only with substance abuse or only with family violence, there's lots of anecdotal evidence of families being turned away because they have these additional problems. So that's the first thing.

The second thing is that we know that many professionals in the community aren't aware of the range of services that exist around them, and that's why mapping

is so important. Schools tend to still operate generally in isolation, and most services do. So the work we have done with communities is around helping them map the services around so that every professional knows where they can refer to.

The example I used in my submission, and I told you that my staff get sick of me giving this example, is you wouldn't expect a child-care worker or a preschool teacher to know what to do about persistent toddler sleep problems. But we know from our clinical experience that a child who keeps on waking up night after night, week after week, month after month causes a lot of stress in a family and can really tip a vulnerable family over the top.

So you wouldn't expect a preschool teacher to know what to do. They are not trained clinically. But you might expect him or her to notice that this mother or father, but particularly mother, is looking very tired these days and to raise the question, "Are you okay, Mrs Smith? You are looking really tired and stressed." "Oh, no. My toddler is up all night, and my husband is really angry and he's frustrated and he might lose his job," et cetera, et cetera. "Do you know that there is a psychologist" - or paediatrician or maternal - "just up the road. They can help you with your sleep problems. Would you like me to make an appointment for you? What about Thursday at 10 o'clock, does that suit you? Here is how you get there. The person is expecting you."

When the parent comes to pick up their child at the end of the day, "Did you keep that appointment? Oh, you couldn't keep it. No problem. We will make another one." So that's me as a universal provider. I'm not

trained to know what to do but there is an expectation that I identify that things aren't quite right and I know where to refer to because the community is mapped and I take responsibility for making sure that referral is kept. That's an organised community, and that's what we should be moving to.

We sometimes say advocacy with government. The challenge isn't more; the challenge is about different. We don't need a new service, or a yellow one instead of a green one. We need the glue to glue together the existing service systems so there are no wrong doors. So everywhere a child and family make contact anywhere with a service system, whether it is MCH nurses or child care or school or a paediatrician, "You have come to the right place. I can't help you, but I recognise you have an issue and I will take responsibility for referring you to somebody who can help you." That's an organised system.

MR MOSHINSKY: Can I perhaps then, just picking up that theme, show you some slides that you have provided and ask you to speak to these slides to draw out some of the points that you have made.

PROFESSOR OBERKLAID: This is a fragmented service system metaphorically or symbolically. We say it's different colours, different shapes, different sizes. Navigating your way around that system is a challenge. A colleague of mine says you need a university degree to find your way around. We are dealing with vulnerable families here. So there are wrong doors everywhere there.

MR MOSHINSKY: So then if we go to the next slide.

PROFESSOR OBERKLAID: This is the mapping we did in Doveton. The background is just a graph or just a diagram of all

the services there. This is a close-up, the one that comes out at you. The crosses are where one service links to another service. So it's a very good example of services delivered in isolation with very little collaboration, and our experience is that many of these services aren't even aware of the existence of other services, let alone use them in a collaborative way.

MR MOSHINSKY: Then if we go to the next slide, it is headed "Blue Sky Project". What was this project about?

PROFESSOR OBERKLAID: This is a project we did in Melton in conjunction with the government, with the department, where we actually mapped existing services. This is a complex slide. We actually mapped a child's journey negotiating between health, education and welfare. You can't see the detail there, but there's barriers all over the place. There is duplication, you need new referrals, there's waiting lists, on the other side of town, parents don't keep appointments.

So it's not as if we need new services. The services are there. In all but the most isolated towns there are lots of services. We need to reconfigure them in a different way so there is no wrong doors.

MR MOSHINSKY: If we go then to the last slide, what does it depict?

PROFESSOR OBERKLAID: Again, this is a diagrammatic representation. So we have tried to group the services with one entry point, and this is a no wrong door. Everywhere you make contact with the service system, "I don't know what's going on with you, but I will help sort things out. Then I will know where to refer to."

It's very easy to put in a diagram like that, but

it is very, very challenging work because these are services that are funded by Federal Government, State Government, local government, philanthropic, for profit, not-for-profit, and each of these providers individually does a very good job but they are not part of a system and they have different awards and different training and different language, et cetera. So pulling those together is a very challenging task. I don't for one moment want to think it's simple.

MR MOSHINSKY: Another point you make in your statement is that part of the solution, I think as you see it, is the notion of tight loose controls. Would you be able to speak to that concept?

PROFESSOR OBERKLAID: Traditionally policy and programs, not only in this jurisdiction but everywhere in the world, it's usually top down, that the government decides we need to address family violence or child abuse or language disorders or mental health; they make an announcement, which is usually money terms, $10 million, $20 million, $50 million; we will have this program that everybody will use or we'll employ some more social workers, et cetera; and that doesn't work or it rarely works because every community is different in terms of its demographics, its service mix, its aspirations, its resources.

So the cutting edge of service reform is very much having communities participate and co-design the services they need. So tight loose controls means that the government negotiates with a community to improve that and reduce that and change that, are very tight on the expectations they have to the community but are loose on inputs. In other words, they allow the community to

decide how best to spend that money to achieve the outcomes they want.

So even in a disadvantaged community - quote, unquote - there are neighbourhoods where kids are doing better than expected and there are other areas where kids are doing worse than expected. So what is it about the characteristics of that particular community where children are better or worse than you would otherwise expect? The community probably knows why, and if you give them the resources to fix up or reduce the chances are they will deliver a much better product than central government. In other words, the closer you get to where the problems are, the more likely it is that you will know exactly how to fix them.

MR MOSHINSKY: There is just one other point I was going to ask you about, a particular matter, which is the maternal and child health program. We will be hearing more about it later in the day, but could you just give us an overview of how that program works?

PROFESSOR OBERKLAID: I think in my submission I said that was the jewel in the crown of Victoria's system, and it is. When I go overseas and talk about our service system here and say we have a statewide system of maternal and child health nurses, located in the community, co-funded by central government and local government, free, highly trained nurses, they don't believe that I'm saying that.

So it's a fabulous system. It's evolving with the times, perhaps not as fast as many of us would like, but they make contact with about 98, 99 per cent of all families, all children after birth. There's a legal requirement that the maternal and child health nurse gets

notified after the birth of a child. They do a home visit within two or three weeks. Then the parents can take that child on a regular basis to the nurse to weigh, measure, get advice about various health issues.

There's also what's called an enhanced visiting program in Victoria. So families deemed at risk have more than one home visit. I can't remember the exact number, but they can be visited by that nurse on numerous occasions. That's really in order to build a relationship, and that's again a very strong part of the universal system. So the nurses are well trained in child development. They develop good relationships mostly with the parents. They are in an ideal position then to refer early once the risk factors become apparent or once signs that things aren't going really well become evident to her.

MR MOSHINSKY: Thank you. Commissioners, those are my questions. Do the Commissioners have any questions?

DEPUTY COMMISSIONER FAULKNER: Professor Oberklaid, I will go back to the graph with the bars that show the cost of early intervention versus tertiary interventions. As I understand the objection to that thinking, is that with a universal intervention you are spending that on many, many families and with the late intervention you are spending it on fewer families and hence the overall cost is less. Is that still an argument that's made and do you have a response to that? So that if the cost is 1/20th at the early stage but you have to spend it on 200 families, then the load on the budget is much higher; is that still the argument that's made, and what is your response?

PROFESSOR OBERKLAID: Waiting until problems become established

and then trying to treat them isn't effective. We have done that for the last 100 years. We have targeted disadvantaged communities, we have targeted families with problems. There is no evidence to suggest that a new program or doubling the amount of money is going to work, when all the research evidence is suggesting that many - probably most of these problems are amenable to early intervention.

We have pretty good research evidence now of how to be building that fence, and stress exists on a continuum. So the families on the left-hand side there - the majority of families do fine, they will use the existing service system. They just need reassurance. They can find their own information. There's no particular family stresses. That's the cheap end of the spectrum. We call this universal plus or proportionate universalism.

Then you keep on adding to families all that they need to support their children and create a nurturing environment. There are those families at the right-hand side of that graph that we call the intensive care of support. They cost a lot of money, but it is still cheaper than waiting until somebody is in prison or the young people turn to drugs, et cetera, et cetera.

The evidence is so abundant now about these pathways to later problems it's not contestable. There's not much evidence that at a population level trying to fix up problems once they are entrenched is all that effective. So if we follow the research evidence and try to ignore ideology, try to ignore what we have done previously, the research would suggest we have to start

early in the pathway, because our intervention is cheaper, the problems aren't entrenched so intervention is often more straightforward, and certainly more straightforward than waiting later in the life course.

DEPUTY COMMISSIONER FAULKNER: Thank you.

COMMISSIONER NEAVE: I have a question. There has been experimentation with a number of methods for dealing with the issue of the wrong door in the area of family violence. There are a number of multi-disciplinary centres, so a person can go to a centre and at that centre there will be people with a range of expertise who could help - drug and alcohol issues, specific family violence issues, legal issues and so on.

The other method has been outplacing. The Women's Hospital, for instance, they have a lawyer who goes in to help people with legal problems a couple of days a week; some of the police stations now have a social worker there. Do you have any views about these two approaches, which of the two might be better, or do you need a mix of both if you are trying to address the wrong door issue? That's not quite what you are talking about, because you are talking about universal service providers sending you off to the right person being able to recognise the problem. But I wondered if you have any thoughts about these particular strategies?

PROFESSOR OBERKLAID: I think they are both innovative. It is not my area of expertise, so I can't give you an informed answer. The problem is we call this - just because services are there doesn't mean that people use them, and we call this the inverse care law academically. There is lots and lots of evidence that those who would benefit the

most are the least likely to use those services. So just because you have a multi-disciplinary centre there doesn't mean you capture 100 per cent of people who are there.

Another term we sometimes use is these are children and families that live in double jeopardy. They are at risk because of various biological, environmental factors, but these are children that would benefit the most from high-quality child care, are the least likely to go. These are families that would benefit the most from support, the least likely to get them. Just because you have those sort of programs doesn't mean that people use them.

Having multi-disciplinary, multi-professional centres like that is certainly better than our traditional approach of having silos. But the question is: how do people get there? That's what I was saying about universal services, that everybody in a community at some stage will make contact with somebody - GP, nurse, child care, preschool. All kids go to school, and I haven't spoken much about school.

School is the ultimate universal hub. The school as a core community centre, it has just huge, huge potential. Imagine if there was a person in every single school whose sole responsibility it was to be a support or identify kids and families that were vulnerable or not quite making it and whose job also it was to have mapped and know all the existing resources in that child's community, and whose job it was to be linking up children and families not just with education department services but also with services in the community. I think you would see vastly improved educational outcomes in that

context for these kids rather than focusing only on teacher quality or only on the curriculum.

COMMISSIONER NEAVE: It has been said on numerous occasions that even when you have referrals there is often nowhere to send a person because some services, particularly services in the area of family violence, are very heavily overloaded. I wondered if you wanted to comment on - - -

PROFESSOR OBERKLAID: I'm sure that's right. Mental health services are similar. Many of these tertiary services have long waiting lists and unarguably need more resources there. But just more tertiary services alone isn't going to solve problems long term, because there will never be enough resources.

So again there's this question we keep on asking ourselves as paediatricians: what went wrong in the community that this child needed tertiary care? What went wrong with this family that they needed to end up with mental health or drug and alcohol services or family violence services? What points of intervention did we miss somewhere along the line where we could have intervened at an earlier stage? There's no simple solutions to that. They are very challenging questions.

COMMISSIONER NEAVE: Thank you very much.

MR MOSHINSKY: If there are no further questions, I ask that Professor Oberklaid be excused.

COMMISSIONER NEAVE: Thank you, Professor Oberklaid.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: I appreciate it is early in the morning, but because the next witness has to be lined up by videoconference we might take the adjournment now, if that's okay, for 15 minutes.

(Short adjournment.)

MS DAVIDSON: Commissioners, we have a panel of four experts next. We have Professor Kelsey Hegarty from Victoria, Dr Brigid McCaw, who is joining us from California via videolink - can you hear us, Dr McCaw?

DR McCAW: Yes, I can.

MS DAVIDSON: We also have two experts from New Zealand, Helen Fraser and Miranda Ritchie. I will ask that each of the witnesses be sworn, perhaps commencing with Dr McCaw.

<BRIGID REGINA McCAW, affirmed and examined:

<MIRANDA SALLY RITCHIE, sworn and examined:

<HELEN JANE FRASER, sworn and examined:

<KELSEY HEGARTY, recalled:

MS DAVIDSON: Thank you. Perhaps if I start with you, Professor Hegarty. You are a Professor of General Practice at the University of Melbourne and a practising general practitioner in Clifton Hill?

PROFESSOR HEGARTY: Yes.

MS DAVIDSON: You are also director of the postgraduate primary care nursing course at the University of Melbourne. You lead an abuse and violence and primary care research program, and your current research focus includes the evidence base for interventions to prevent and respond to violence against women, educational and complex interventions around identification of family violence, including perpetrators and primary care settings, and responding to women and children exposed to abuse through primary care and the use of new technologies; is that correct?

PROFESSOR HEGARTY: Yes.

MS DAVIDSON: You have made a witness statement for the

Commission?

PROFESSOR HEGARTY: Yes.

MS DAVIDSON: You have previously had a witness statement that we have tendered, but you have made a further witness statement for the Commission in relation to these areas; is that correct?

PROFESSOR HEGARTY: Yes.

MS DAVIDSON: Are you able to confirm that that witness statement is true and correct?

PROFESSOR HEGARTY: I am.

MS DAVIDSON: Can I turn then to you, Dr McCaw. Perhaps can I ask that you just outline your role and where Kaiser Permanente fits within the sort of medical system or health service system in the United States?

DR McCAW: Sure. It's not entirely simple. As you know, our health care system is quite complicated. I am a practising internal medicine physician, and I lead our family violence prevention work for the northern California region for Kaiser Permanente. Kaiser Permanente is a not-for-profit health care organisation that we've described as being fully integrated, meaning that it includes inpatient/outpatient care, mental health services, laboratory, radiology, pharmacy and so forth. We have about 18,000 physicians who work for Kaiser Permanente in total. I'm one of those doctors in northern California, where we have about 8,000 physicians. In northern California we have about 46 clinics and a number of hospitals. Kaiser Permanente is one of the health insurance choices in the states in which we are located.

MS DAVIDSON: You have made a witness statement for the Royal Commission?

DR McCAW: Yes, that's right.

MS DAVIDSON: Are you able to confirm that that's true and correct?

DR McCAW: Yes.

MS DAVIDSON: Just in relation to the work that you have done in relation to the area of family violence, can I just ask you to briefly outline the program that you are involved in in relation to addressing family violence within the Kaiser Permanente system?

DR McCAW: I would be happy to. The program that we developed is called the family violence prevention program, and it started in the late 1990s, and initially the focus was on intimate partner violence. We learned, as I mentioned in my statement, early on that just simply training clinicians boosted awareness but didn't necessarily lead to any long-term behaviour change on their part.

So using the research that's been done in the public health arena about systems model we decided to adopt that for the issue of family violence. What I mean about the systems model that we use is that there are four key components that has to do with the physicians, the training, the enquiry and referral. Another element has to do with creating an environment called the supportive environment so that patients who come into the health care setting will feel comfortable disclosing. Another element is having on-site response, and then the fourth is community partnerships.

So what we set about doing was making use of the entire health care environment and implementing that approach in all of our facilities. So what I do is lead the physician champion and multi-disciplinary team at

every facility, whose job is to put that systems model in place in their particular clinic.

Then we have metrics that help us track how we are doing implementing that and then also how we are doing at increasing the identification of our patients - we call them "members" - who are experiencing intimate partner violence. The systems model turns out to be a pretty robust way of engaging the health care environment. So we have seen marked improvement in identification and follow-up.

MS DAVIDSON: Thank you, Dr McCaw. Perhaps if I can now move to Ms Fraser and Ms Ritchie from New Zealand. Perhaps if I start with you, Ms Ritchie. Can you outline what your role is and who you are employed by?

MS RITCHIE: I am the National Violence Intervention Program Manager For District Health Boards contracted by the Ministry of Health to support the implementation of child and partner abuse intervention, and our district health boards. Previously to that role I worked as a senior emergency nurse in both New Zealand and in the UK.

MS DAVIDSON: Perhaps, Ms Fraser, can I ask you to outline what your role is?

MS FRASER: I'm the Portfolio Manager for the Ministry of Health in New Zealand. I look after the Violence Intervention Program - that is a national program - and all of our DHBs. It concerns identification of family violence and child abuse and neglect. I'm also the issues lead for the Ministry of Health on pretty much all the family violence matters across the ministry.

MS DAVIDSON: Ms Fraser and Ms Ritchie, you have made a joint witness statement for the Royal Commission; is that

correct?

MS FRASER: Correct.

MS DAVIDSON: I will ask you first, Ms Ritchie, can you confirm that the witness statement is true and correct?

MS RITCHIE: Yes, it is true and accurate.

MS DAVIDSON: Ms Fraser, can you confirm that it is true and correct?

MS FRASER: Yes, it is true and correct.

MS DAVIDSON: That witness statement was also made together with Dr Toohey. Is one of you able to outline what Dr Toohey's role is?

MS FRASER: Dr Toohey is the Chief Adviser, Child, Youth Health for the Ministry of Health.

MS DAVIDSON: Perhaps before we go on to the sort of programs that you have all implemented, there was an issue that Professor Oberklaid identified about using schools as hubs and having a potential specialist in a school in order to identify vulnerable families and to work with them. Ms Fraser, I understand that there may be a program similar to that operating in New Zealand?

MS FRASER: This is not due to my current role. This is from a previous life that I had when I was working at Child, Youth and Family, which is the statutory agency or government agency that looks after children that need to be taken into care. In my role when I was working with them we had a program called Social Workers in Schools, and all low decile schools - I think it's from one to four decile schools - and high-deprivation areas had a social worker in their school.

The role of the social worker was - they were employed by an NGO, a non-government organisation, but

funded by the government. They were situated at the schools. They had their own office at the school. Their role was to engage with families or children that were struggling at the school or they were having difficulties at home.

So there could be a referral from a teacher to the social worker in the school. If they had concerns about a child maybe coming to school with no lunch or bruising, no shoes, never coming to school, falling asleep at school, bad behaviour within the school, they could make a referral to the social worker. The principal could make a referral to the social worker or the social worker might actually notice behaviour either from the parents or from the children themselves.

They would then engage with the family and work with them. They would be a key point for that family. So they would design - if the family were willing to engage, they would do a plan with them, sit down and see what their needs were, assess their needs. From there they would act - they would walk alongside of that family to access those needs. So they would advocate for them if they needed health services. If they needed extra supports for their children in school, they would advocate for them on that. They would get them into other supports - budgeting advice if they needed it, alcohol and drug programs - and the whole time they would keep the headmaster informed of what was happening.

They also worked very closely with Child, Youth and Family, so if they had concerns about a family or a child that needed to be elevated to Child, Youth and Family, have state intervention, there was a protocol that

they could refer irrespective of whether the principal or the teacher felt that it needed to be elevated. They could actually refer straight through to Child, Youth and Family because the paramountcy of the child principle gave them that right to do that. But generally it was always in conjunction with the principal of the school because at the end of the day the teacher and the principal are the ones still left facing that family each day.

So they worked very closely with Child, Youth and Family and other agencies within the community and with the school. It was having some really great success and fixed some very hard-to-reach areas. Some of the families were finding them a central point, I guess, when they felt they had sort of been pushed around from pillar to post, where there was no one central place where they could get the supports that they needed.

So, rather than having to go to different NGOs the whole way around to get the different supports, they could go with the social worker and the social worker would help them make their appointments, try to see if they could get all the support from one place or minimise the amount of time they were going from one place to another to another to another to another. So it has been really successful.

When I left there quite a few years ago they were thinking about rolling it out to - I know they had some pilot in high schools - I think they were called "MASSIS". But I think they were looking at rolling it out to all high schools. I don't know if that's actually happened. I haven't kept up with that, sorry.

COMMISSIONER NEAVE: Can I just clarify one piece of

terminology you used. You referred to certain kinds of schools, and I wasn't quite sure. You were talking about primary schools, as I understand it.

MS FRASER: Primary schools. Low decile, which means that they're - - -

COMMISSIONER NEAVE: Low decile, I'm sorry.

MS FRASER: It's the accent.

COMMISSIONER NEAVE: So low socioeconomic status decile.

MS FRASER: Correct.

MS DAVIDSON: Just to clarify, the New Zealand education system runs on a system of a 1 to 10, is it?

MS FRASER: Yes.

MS DAVIDSON: Decile system.

MS FRASER: Of rating for the school.

MS DAVIDSON: That's a rating depending on the socioeconomic makeup of the school.

DEPUTY COMMISSIONER FAULKNER: You said the bottom four deciles, didn't you?

MS FRASER: Yes, one to four.

MS DAVIDSON: Now if we turn to the issue of the health system. Perhaps if I could start with you, Professor Hegarty. Why should we respond to family violence in health care settings?

PROFESSOR HEGARTY: We absolutely know that family violence is a common hidden problem across a lot of health settings. We know there are barriers for doctors, nurses and other health professionals to be asking, and for women and children in the main to be disclosing. We also know that it damages the health of the community as a whole. So people who are using violence, often in the main men, are also having health issues that present to a variety of

health settings.

But we know it has a broader impact economically, socially, across the whole community. VicHealth did a lovely study quite a while ago that said it was the leading contributor to death, disability and illness for women of child-bearing age. I remember being a touchy-feely mental health GP in Brisbane and heard the figure was around one in four, and even when I came here and heard about the leading contributor by then I had been doing some research, but it's still hard to confront as a general practitioner or as a health practitioner that you are missing this whole area underlying many of the health issues that present both emotionally in terms of depression or anxiety or not sleeping or suicide, or physical issues such as chronic pain, chronic diarrhoea, chronic headaches, all a spectrum of physical things that are a consequence of family violence in both children, young people, women and men.

I think that it means that we think of the black eye or the injury, and that's probably presentation that occurs in emergency departments. But in a lot of other areas it's much more hidden. So I think it's been 20 years of my research and practitioner life to come to this year where we have got such a focus on it.

MS DAVIDSON: Dr McCaw, what led you to be involved with the - why did Kaiser Permanente implement a program? Particularly when you are in a private hospital or a private health system, what led you to consider that it was important to tackle family violence in health care settings?

DR McCAW: One of the things that is unique about Kaiser

Permanente is that there is a very strong commitment to prevention. We have been able to achieve quite a bit in certain areas - for instance, obesity, hypertension, cardiac disease. But the research, and Professor Hegarty has contributed a lot to this research base, became clearer about the prevalence of domestic violence and the associated health and psychological issues. I think also Professor Oberklaid mentioned that health care is one of the key places that everyone intersects in their life, and for women it occurs multiple times, and for children also.

So the commitment was to a condition that was becoming clearer and clearer both prevalent, associated with a lot of health care problems and also with health care costs, both short term and long term. I think those are the primary reasons that as a health care plan there was a commitment to it.

But I have to say that there was a long period of time when many of the professional health care organisations - the American association of obstetrics and gynaecology, of paediatrics, of emergency medicine - had been calling for routine screening and enquiry and intervention. So it went along with what was also being called out as an important area for professional health care workers, nurses and physicians to pay attention to.

MS DAVIDSON: Perhaps I can turn to Ms Fraser and Ms Ritchie, and I will refer to both of you. You choose who answers the question, perhaps. New Zealand began work on this and ended up rolling out a program nationwide, started working in the early 2000s. But you identify in your witness statement that there was a catalyst of a very tragic event. Can you outline what the sort of catalyst was in

New Zealand that resulted in the work that has been done?

MS FRASER: I will start and I might let Miranda fill in the blanks. Miranda actually worked down there in the hospital where this significant event happened. It was the death of a little boy who was four years of age, and a review of the - a review was requested. What was found was he had gone through a lot of health and social services. He had had contact with a lot of agencies during his time and nobody had picked up that this child and family were in trouble, basically. But I will let Miranda talk to that. She knows more about it.

MS RITCHIE: The review identified that he had been through 40 health services. He had had 40 contacts with health practitioners and four presentations to hospitals.

I started working in the hospital concerned after the review had been released. The Children's Commissioner conducted I think it was - my understanding is it was one of the first independent investigations which identified systems issues across a range of services, including health and the social services, and basically from that there was a multi-ministerial inquiry and recommendations for all services, and one of those was for health.

It was identified within the investigation that clearly there had been extensive physical abuse of this little boy, but also the mother had experienced partner - extensive partner abuse as well. So from the health service it was - guidelines were developed around how the health service response would be. Based on what we know about the co-occurrence of child and partner abuse, it was identified that our intervention within health would have both an intimate partner violence or

partner abuse response linked and integrated with a child abuse and neglect response. So that's where the family violence intervention project within the Ministry of Health was initiated in 2002.

It is recognised that both forms of abuse are really common, have long-term negative health effects, as already has been identified, but also that, as has also been identified, we have unique access to provide support to families that come through our services.

MS DAVIDSON: If I perhaps read from paragraph 12 of your statement, which has an extract of the recommendations. It talks about James having been seen 40 times by health practitioners; four presentations at hospital emergency department; two admissions and one outpatient clinic; three face-to-face Plunket, which is a child infant support service, contacts; and 30 visits to general practitioners at four practices. Collectively the health sector had available a telling picture of James's circumstances. This picture was never put together because of poor communication between practitioners, information was not passed on or was incomplete, previous records within the same hospital or practice were not viewed and where James was not known, and records suggest that social and medical histories were not sought or provided. Some individual practitioners appeared to be unaware of signs of possible risk.

I understand that the health side of this was part of a broader response by the New Zealand government to family violence. Can I ask you to just speak to that?

MS FRASER: The government at the moment has recognised not just the health impacts but the social impacts of family

violence upon society and the individuals within that. They also have a very targeted response to child abuse and neglect, and ensuring that children have the best start possible to life.

So currently at the moment we have what we have called better public services targets, where the government has made every government department responsible for I think it's 10 targets, and one of those is around vulnerable children and preventing or halting the rise in child abuse. The other targets are reducing crime, reducing - what are the other ones? Sorry, I'm just trying to think off the top of my head. But they are all reducing the top factors, like getting back into employment again, keeping people employed.

So they have a real program of work happening, and everybody has to buy into this. It's not acceptable, for example, for Health to say, "Actually, that belongs to Child, Youth and Family," or Justice to say, "Actually, that should belong to Education." It's everybody has a part to play in this. So it's very wide reaching. It's still ongoing.

We are looking at what is family violence - actually defining family violence, looking at its reach, looking at how do we all work together and prevent the siloing that goes on. Ensuring that information is shared is a big one for us. We are still finding that there are silos, that people are nervous about sharing information in case they breach the privacy laws or think that somebody else is doing the work and don't bother - it's not that they don't bother; they don't think to follow up with that other person to ensure that

work's being done and then that person is not aware that they are supposed to be doing something.

Children, we have a big focus on certainly under twos and then up to school age. So we have programs in place where children - all children should be attending preschool, early education where possible. We have a raft of initiatives such as - I have a big list of them here. We have social sector trials that are happening where NGOs and government departments are all linked up and working together out in the community. We have services mapping happening, or has happened, actually, by the Ministry of Social Development. So you can look up who all the agencies are in your area and you are able to see what services that they provide for you.

We have Gateway at the hospital, which is a multi-disciplinary team, or is it purely a - no, Gateway multi-disciplinary - we have education, health and children in care are able to be referred into it where they have a thorough health needs assessment. We have Whanau Ora programs, which are run by NGOs, that are supposed to be a one door in, and then that agency again will work with that family to get them the services and supports that they need.

So there is a huge range. There is a big program, a very big program. I think we are still sort of in its infancy in terms of outcomes, but it's moving ahead at full steam. Everyone is involved in it. So it's great.

MS DAVIDSON: Perhaps I could turn to you, Professor Hegarty. You have done quite a bit of work in relation to working with health professionals in Victoria and the health

profession in terms of family violence. Can I get you to outline what sort of work you have done and where you see Victoria is at in terms of that work?

PROFESSOR HEGARTY: Okay. I will start with the general practice practitioner work, and obviously there's a large number of general practitioners who work in this state, but obviously because it's Medicare funded it's got a Commonwealth part to it as well. But we did a large randomised controlled trial of trying to do an intervention in general practice where we screened 20,000 women across 55 general practices, and we found 12 per cent of women were afraid of their partner in the last 12 months.

We then invited some of those women - and obviously some people didn't answer the screening questionnaire and some people didn't come into the trial, so we ended up with much smaller numbers. But essentially that training was to get general practitioners to deliver a first-line and an ongoing response. As part of this I want to make clear, because I think maternal and child health nurses and general practitioners are in different categories to teachers and Centrelink. They have some skills, and so, as Professor Oberklaid laid out this morning, getting people who are not sleeping by a teacher to a school. But, really, I think when we are dealing with health practitioners they have to give a first-line response.

So what we taught the GPs to do was essentially the World Health Organization recommendations of a first-line response, which is, once someone is identified, to listen, inquire about their needs, validate their

experience, enhance their safety and ensure ongoing support. It's got a mnemonic of "LIVES", and I think that that's easy to remember because we are trying to save lives. I have also done that work with maternal and child health nurses and also antenatal midwives.

I think the idea that a health practitioner could just identify and refer - if you role play it, it looks ridiculous, "Thanks for telling me. We would like you to go over here," because there has to be obviously more than that and there has to be a basic safety assessment.

So when we taught GPs that as well as to - under the mental health care plans that exist to see them in an ongoing way we found that women were less depressed. So we certainly know that we can - and when women are less depressed they take further actions often to keep themselves and their children safe. So that was quite a large piece of work that we did about that.

We have also done some work that's probably a decade old with the Mercy Hospital for Women. Do you want me to talk about that now?

MS DAVIDSON: Yes, that would be useful.

PROFESSOR HEGARTY: This was in conjunction with La Trobe University and the Mother and Child Health Research Centre and the Department of General Practice at the University of Melbourne. We were funded through the Department of Health to have a look at particularly what the antenatal clinic at the Mercy Hospital for Women could do. At the time we didn't elect to go with screening for psychosocial issues. We didn't feel there was enough evidence. So what we wanted to do was actually change the culture and the system of the antenatal clinic at the time.

I think we have heard throughout the Royal Commission that people have mentioned that often there's a biomedical focus in some maternity hospitals, and there was probably to some extent - it was a decade ago - a bit of a focus on that. So we were trying to shift them to a psychosocial focus.

What we did is we actually invited all the midwives at the time, which was around 25, 27 I think practitioners who were working consistently in the antenatal clinic, and we did a very intensive training program basically to shift how they saw - at the time they did have some risk screening so, "Do you smoke? What's your family history? Are you a domestic violence victim? Almost. Right, okay, next." A bit of a checklist approach, and none of us would be suggesting anything like that. Many practitioners at the time weren't using it that way. But some people saw - they hadn't had any training; they were trying to use a checklist approach.

So we did an intensive communications skills. We had strong management support, which is something we will all talk about as a system, to the extent that nurses were released in overlap of shifts to go to the training. It was over a six-month period. It ended up being about an hour in a week. So it was very intensive. There were four two-hour programs. Then they had peer support in small groups where they could get together and talk about cases in an ongoing way.

Really we know that training always changes self report. So everybody is more confident. Everybody likes it. Everybody thinks they would recommend it to others. Everybody's confidence tends to go up. Everybody's

awareness goes up. I think Brigid was saying before that, really, that's not sufficient; we know that's not sufficient.

So in this case we were also trying to change the system where people would be aware that some practitioners might need to take a bit more time; so time is an issue. So what we heard was that people would say - the project was called A New Way to Support Women in Pregnancy, and for short A New. People would say, "She is taking a bit longer because she is doing A New work," the same as if there was an emergency with a postpartum haemorrhage or bleeding after birth. So in fact we did succeed in changing certainly the culture in the antenatal clinic at the time, but with very strong management support.

Then we looked at women's outcomes. This wasn't a randomised control outcome. It was a before and after. We surveyed around 600, 700 women before and 600 or 700 women afterwards. Essentially they weren't the same women, but we were within a year of each other and we were looking at outcomes for women around feeling comfortable to discuss psychosocial type issues.

Certainly what we found - and I will just look at my report - was that women were significantly more likely to report if midwives asked questions that helped them to talk about the problems and more comfortable to discuss a whole range of issues, and they were also more comfortable to discuss with doctors concerns relating to sex or their relationships. So we saw this as a very positive thing.

We did do some Train the Trainer. I trained some midwives to roll that out across Sunshine and the Barwon area in around 2004, and it was also transferred to some

postnatal midwives by the La Trobe University midwife group who was working with us. Again for that they only looked at the health professional self-reported changes which, as I said, are usually always positive for any decent training program. But they didn't look at women's outcomes.

Then I didn't hear anymore about this program. The Mercy Hospital for Women was moving. Just soon after that I think the government changed. The personnel changed at the Mercy. I don't currently know what's happening there. I think they have got quite a strong mental health program.

I could also talk about the MOVE program on behalf of Angela Taft which is with maternal and child health nurses, or I could do that later.

MS DAVIDSON: No, it would be useful if you talk about that now.

PROFESSOR HEGARTY: The MOVE program was led by Professor Angela Taft from La Trobe University mother and child health research. I was on it, and Cathy Humphreys and others as well. They were very interested in looking at whether maternal and child health nurses could be enhanced in this area. This was probably about six or seven years ago. Just as they were about to start quite a large trial to maybe even introduce screening, screening was mandated in Victoria for all maternal and child health nurses to screen for partner violence at four weeks as part of the key stages and ages program.

So that meant that we couldn't have a control arm that weren't screening. So then we changed what we were doing and in particular we were looking at could we see

whether screening was sustainable over time and what was different if you implemented a systems type model.

So essentially with MOVE the focus was on whether a theory informed - and there are some complex theories, because these settings are really complex; hospitals are really complex settings, and maternal and child health nurse clinics are similar. So we used a normalisation process theory which has been used in cardiac disease and other diseases to change programs in hospitals. We also know that interventions that are informed by theory are more likely to be enacted.

So we were looking at whether also involving the maternal and child health nurses themselves in designing what went on. So I think Frank Oberklaid was talking about working with communities, but this was working with the maternal and child health nurses to say, "What would you like? What would you like?"

What they wanted was some clinical practice guidelines. They wanted flowcharts. They wanted the protocols, which you will talk about a lot and so will Brigid. They wanted things that would give them some more structure. Some of them had had the Common Risk Assessment Framework training and had benefited from that. But they wanted additional training as well. They wanted to have some nurse mentors and support.

So really they came up with the things that are often in a system model. It's hard to do this work. Obviously some of them may have actually experienced violence themselves; so this idea that you need mentorship and support for the health professionals.

There was also a self-completion. So the

patients self-completed a maternal health screening checklist. The nurses wanted that at three or four months consultations in the intervention arm. At four weeks they thought it was too early to try to screen. The mother is worrying about the baby and the breastfeeding and she's just coping after birth, and it was very hard to pack the screening into that time. So they really got the women to fill out some questions prior to it. So that's quite a number of interventions that the nurses came up with themselves.

Unfortunately, the intervention didn't find any significant difference in screening rates between the intervention arm and the comparison arm using the routine data that is collected. That's similar to systematic reviews. The level was around 20 to 30 per cent. Systematic reviews, if you say to a whole set of health practitioners, "You screen," about 20 to 30 per cent of them will do it, and that's been found in quite a number of studies and when you pool it together. So you need more than that. Even though we had more than that in that, we didn't make a difference to the screening rates.

The referrals remained low in both groups. But safety planning rates were much higher. So what they were doing with the women that they were screening and identifying, they were doing some safety plans with.

So I suppose the message from this and from A New and from even WEAVE is that it's actually very difficult to make changes in health practitioner behaviours that result in women's outcomes. The point I was going to make before is that we need to be very careful because if we just follow a group of women - and we know this from

trials. Say we are doing an intervention in this arm and we are doing a comparison usual care, and we follow the women over time, say, with violence. Both groups the violence goes down. So if we were just doing a before and after we would say that we had improved because the violence went down. But in fact in almost every usual care arm the violence goes down. So I think we need to be very careful even if we are using before and after.

I'm not speaking about the Women's, because they are coming after us, but of course there's an enormous amount of work that has been led by the Women's. They've had a violence against women strategy for over a decade. They have had various projects and I'm really not going to speak about those in any depth because I know they are speaking after this. They have had the Acting on the Warning Signs, which was very successful training. Again the health practitioners showed a difference. The co-location of the lawyer really helped referrals from social work to there. Again it was hard to increase referrals from health practitioners. They have recently had the Strengthening Hospital Responses, which someone is going to speak about.

But again it's the same message. They have had strong management support. They have had in some ways short-term - 12 month or two year are short-term to make changes, external money or Department of Health money. I feel like all these projects, if we just sustained them in a longer term project and evaluated it well we could really - we are on the brink of having a really good system model, and certainly the Women's would be a very good place to trial that.

MS DAVIDSON: Thank you. Perhaps can I turn then to the two jurisdictions that have implemented a more detailed systems base model. Dr McCaw, can I just ask you to first identify what type of family violence your model at Kaiser Permanente is targeting and in which health care settings are we talking about; just hospitals or what sort of settings are you talking about within Kaiser Permanente that these systems have been implemented in?

DR McCAW: The initial focus and the main focus that we have data for in Kaiser Permanente has been intimate partner violence. The last four years we have expanded to begin including child abuse prevention and we are on the brink of moving into elder abuse.

The idea was that we would make enquiry about intimate partner violence part of everyday work in every part of the health care setting. So that means in hospital, it means in primary care, it means in the emergency department, in paediatrics. The idea was to help clinicians feel more comfortable knowing how to ask, how to respond and then how to make appropriate referrals.

So our mantra has been to help the clinicians know how to - making it easier for them to do the right thing; and it isn't easy. But I think our work has been to try to go for that goal.

It's been helpful to have quality metrics. I think when Kelsey talked about having managerial support that has been very important, but also having data that allows you to feedback where there's been success and progress has been one of the reasons that we have been able to sustain our work over the past 15 years. So this idea of executive sponsorship, of managerial oversight, of

making it part of the everyday workflow and then being able to show where you are improving and where you are not so that you can focus your work has been an important element.

In Kaiser Permanente there's a lot of focus, as there is in most health care systems, on quality improvement metrics and using the tools of quality improvement for other health care issues - diabetes, depression, asthma, cancer et cetera - and we have applied those tools to the issue of partner violence, and I think that has served us well.

MS DAVIDSON: Perhaps then I can turn to the New Zealand witnesses.

COMMISSIONER NEAVE: Counsel, just before you do that, I just wanted to explore that issue of quality metrics. Is that based on the report of the patient or is it based on the report of the professional? How do you measure quality in this area?

DR McCAW: It's not simple. But what we do is help our clinicians know how to ask questions in a way that fits with their practice. When a patient discloses that they are experiencing abuse by answering a question like, "Are you being hit, hurt or threatened? Are you frightened of your partner," then we ask the clinician to document that as part of the progress note and in the medical record. So they are able to document that the patient is experiencing domestic violence or partner violence, and those are the data that we then collect and feedback to our departments to show them whether they are doing a better job in incorporating enquiry and identification. Then we also check to see what per cent of those members

who have had an identification documented are getting follow-up with mental health.

COMMISSIONER NEAVE: Thank you.

DR McCAW: So it's those two metrics: has an identification been made, and then is there follow-up in mental health? That makes sense to clinicians. Those are clinically relevant metrics for them. So people are comfortable having those measures reported back in terms of their own clinical quality.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: If I just follow up from the question from the Commissioner. In terms of the patient record and Kaiser Permanente, is that a paper based record or an electronic record?

DR McCAW: When we started our work it was paper based, but we have now been on an electronic health record for more than 10 years. So these are identification or diagnoses. That's not really the right word for domestic violence, but that's the word that a clinician might use. We have had that available to us, really, for the last 15 years.

MS DAVIDSON: You were able to implement this, though, with a paper record?

DR McCAW: In the paper record?

MS DAVIDSON: Yes.

DR McCAW: Yes, we did initially. But you lose the benefit of the communication that happens when you have an electronic health record. The child that we heard about where clinicians couldn't recognise that that child had been seen multiple times, some of the benefits of the electronic health record is that that becomes quite visible.

MS DAVIDSON: Thank you. Perhaps then turning to Ms Fraser and Ms Ritchie. You have identified that in New Zealand you started with both child and partner abuse. I think you talk in your witness statement about the big report - the family violence prevention strategy is called Te Rito. You have outlined in your statement what Te Rito means in relation to children and families, and talked about what it means in the Maori language. Is there a bit more of a child centred approach in New Zealand? Is that part of why you have a child and intimate partner guideline as opposed to just intimate partner?

MS FRASER: I will let Miranda talk to that shortly, but I think as Professor Oberklaid said a child doesn't develop - its brain doesn't develop properly in a home where there are stresses. We have found that there is a high incidence or co-occurrence of family abuse and child abuse and/or neglect, but particularly child abuse, with the child witnessing or hearing or actually suffering from child abuse where there is family violence going on in the home, and those tensions don't allow the child to flourish.

If a child comes in for an injury, a broken arm, and it's a non-accidental injury more often than not there's family violence happening at home. The violence is not just visited on the child. If mum comes in and she screens positive for family violence, more often than not those children have been affected in the home. So it didn't make sense to just deal with mum and ignore the children or deal with the children who might be still going home with mum to that home. So we take a joint approach to family violence and child abuse.

MS DAVIDSON: In terms of the child and partner guidelines can you explain what kind of routine screening there is for both partner violence and child abuse?

MS RITCHIE: The Ministry of Health family violence intervention guidelines child and partner abuse recommend that we routinely screen all women 16 years and over for partner abuse, and part of that screening is asking about physical abuse, emotional abuse and sexual abuse. We question men on signs and symptoms or indicators of abuse. In the absence of a validated screening tool for child abuse and neglect, the identification of child protection concerns is also on signs and symptoms of concern.

When abuse is identified, similar to the models that have been identified previously, we acknowledge and respond to that and then do a risk assessment which again in our approach looks at both child and partner abuse. So if you have identified child protection concerns, part of that risk assessment would be asking the female caregiver about intimate partner violence, so that screen, and then obviously a safety plan, referral and documentation. So it's a very similar model.

MS DAVIDSON: Which health settings are given priority?

MS RITCHIE: Within the Ministry of Health contract with district health boards - there are 20 district health boards throughout New Zealand - the designated services which are the areas that we have prioritised first are the emergency department, child health, maternity, mental health, alcohol and drug and sexual health services. In saying that, we have DHBs - or district health boards - that are bigger and have a range in size. So once services have rolled the program out into those areas then

obviously they can expand it out. But the first priority areas are those six designated services.

When we talk about child health there is both inpatient - so children's ward, special care baby units, neonatal intensive care units as well as our community, so public health nurses and the community providers for child health as well. Maternity is antenatal through postnatal period.

MS FRASER: On top of that we are very slowly and incrementally offering screening or services, a program for GPs we haven't rolled out yet to public health organisations which are your GP practitioners, your psychiatrists, your psychologists. They are able to enrol on a course if they choose to. It is a one-day training. But it is not mandatory for them to undergo the training.

MS DAVIDSON: When did you implement the guidelines for child and partner abuse?

MS RITCHIE: The guidelines were released in 2002 and again, as has been previously identified, this is a significant attitude and behavioural change. So we have made some really slow and steady progress, but it is a significant implementation. From 2002 to 2007 the ministry contracted four DHBs to be pilot sites to essentially try and work out how to implement the guidelines. It was interesting because the four pilot sites obviously were funded to be able to make that establishment, but almost all of the DHBs by 2007 had appointed somebody to be implementing or coordinating the implementation of them which then lead to the improvement in systems which meant that the Ministry of Health then was able to get additional funding to be able to fund all DHBs.

So since 2007 all district health boards have received some funding to support program coordination. So that's appointing at least a full-time coordinator to be able to support the implementation and the DHB to set up the systems that we know that we need and then implement the program in a slow and incremental way.

As far as outcomes at this stage, we have evidence that we have those systems. Now we are going to move on to be able to do some more work around what difference it's made as far as outcomes for patients. We have some of that, but we want to formalise that in the future.

MS DAVIDSON: You talk in your witness statement about the systems approach and you have a diagram I think at paragraph 32. You talk about a clockwise implementation with the elements being mutually reinforcing. Can you explain what you mean?

MS FRASER: It's not actually a clockwise implementation. It almost seems like it's a clockwise implementation. But what that means is you can't just pick one or two out of this pie chart and use that and say that you have got a good system. What we have found is that through the guidelines and through the system that we have implemented that each one of these sequence is important. You need it as a whole to have a good foundation for a good system. So you need the management support. You need guidelines. You need resources. Training is almost last. It's almost like the last thing that you do. It's not a pick and mix. These are the basics that we have found that work to make a good system work.

COMMISSIONER NEAVE: Can you just clarify for the Commission

why training is almost the last, because that's counterintuitive?

MS FRASER: It is. Training alone actually won't make a difference either.

MS RITCHIE: Our experience is that the optimal time for - as I identified before, this is a significant attitude and behavioural change as far as asking staff to ask about intimate partner violence. It's certainly our experience in New Zealand. People are quite apprehensive about actually starting to do that. So we really need comprehensive support.

The most likely time that they are going to start screening is the next day. So what we say is it's really important to have the management support. So managers are actually giving a very clear message that, "This is important; that actually you need to go to training," and that actually checking the next day if you are charge nurse - so I'm going to talk from a clinical point of view - the charge nurse manager walks around the next day and actually says, "You went to training yesterday. Have you managed to ask the screening questions today," and supporting them to do it actually provides a really clear message that, "This is important. This is really serious. We are taking this seriously. We want you to do that."

We need the community agencies support. You need to know who those are. Then your policies. The problem is that you can have the training and you can start asking the questions, but you might have a challenge a bit later on where you just want to check something. So the policy and the guidelines are the document that you can go back to as far as reference.

The resources. Having posters. Posters in every clinical area, posters in the waiting room set up an enabling environment. If I'm going to ask the screening question and the patient has already actually seen the posters out in the waiting room or there is a poster on the wall, when I say, "We are really concerned," there is a visual message that says that too. We have cue cards, posters, pamphlets, all those things.

So if you walk back into your department the next day and the screening question is on your documentation, there are posters on the wall, I have the cue cards on my ID badge, I have had the training, I feel equipped, I'm ready now to go and actually start asking those questions. So you need that whole thing.

Then picking up the point about the evaluation and the audit you then do that afterwards and you get that affirmation that, "Actually you have done this, and it's really important, and actually here is the feedback." It is slow to start with. But actually it's a bit like in the other clinical practice change. The more you do it the easier it becomes, or that's certainly the general experience. So it's about putting as many supports available to that person so that they are actually going to start doing this.

Our experience is that if you do the training and you come back and you haven't got the policy, that people can then turn around and say, "Where is the policy that says I actually have to do this or where is the documentation to remind me to do it?" If you are going to make that huge investment in the train, which it is - we have eight hours of training for every clinical staff

member for child and partner abuse; that's a big resource investment, so we want to make sure that it's really effective. That's the way of at least optimising that change.

MS FRASER: Management support is key. Particularly in DHBs, they are often having a lot of new policies or practices, of new initiatives being rolled out. Without the management at a very, very senior level, support, it will actually - it will just drop off. It will fall by the by. "They have more important things to do than to worry about this." So that's kind of key as well. You have to start from there.

PROFESSOR HEGARTY: It is management support. But without dedicated funding for that coordinator such as Professor McCaw - for the clinical lead in the hospital, for the - ours are called regional or metropolitan public health services - without people who are dedicated to implementing that system. So it is financing as well. I think we have had a lot of goodwill. I have described the Women's. We have had enormous management support there, we have had Mercy Hospital for Women emergency management support at one time, but not the corresponding funding for a dedicated family violence person either at the hospital level or the higher level of the region.

DEPUTY COMMISSIONER FAULKNER: I'm missing the middle bit, I think. So you talk a lot about training people to screen and at the end point they make appropriate referrals. I'm interested in how much we now have family violence informed practice within the hospital. Has it affected things like discharge policies? Do you have now new guidelines that recognise the existence? I think the

most obvious example is have people changed their antenatal processes. But also discharge is very interesting. Do people still discharge women to homelessness if they are experiencing family violence? So I'm interested in the middle bit. Can you talk just a little bit more? Any of the people are welcome to contribute.

MS FRASER: I think that we are getting there with that. I think that it is recognised that there are still some gaps. It's not a perfect system as yet. We have finished our implementation phase of the VIP and the DHBs. We are building those relationships or strengthening those relationships with the NGOs which is going broader than just the family violence. So it will be looking at things like, "Where are you going home to tonight? Is it to a refuge? Have you got somewhere to go?" That should be part of the discharge. That is part of the assessment and referral. That's standard practice.

DEPUTY COMMISSIONER FAULKNER: But would you keep a person in hospital? I'm really looking for has any practice changed. I can understand you would be more knowledgeable about referral, but would you keep people in or treat them differently than you would have before you had this sort of structure?

MS RITCHIE: Part of the infrastructure is also having a safe discharge policy and a safe emergency as far as - so we won't necessarily have, because it can be sometimes a little bit tricky to have it actually written down in hospitals as far as you will do social admissions, but we certainly do have a policy that says, "You need to make sure you discharge safely." So part of your safety

planning is to make sure that they have got somewhere safe to go home to that night, or otherwise we do keep them. So we will admit them to a short-stay ward for a social worker assessment potentially in the morning so that you have time to actually - there are ways of ensuring that you - or part of that system infrastructure should be to ensure that they have a safe place to discharge to. That's for children as well. So, for us, that's actually about making sure that we ensure that you either admit them or you have a safe discharge plan.

MS FRASER: It's not perfect. It's still evolving and it's still being implemented across the designated services. But you have seen a definite shift, and I think a lot of that is actually led by the government as well who has put such a huge focus on it that there is no more sort of saying, "I have better things to do" or "I'm busy doing other things" or "I need to focus on that." The government has said, "It's not an option. This is primary work. You need to be focusing on it." So it has given us the mandate to work alongside DHBs and ensuring that this is a priority.

DEPUTY COMMISSIONER FAULKNER: We have just heard a lot of evidence that people get referred but there is nothing at the other end to meet their need.

PROFESSOR HEGARTY: I was going to say that I was on the World Health Organization guidelines group where we tried to look for the evidence of what you are describing, what are actually women's outcomes. Of course these are difficult things to implement, the system models, and then they are difficult things to evaluate. Attached to my submission was a Lancet article that has a much more complex system

intervention, because I think even the things we have talked about, I think it's more complex than that to actually make sure that women are not sent home where they have got nowhere to go.

We also, I don't think, have evaluated to that level of women's outcomes. I think we can say that we think we have changed it in some areas, and I would be interested in Professor McCaw's thoughts about it. But the infrastructure ranges from - and I think trauma informed principles are another area that Australia has done quite a lot on where respect, privacy, confidentiality and safety, if those principles are core to the whole environment, then you start to look at infrastructure things such as, "How is the antenatal connect designed? Is it soundproof? Can women disclose? Are they seen alone? Are the discharge summaries audited to see that people aren't going home?" It can be that once you get those principles embedded you can look at that. We didn't see any evaluations that were looking at that sort of level of women's outcomes.

I think that women's needs are wide and varied, and one of the commonist ones that is not met is issues around their children. So women's needs around parenting are often a great concern for them and about their children's safety and wellbeing. We have a distinct lack of child/mother services and child services in Victoria that I don't find people to refer to.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MS DAVIDSON: Does anyone want to contribute any further to that?

MS RITCHIE: I would make one more comment which is about the

community agency feedback. Part of the program that we have is actually asking DHBs to seek that community agency feedback, so what's the quality and the quantity of the referrals that the key agencies that we would be referring to, which provides us feedback as far as how the program has been - so particularly women's refuge might give us feedback about how the women were funded or how they were referred.

But one of the critical things is again about that capacity. So we have always been very conscious of the fact that it would be unethical to be asking the screening questions if there wasn't a referral pathway to be able to refer the women and/or the children if they need to to those services. So actually seeking that feedback around, "Are we making the right referral; what's the numbers; how is that affecting your ability to be able to provide care for the people that we are referring" is really important. So it's the quality. Are we making the right referrals and what are the numbers?

Within health we don't have - it wouldn't be the DHB that would potentially be providing funding for those non-government organisations or agencies. But it would be about the fact that if we could demonstrate that since we had rolled the program out there had been an increase in referrals, certainly there's the capacity to be able to write a letter of support if they are applying for additional funding. So it is about that really important partnership with community agencies, they are part of our governance group, they are part of the training, but also there is that commitment to actually seek that feedback and make sure that they have the capacity to respond.

MS DAVIDSON: Dr McCaw, can I just pick up an issue about the supportive environment that I think Ms Ritchie talked about, the importance of having posters to make the woman feel - already be aware that this might be an issue that she might be asked about. I think you have identified in your statement that it's not just a cue for the women but that supportive environment also reinforces the clinician or the health practitioner's role. Can you explain what sort of systems you have in place in terms of using the material for both the benefit of the patient and also for the health professional?

DR McCAW: Sure. I think the point that was made that you want to wait on doing the training until you have a number of the pieces in place is an important one because if you get a group of clinicians very excited about screening but then you don't have the response in place that's credible and effective and efficient, then you get people who are probably worse than those who weren't trained. They are ones that are discouraged and feel like they were sort of betrayed.

So everything that we can do that really does I think improve for clinicians the ideas that they are being supported - this is one of the posters. It is exactly what we heard. This both reinforces for patients that this is an issue that the clinician wants to hear about, but it also reminds the clinicians that they should be asking and that it's part of everyday care, and having the materials that they can hand to a patient when they make an intervention that has the phone numbers, those are all things that really helps cement a feeling that this is part of what we do.

One of the things that I mention in my testimony is the need to really make sure that information is available on-line, because so many patients nowadays go on-line to try to understand what's going on in their lives and what resources are there. So we have sort of moved from health education 1.0 to what I think of as health education 2.0 in trying to really create materials that will meet people where they are. Is that what you have in mind?

MS DAVIDSON: Yes, thank you.

DR McCAW: If you don't mind, I have one other thing that I wanted to say which is that one of the learnings along the way has been how important it is to have the opportunity for the clinician and patient to talk in private. This came up in a number of the testimonies that were given.

I just wanted to say that one of the things that we have done in the way of creating an environment is to have posters that let everyone know that a patient will be roomed for a period of time by themselves so that that's expected; that there is an opportunity to speak with their provider with confidentiality and that the family members can be brought in later on. But that makes a policy in place so that people don't feel like they have to make up a reason to have the patient seen alone so that they can ask about issues that are sensitive; and obviously not just partner violence, there are other issues that are sensitive that require the patient having privacy with their clinician.

MS DAVIDSON: In terms of the idea of providing a response or a referral, perhaps, Dr McCaw, as part of your systems model

you include as part of the response an in-house response, is that right, that there needs to be a referral or some sort of response in-house, not just handing out a phone number for a family violence service and just letting the patient phone. Can you explain what you expect in terms of having an appropriate response for the woman?

DR McCAW: Because Kaiser Permanente does include mental health services we wanted to make sure that our colleagues in mental health knew what their role was so that when we made the identification for a patient if she was experiencing abuse that we could both talk about what was available in the community but also what could be available to her if she wanted to speak with the mental health professional.

As many have said, there is so much overlap between conditions like depression, anxiety, insomnia, substance use, suicidality and domestic violence that we thought we needed to have something that the patient could access right there in the health care setting that was familiar to them. That's why the on-site services which refer to social services or mental health are important.

Sometimes a patient will be identified at a time of the day when there isn't an available social worker or a mental health professional. In those cases we really encourage our clinicians to allow them to sit down in the clinic or in their office and make a phone call to the hotline - there's a national hotline - so that she can begin right then starting to get some connection to services. So that on-site response generally refers to a mental health or social service professional, but can also mean providing a private and secure place for the patient

to make a phone call.

MS DAVIDSON: Ms Ritchie and Ms Fraser, can you identify what sort of response your guidelines would require and how that's facilitated?

MS RITCHIE: Based on the risk assessment we would use the risk assessment to identify the safety plan and who the referral partners would be. Obviously if there's immediate safety concerns that would involve a statutory response. But otherwise it's actually about knowing who in the community are the right referral pathways that are available.

So again within your 20 district health boards it would be really critical to have - that the coordinator of the program actually knows who are the referral agencies that they would be using, who are the local supports that they have.

They are part of the whole infrastructure for the program. So we recognise that partnership. We are not asking health professionals to become the experts on family violence, but we are asking them to at least be able to do the six steps and make the referrals.

Some of our hospitals - in fact one has a domestic violence advocate on-site. Social workers are obviously key as part of that referral pathway. But in most of our hospitals we don't have 24 hour social work cover. So it's really important that we know who those referral agencies are.

When you are doing the training you talk about who your referral partners are and how do they operate so that you know their hours of operation. Again that links back to the response as far as do we need to consider

whether or not an admission is required until we can actually make the appropriate referrals and how we are going to manage that.

But it's a little bit individual, depending on which DHB you are at as far as who the referrals are. The statutory ones remain the same. But it is critical that each area knows their own referral pathways, have those relationships and then make the referrals. We would actually expect that it is a proactive process. So we are teaching that the staff member will contact - make that private area available. We only screen them private or with children under the age of two present. But you would then try and facilitate as much as possible that response. Most DHBs have some form of agreement about whether the agency will be able to come up and provide on-site service.

MS FRASER: Can I just add to that. Another key thing that we are finding is working really well and is making quite a big difference is we have Child, Youth and Family as part of the program. We have a memorandum of understanding with police and Child, Youth and Family - well, the DHBs do - to have a Child, Youth and Family social worker on-site. That makes a big difference in terms of the referrals or in terms of a doctor feeling comfortable making a referral to Child, Youth and Family or having even a discussion with Child, Youth and Family about a family or a child with a possible non-accidental injury.

It also helps the relationship between the DHB and Child, Youth and Family because we often find language - the language used, they miss each other at times. So social workers, because they are based in a

hospital, are able to advocate on behalf of the doctor that this needs an intervention by Child, Youth and Family and make those pathways a lot more seamless. That is a really big relationship for the DHBs to have and it has been working really, really well.

MS DAVIDSON: Professor Hegarty, what is your view about an appropriate response in a hospital setting?

PROFESSOR HEGARTY: I think that it is really important. We have just heard from both sets around what we would call a warm referral; that in fact either you know what the service is like or what they are going to offer. You are not sending them there and then it's not meeting their needs because they are not in the right area or they don't meet the means test or whatever; but also the idea that you have something to offer.

We are certainly moving towards developing internet based responses, technological responses as well, because we understand that if we actually sent one in three or one in four women, whatever figure you wanted to say, to specialised family violence services in this country we are never going to have enough services for that many women.

Secondly, in my work with universal services, so with nurses, antenatal care or maternal and child health nurse or with GPs, the women who attend there, they don't particularly want to go to a domestic violence or a family violence service. It is in my submission and certainly in the Lancet article attached as well. Many women are not even recognising that what they are experiencing is domestic violence.

So, as I said, if you role play someone telling

you and then you say, "Here is a domestic violence service number or a card," it just doesn't work. So you are actually working where the woman is at. You are doing woman centred care. If she needs help in naming what's going on with her, that's what you do. If you can't do that, then you get her to a service that can.

As I said, if her needs are financial you are trying to help her with that. Parenting. Some of them obviously need domestic violence advocates. We do know that co-location of domestic violence advocates will actually help a health service do referrals. We know that screening alone will not necessarily increase referrals. It will increase identification. So what everybody said is that we need more than that. So the co-location is very key, and who you co-locate. Really we would love to have housing and finance and legal and parenting and a whole set of things. So it's how you map out that pathway.

I think you need internal and external options, because no one service is going to - a social work service at a hospital is often not 24 hours. In fact many women are afraid of child protection issues when they go to see a social worker. Really I'm suggesting that people work with the woman, as you would be as well, to find out what are her needs and where does she want to go, and you have an array of options that are clearly mapped.

MS DAVIDSON: Dr McCaw, you have talked about in your statement the sort of journey that Kaiser Permanente has been on in terms of health clinics developing referral relationships and pathways. Can I just get you to outline what might have initially been done for women in terms of external

referrals and what some clinics might be doing now and where you are moving to?

DR McCAW: Yes, I can. I really reinforce what Kelsey has said because it's quite clear that simply handing someone a phone number does not necessarily meet where they are, and that many women prefer other interventions besides those that can be offered through social services or even through an advocacy organisation. They may want parenting or they may want financial help.

But one of the learnings I think that reinforces what's been said is that co-location of services really does improve the likelihood that when a person is identified as experiencing domestic violence that they will get that next step to a person who can then work with them in more detail to find out what they need. So we have a couple of clinics where we have an on-site advocate who is there and provides that warm referral.

Also having our staff work in partnership with the advocacy organisations, whether it's on their board of directors or by participating as volunteers themselves, that also has helped really bring a better understanding of what are the issues that they are dealing with, and our implementation teams frequently have someone from law enforcement and the advocacy organisations that are local so that there can be that sort of relationship building which is the glue that really helps people know what services are available and how to help their patients avail of them when they are ready.

MS DAVIDSON: Thank you. Can I ask each of the panel members to address the issue of the importance of evaluation. How important is it? When does it need to be done? What

should be measured? Who should be doing it?

PROFESSOR HEGARTY: I'm going first as the pointy-headed researcher. Evaluation is key. We have a plethora of activities in Victoria. The people who are doing it want it evaluated, but the evaluation money is usually so tiny that it's ridiculous, that no-one could possibly do an efficient, effective evaluation.

I think the replication across the programs and the replication of how to develop a survey to measure health practitioners, changes in attitudes, the replication of women's outcome surveys is enormous. So, as well as coordination of all these activities, there needs to be coordination of what evaluation tools and methods we have.

I have probably spent too long on systematic reviews and Cochran - the meta analyses. But I do think, because of the reasons I said before, that where possible we should be having a comparison arm or a comparison hospital or a comparison in some way, or we are trying different things in different areas and really getting women and, if possible, children's voices to tell us what that can be. That doesn't always have to be quantitative. It can also be qualitative as long as people are carefully - it's carefully looked at, the people who participate and the people who don't get asked, for example, that everybody gets a voice in those sorts of things.

But, ultimately, I think if we are investing a lot of money in a coordinated systematic response we need to have patient outcomes. Sometimes that has to be before and after, like I described before for the A New program,

and maybe that's what we need to look at. But we need those figures. Obviously the more routinely collected data - so improving our existing hospital data systems so that we can map across regions or we are doing an intervention in this area and not in that area, if it is routinely collected like, say, the maternal and child health nurse data of routine screening, then that's helpful as well.

COMMISSIONER NEAVE: One model for ensuring that there's rigorous evaluation of various social policies is to set up a body, state funded, which has responsibility for doing that. So I think of, because of the background I come from, for example, the Sentencing Advisory Council, which has done a great deal of work looking at sentencing issues and what works and what doesn't. Is that a model that should be perhaps considered in this area? It could be in combination with a university, for example. But it's recognised that it makes an important contribution to the development of social policy in a particular area. It is reasonably cheap to do these things, but it's overall.

PROFESSOR HEGARTY: Yes, I feel if I get consulted one more time about how to do those surveys - I'm not saying me, but, yes, a standard repository and a body that had good evaluation methods, good advice about what to use, how to use it would be amazing.

The other trick I think which we haven't done to any great extent is do partnership grants with NHMRC. Our university is going for a centre of research excellence this year. They are opportunities to really have a focus with the Royal Commission findings with getting evaluation money from the existing research. ANROWS obviously is

another organisation.

COMMISSIONER NEAVE: Some of the evidence that we have heard suggests that there is an enormous amount of money being spent on little pilots all over the place, not just in this particular area, and sort of little evaluations done for nothing, or very little.

PROFESSOR HEGARTY: They are not done for nothing. There are lessons learned from those.

COMMISSIONER NEAVE: I mean, sorry, done with very small resources.

PROFESSOR HEGARTY: Yes, very small amounts of money; yes.

COMMISSIONER NEAVE: And then all of that information is not really pooled together in any sort of systematic way. Maybe the source should be ANROWS, because that is after all a federal body. So would there be a point in having a state stand-alone body given the work that's being done by ANROWS?

PROFESSOR HEGARTY: I think that ANROWS has a particular function and I think that - I was actually talking to the CEO, Heather Nancarrow, about it because of some work we are doing together, and she said that really they have got a mandate to roll out the national plan and that has to be cross state and has to be cross jurisdiction, all those sorts of things.

In some ways I think Victoria has had a lot more activity than many of the other states, not just in health but in many areas, and has led the way in innovation. I think to actually have a state body would have a different focus and you would clearly define the different focus. But really ANROWS is mandated to evaluate things to do with the national plan. If you look at the national

plan it doesn't have, for example, a lot of health related things in it. It's got particular focuses. So I think if we were looking at a state based innovative new model in health, for example, ANROWS couldn't do that in Victoria.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: If I can ask Ms Ritchie and Ms Fraser, the Ministry of Health partnered with Auckland University; is that right?

MS FRASER: Yes.

MS DAVIDSON: Can you identify why you did that and what that particular university was able to offer?

MS RITCHIE: The partnership was with Auckland University of Technology in 2003 - '2/3. Essentially that was a national evaluation looking at the infrastructure. So when we took up the systems model it was actually a Delphi tool that's looking at whether or not district health boards or hospitals have management support, child protection policies, standardised documentation, good relationships and collaboration with community agencies, training for staff, a standardised intervention or safety checklist. Basically all the infrastructure that we are talking about, it was looking at seeing whether or not that was present for both child and partner abuse.

The results have demonstrated that we had low scores initially in 2003/4 with the baseline results. I can't remember the exact numbers, but they were approximately 20 for partner abuse and the mid-30s for child abuse and neglect. Those scores have been over 92, 93 for the last three consecutive years, which shows that we have the infrastructure that's now required. So DHBs do have the policies, the training and all the systems we

are talking about.

One of the items that is assessed is actually the evaluation; so are we doing clinical audits and looking at our screening rates, our disclosure rates, our standard of documentation. That was quite a low-scoring area, which prompted us to then develop some standard audit tools to provide to each of the DHBs so that they could actually do clinical audits and look at the quality of documentation.

So that audit was obviously external. It started off with visits to each of the DHBs, progressed to a self-audit once the system infrastructure was progressing in the right direction and we were over scores of 70 in each of the DHBs, that became a self-assessment process.

The clinical audits are really important, again for that affirmation and the feedback for staff, but also checking the quality. So we are particularly interested in looking for partner abuse at our screening rates but then our disclosure rates. If you have a very high screening rate but a low disclosure rate we need to be asking how we are doing those screens and how is that happening.

But we also have tools that enable us to look at the documentation form and check that we have done comprehensive risk assessments, that we have documented the assessment we have done, and also the quality of the referrals we make to our child protection service. So we have standard templates for making a referral to Child, Youth and Family and we can look at the information that's recorded on those, which is all in that quality improvement process.

I know Auckland University of Technology

undertook one. We certainly did in a local area in Hawkes Bay when I was based there looking at the barriers and enablers for clinical staff. Usually they are either organisational or personal, so actually asking the screening questions. When we ask them about that we ask them to tell us what would help them ask. So that's also informed the implementation. So it's that ongoing cycle of how are we doing, what can we do to improve it, thinking about what that means and then shaping and strengthening the program from that.

MS FRASER: Implementation of VIP was our first phase, and we now have got that embedded into the DHBs and that will just continue to roll out. Our next phase is actually on more data collection that you were talking about and evaluating the quality of the data and looking at how much, how often and is anybody better off for having been screened and referred on. So it's quite a big project. But I think actually defining is anybody better off is quite a big question just to begin with, otherwise the data is only as good as the questions you are asking. So that's our next phase.

MS DAVIDSON: Dr McCaw, did you want to contribute anything in relation to the evaluation?

DR McCAW: I think they have really hit on one of the critical issues for all of us in the health care environment which is are outcomes better, and what do we mean by "better". Are we talking about reduction in violence? Are we talking about reduction in symptomatology? Are we talking about improvement in quality of life? Who are we talking about? Are the outcomes better for the women? For their family? Is it improvement in the clinical experience for

a clinician? Is it improvement in health care utilisations, putting on the hat of a health care plan? So this is a set of questions that we should all be putting our mind to.

We have been able to show in Kaiser Permanente that we can increase disclosure. We have a 13-fold increase in disclosure. We have more than 60,000 members that have been identified as experiencing partner violence. What I want to know is just exactly what the other panel has said. Are they better as a result and, if so, in what ways? So I think this is the cutting edge for all of us.

MS DAVIDSON: I'm conscious of the time. I had a couple more questions that I did want to explore, particularly from the New Zealand witnesses. You have a model of sort of governance in relation to district health boards. Is my understanding correct that the district health boards are otherwise relatively self-governing? I think you have talked in your statement about sort of the government leadership side of things, but also providing a degree of flexibility to deal with the different environments that the individual health boards might operate in. What do you see as being important in terms of some central leadership from the Ministry of Health? How have you managed to enforce effectively self-governing bodies like district health boards to do this work and where does the balance need to lie between sort of government leadership and local responses?

MS FRASER: How the contract is currently structured - maybe I should go back to the beginning. It started out with a pilot of about four DHBs after the review into the death

of this little boy, and this all started very slowly and built up. So four DHBs piloted VIP. VIP is based on our guidelines. The guidelines provide the framework for the Violence Intervention Program. So that was back in 2000, 2002.

MS RITCHIE: 2002.

MS FRASER: 2002 were the pilots. In 2007 the government committed to funding the other DHBs to start this program, start rolling it out in these six designated areas. So it has grown very slowly. It is run on actually minimal funding, but it is done with a lot of goodwill on behalf of the DHBs recognising that health has a really important part to play in family violence and child abuse neglect. That in itself is almost world leading in a way. It's about practice change. It's about doctors saying, "Actually we are not just doctors. We can ask these questions."

So we have a contract with the DHBs purely for a violence intervention coordinator. So we employ one person to Train the Trainers, to train the rest of the staff in that. The DHBs themselves have said, "We will employ or we will pay for a child protection coordinator." So the two of them work really closely together and they do the training together. They train the rest of the staff together. So it's four hours of family violence training and four hours of child abuse and neglect training.

So we have this little contract, and it's only a small contract, but it has been quite hard to get it noticed, I guess, throughout the DHBs because the coordinators are constantly having to talk to managers and

say, "We are trying to train your department. Your staff need to attend." So it requires buy-in from the CEO for a start of the DHB, or the chief executive of the DHB.

If I were implementing this program again I would make it a KPI, like you do with smoking, so you can get the rates. Then you have that teeth that people have to report on it and it has to be implemented. There's no, "We don't want to do this because we have other things we should be focusing on or doing."

We don't have it as a KPI. What we do is we put it in as part of the draft annual plans. We ask the DHBs, "How are you going in terms of addressing family violence or child abuse and neglect?" We have had a whole lot of new legislation around vulnerable children. So we have children section teams in New Zealand that are rolling out across the DHBs in New Zealand. So it also fits in underneath that, as the DHBs have been able to show what work they are doing to reduce assaults on children. That is their way of indicating the work that they are delivering towards that and part of the better public services plan.

So we have other ways, but certainly if I was doing it again I would make it a KPI, make it a key performance indicator, in the DHBs that they have to report to because then it means management is responsible for ensuring their staff are trained, not one person running around the hospital trying to encourage the departments to get their staff trained. So that would be the only difference. Have I answered all of your questions or did you have more?

MS DAVIDSON: Ms Ritchie, did you want to add to that at all?

MS RITCHIE: I think one of the things with this is also the fact that you have different sized DHBs. So we have 20 loosely small, medium and large sized DHBs. Some of the Auckland ones are employing between sort of 8,000 and 10,000 staff, and then you have somewhere like the west coast where you have probably less than 1,000 staff.

So one of the other things is it needs to be able to be modified to recognise the fact that they are all getting - it's about systems infrastructure, but then the bigger DHBs where you have a children's hospital rather than a children's ward, you are going to have to actually be able to accommodate how quickly they are going to be able to get to that point and that we really want them to go slow and steady and actually implement it really well.

So we want them to also meet the requirements. As we said before, this should be standardised training. Like any other clinical skill, you learn how to do it and that's part of your practice, skill set. If you then transfer to another DHB you take that with you, which is why it's really important that all the training is consistent with the local resources.

But essentially we want this just to become a core practice skill, that it's business as usual and what everybody knows and does. As a senior nurse when I moved between DHBs my training was recognised when I went to the next. I was obviously checked to make sure I was competent. But, once I was, I could practice. That's what we want VIP and child protection and partner abuse intervention to become as well, that this is just part of our skill set. We will get the local knowledge that we need.

That's where I think you do need that national standard and that national consistency so that you can actually get to that point, because it also doesn't make sense from a sustainability point of view that if I go to the next DHB I need to do that training again. Doctors are rotating sort of three-month cycles through hospitals as part of their undergraduate program. So how do we ensure that they get the training in one place and then can become competent and then transfer? So it's both.

MS DAVIDSON: Professor Hegarty, are you able to comment on that and perhaps reflect on the question of how is Victoria's response at the moment in relation to family violence relative to other sort of complex health issues like obesity or diabetes?

PROFESSOR HEGARTY: I was very pleased Brigid McCaw brought up before about how Kaiser Permanente are using the other chronic disease models and complex - we should learn from them. In many ways this is a chronic social condition. But an example is even if we just started at undergraduate training level, I ask the medical students, "How much training have you had on asthma or diabetes?" It's enormous. We have just surveyed all the medical schools and some of them have no training on partner violence. They often have stuff on child abuse. So they are not getting that base level at undergraduate level.

I would like to pick up on this idea that this skill set is relatively easy for doctors and nurses to pick up. They just have never had any training sometimes in their original undergraduate pre-services courses, and then with the competing demands of a million other things they don't prioritise it. So we need some sort of

direction.

I'm going to use general practice as an example. I know from the WEAVE project that we can not just make a difference to their self-report - as I said, women were less depressed, they had more safety discussions, they felt more supported by the GP. So I can teach even GPs, and most people say GPs are the hardest group.

So I think with the supports of requiring people to do this - and so we have heard how you are trying to make it mandated and minimum standards. So one way I have thought of to make general practice mandatory is to actually develop item numbers in Medicare that would - similar to asthma, chronic disease, diabetes, chronic disease, cycles of care, mental health where depression and anxiety care actually allowed people to take an extra bit of time - and I think we could have family safety plans. That's not solving Victoria and hospital, but there's a lot of GPs in this.

It's the same principles of a system approach where you are mandating from the top, and that could be the Australian Health Practitioner Regulation Authority, now is national, for GPs. But for us it could be our regional health services and our metropolitan health services and higher, having coordinators making it expected that this is what you do.

Our mental health workforce needs training. Our alcohol and drug workforce needs training. The whole system that we have been talking about where you feed back data but you also check what's going on, all of it needs to happen but somehow be coordinated and overseen from the top as well as responding to local needs. I think we have

got models, we have just heard them, and I think that it is possible to do if we get the right governance structure in place.

DEPUTY COMMISSIONER FAULKNER: Can I just follow up on that idea. Did the New Zealand system through its funding arrangements incentivise disclosure in any way? In Victoria for a long time our case mix system paid an extra amount for identification of a person as an Aboriginal person.

MS FRASER: No, we don't do anything like that. We are really lucky with the government having that focus and putting the message out there very clearly. We are focusing on family violence. I think also it's been quite timely because NGOs have been doing some phenomenal work on the ground for many, many years and didn't feel like they were kind of getting traction. So it is kind of like the two worlds are now meeting and dovetailing together. It's like a big wave at the moment throughout New Zealand.

People are really happily getting on board with it. The GPs are desperately - they are attending training; they are desperate for training. Everybody has recognised - yes, worlds are colliding. It is amazing. It is really interesting to see. We don't need to incentivise people or make those - - -

DEPUTY COMMISSIONER FAULKNER: I'm really sort of thinking about in the case mix systems as I understand them, and I'm not sure what New Zealand has, that in fact if you had a person who was pregnant and had diabetes you may attract a higher payment. So I'm saying if there was a person who was pregnant and was well known to have a domestic violence problem would there be a way, in the same way

that you have just described with payments in the general practice system, but you don't do that, you wouldn't say it is a co-morbidity of some sort - - -

MS FRASER: No, we don't have it currently.

PROFESSOR HEGARTY: The only incentivisation I know of is that general practices were given extra money to ensure that the primary care nurses working in their practices were trained. There was a period of time where there was a practice incentive payment for the nurses to be trained. But, again, that was just training with no other system change, and I'm not sure what effect it had.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MS DAVIDSON: Do the Commissioners have any further questions for these witnesses?

COMMISSIONER NEAVE: No. Thank you. Thank you very much.

MS DAVIDSON: I ask that all four of them be excused, and thank you also to Dr McCaw from California.

COMMISSIONER NEAVE: Thank you. That was fascinating evidence. Very interesting.

<(THE WITNESSES WITHDREW)

MS DAVIDSON: Could we have a two-minute break?

COMMISSIONER NEAVE: Two minutes.

(Short adjournment.)

MS DAVIDSON: Thank you, Commissioners. The next panel are three witnesses who will be talking about programs that are run and the experiences of the Royal Women's Hospital. They are Lisa Dunlop, Amy Watson and Linda Gyorki. I ask that they be sworn.

<LINDA SOPHIE GYORKI, affirmed and examined:

<AMY MORGAN WATSON, affirmed and examined:

<LISA ANNE DUNLOP, sworn and examined:

MS DAVIDSON: Can I start with you, Ms Dunlop. Have you made a statement for the Royal Commission?

MS DUNLOP: Yes, that's correct.

MS DAVIDSON: Are you able to confirm whether it's true and correct?

MS DUNLOP: Yes, it's correct.

MS DAVIDSON: Can I just get you to outline what your role is with the Royal Women's?

MS DUNLOP: I'm currently the Executive Director of Clinical Operations at the Women's. That has a management and leadership responsibility for the clinical services at the hospital, they being maternity, gynaecology care, women's health, women's cancers and newborn services as well as the clinical support services that are the foundations of those, such as theatre, emergency department and the allied health teams.

MS DAVIDSON: Thank you. Can I turn to you, Ms Watson. You have made a statement for the Royal Commission.

MS WATSON: Yes, I have.

MS DAVIDSON: Are you able to confirm that that statement is true and correct?

MS WATSON: Yes, I can.

MS DAVIDSON: Can you outline for the Commissioners what your role is at the Royal Women's?

MS WATSON: I'm currently an Associate Nurse Unit Manager for the Women's emergency department and I'm also a registered nurse and registered midwife.

MS DAVIDSON: Can I perhaps turn to you now, Ms Gyorki. You are not employed by the Royal Women's; is that right?

MS GYORKI: That's right.

MS DAVIDSON: Can you outline for the Commission what your role

is?

MS GYORKI: I'm a senior project manager and lawyer at Inner Melbourne Community Legal, which is the Community Legal Centre based in North Melbourne that services the City of Melbourne area. But I manage health justice partnerships on behalf of Inner Melbourne Community Legal with the Royal Women's Hospital, the Royal Children's Hospital and Inner West Area Mental Health Service.

MS DAVIDSON: Have you made a statement for the Royal Commission?

MS GYORKI: I have.

MS DAVIDSON: Can you confirm that that statement is true and correct?

MS GYORKI: I can.

MS DAVIDSON: Ms Gyorki, can I get you to outline the program and the project that you have running at the Royal Women's?

MS GYORKI: The project with the Royal Women's Hospital is a health justice partnership and it is called the Acting on the Warning Signs project. It builds on research in a number of areas, a lot of which has been touched on this morning. So a lot of the work that we do at Inner Melbourne Community Legal, whilst we are a Community Legal Centre, we recognise the findings of the legal Australia wide survey or the law survey from 2012 which shows that it's only in about 16 per cent of cases that people turn to lawyers for legal advice, and it's in about 30 per cent of cases that they turn to health and welfare professionals for legal advice.

So a lot of our work is outreach and integrated service deliveries with health care settings in hospitals.

The Royal Women's Hospital is one such partnership, and the focus of that partnership is on women who are experiencing or at risk of family violence.

We have been providing legal services on-site at the Women's for a number of years. It received funding from the Legal Services Board major grants program in 2011 and has since been refunded for a further two years. That funding is due to expire in the middle of next year. It's got three main components: an on-site legal service, training, and an evaluation component as well.

So the way the legal service currently looks is that we are on-site five times a fortnight, every Tuesday afternoon, Thursday morning and once a fortnight in the women's alcohol and drug service clinic. On the other occasions we are based in the social work department. We provide free legal advice and assistance to any inpatients or outpatients of the Royal Women's Hospital.

It's a generalist legal clinic, but since 2009 about 62 per cent of the women that we have seen at the hospital have indicated that they are at risk of family violence. So a lot of the work that we do at the Women's Hospital is family law and family violence work. But, as I said, we see pregnancy discrimination, tenancy debts infringements and the other range of legal issues that Community Legal Centres would otherwise see.

In terms of the training component of the project we provide training to front-line health professionals. Recognising what I was saying earlier about people often turning to front-line health professionals and welfare workers for legal assistance, we provide training. We also recognise that health professionals are the major

professional group to whom women disclose violence.

So the training that we provide is to really upskill clinicians at the Women's to recognise and respond to the warning signs of family violence and to refer appropriately, and also to act as catalysts for the referral to the legal service so that they are aware that the legal service is there.

I'm fortunate to work with some fantastic people at the Women's Hospital. So that training is a multi-disciplinary training. The legal component is one part of it. We also have clinicians presenting about the clinical warning signs of family violence; corporate counsel presenting about when mandatory reporting is required; social workers presenting about how to respond to a disclosure of violence and what their role is in the hospital; HR presenting about support for staff and self-care; and the police, who are across the road from the hospital, come in as well and talk about how the police respond to family violence.

Lisa, on the panel, has kindly given her time at every study day to either formally open or close the study day to show that there is that executive and managerial support for the training as well. So it's a full day training. Then we also have a doctors' training which is a separate model which is a 90-minute training session which receives professional development points from a number of different colleges. Again based on a multi-disciplinary model, social workers, corporate counsel, a doctor and myself present and then we have two senior medical staff on a panel at the end for a question and answer session.

So we have trained over 200 staff at the hospital through that model. Under the first phase of the project we trained over 10 per cent of clinical staff. Professor Hegarty, who was on the panel just before, was part of that evaluation and there were some really positive findings of that. We are also evaluating the project again this time internally, rather than externally, as was done under the first phase.

MS DAVIDSON: Perhaps can I turn to you, Ms Watson. You have undergone a fair bit of training in relation to family violence. Can you outline the different types of training that you have received?

MS WATSON: Yes. As well as my qualifications as a registered nurse and registered midwife, I also undertook a Diploma in Nursing Science in child, family and community which means I'm a qualified maternal and child health nurse. I graduated in 2013. Compared to my undergraduate and postgraduate studies in nursing and midwifery, it was only when I went to do my maternal and child health nursing that I received formal education or curriculum into family violence. It was displayed within a subject. I had to do a 2,500 word paper on family violence and the health implications to family violence and whether routine screening was an appropriate way of tackling family violence. It wasn't until then that that training was sort of embedded into the curriculum.

I have also undergone the eight-hour Acting on the Warning Signs training at the Royal Women's. I did this because in my managerial role I am supporting junior staff, being graduate nurses and midwives. So I wanted to further train myself in that. The Women's has also

undergone a pilot in our emergency department only which is with Bendigo Health and also Our Watch, and that's called Strengthening Hospital Responses to Family Violence. We had a project manager who was a social worker come down and in double staffing time present two sessions, one on identifying family violence and how that is incorporated within the emergency department and the presentations, the clinical health presentations that we see, and also how to sensitively enquire and respond and appropriately refer.

MS DAVIDSON: We have heard a bit about training alone not necessarily resulting in additional outcomes in terms of screening. From your perspective, having had the extent of training that you have had, have you implemented screening into your practice as a midwife?

MS WATSON: Yes, I have. I started at the Women's in 2009 as a graduate nurse and unfortunately I could only count on a handful of times that I have actually, I guess, had the knowledge and the confidence as a health care professional to identify someone, to sensitively enquire and also appropriately acknowledge or how to respond to family violence.

It wasn't until I attended training or went through this training in my first initial maternal and child health curriculum that I understood as a health professional that not only do we respond to, I guess, the physical presentation on why a person is in hospital or receiving health care but also the psychosocial aspects of that woman's wellbeing and safety.

MS DAVIDSON: Can I perhaps turn to you, Ms Dunlop. You have talked in your witness statement about some of the things

that were learned in relation to the Strengthening Hospital Responses to Family Violence project and particularly in relation to sort of data and documentation issues. Can I get you to first outline what kind of medical records and systems you have in place at the Royal Women's Hospital and how those sorts of systems might operate in other hospitals?

MS DUNLOP: There are three main data sets that hospitals use and report from. One is in relation to emergency presentations. So, every person that goes through an emergency department, that data is captured through that system and that data is sent through and collated system wide.

Then there is a different system which captures outpatient occasions of service. It is not a clinical system in that really what it identifies is who has been to a specific service on a particular day and what services they used. It doesn't pertain any medical or other sorts of information.

Then the third dataset is around the inpatient episode of care. At the Women's we are still predominantly paper based for our medical records. There are obviously some health services who are moving or have moved to an electronic system. But we are predominantly paper based at this point in time.

MS DAVIDSON: Is it the case that different hospitals will have different systems?

MS DUNLOP: Yes. Each particular health service could have different software packages that they use. The central reporting is the same regardless of what those particular software packages are, but individual health services will

have different systems in place for potentially all three of those areas.

MS DAVIDSON: You have identified in your witness statement that, although different hospitals will have different systems, the data that is collected is relatively consistent across hospitals, or the notes that record that information. You talk about the reasons for collecting that sort of information are consistent across health services. What are the different types of data that have to be collected and what are the drivers for them being collected?

MS DUNLOP: There are a couple of different drivers. Obviously the first one is about direct patient care so that the clinician knows who has seen the patient previously, what their medical history is and what the specific treatment is.

A second area of data collection is around funding and what is required for funding purposes.

There's also a third area of data collection which is around some of the more population wide data collection; so, for example, cancer registries, infectious disease notifications and those sorts of things which are used for a much broader use within the system.

MS DAVIDSON: Who dictates those?

MS DUNLOP: Predominantly government. Most it would be state, but some of it is Federal Government, for example, in terms of some of the registries.

MS DAVIDSON: What are the requirements from government in terms of collecting information about family violence?

MS DUNLOP: There are opportunities for it to be recorded. For example, in the emergency department there are areas that

it can be recorded. I think one of the problems is that the systems don't necessarily gel at a patient level. So we have data from emergency presentations, we have data about inpatient episodes, but it's not necessarily linked to an individual patient.

The other thing that is missing is some standardisation around definitions and then what actual data do we want to collect. I think we have heard previously that it is one thing to identify how many people disclose, but that in isolation is actually not going to give you particularly meaningful information. What we want to know is who was asked, who wasn't asked, if they have disclosed what was done about it, and then more importantly longer term actually did it make a difference to that individual's health care both in the short and long-term, particularly in a maternity setting around the longer term impacts on the infants.

MS DAVIDSON: Can I turn to you, Ms Watson. As a midwife and working with these information systems, what does that mean for you in terms of your practice? Where do you record that you have screened someone? Where do you record that they have disclosed? How do you know what previous practitioners might have done, for example?

MS WATSON: At a clinician level it's quite fragmented. I don't know whether this is because we have a paper history or whether it would be more seamless with an electronic history base. For example, if a woman was to present and I saw somewhere in her history that she had previously disclosed family violence I guess that would be a trigger to then sensitively enquire about this presentation that she was currently presented for.

Otherwise if it was 12 months ago and wasn't somewhere that I could clearly see, we have an alert page on the very front of the history, so after the front page, and usually that alerts things that are medicalised. If you had an allergy it would be right there in front of you. Family violence isn't alerted in that way and you would have to, I guess, flick through a history to see if a woman has been involved in social work, legal or if someone's previously asked or if she has disclosed.

MS DAVIDSON: If you have asked where would you record in the notes? Is it in the paper record or would it - - -

MS WATSON: It would be in the paper record. I would personally document that I have asked about family violence, whether it was disclosed. I would enquire about immediate safety for the woman, because most women who attend our emergency department are likely to be discharged home. So I ask, "If you are going home, are you going to be safe?" I would also offer the services that we have at the Women's, so the social work service and also legal; whether she accepted or declined the referral, again this is all through the paper base.

We also have an electronic emergency department information system. For example, if someone presented with pelvic pain there's tick boxes. So you could say that the pelvic pain was a gynaecological issue and you could say, "Yes, this is a gynaecological issue," and that would bring up another set of tick boxes and you could hit "pelvic pain". Unfortunately, from my understanding, there isn't a tick box to describe that family violence is a presentation. We do have psychological distress or if a woman presented with a psychosocial need, but no family

violence.

MS DAVIDSON: As a practitioner how important do you think it is to have that documentation as part of - I'm not saying it's the only part of - a system that prioritises family violence as a public health issue?

MS WATSON: I guess at a patient level it would make it a more seamless approach and putting the woman at the centre of the care. Because of the nature of an emergency department, a lot of the women that we see we may never see again. So we want to know that if we have enquired about family violence, if family violence has been disclosed, if she has declined referral on that day, if she's pregnant and going to attend a pregnancy clinic, the clinician may not find that I have previously asked. So I think it's extremely important that it is somewhere to be found in a history and easily accessible as a clinician.

MS DAVIDSON: In terms of the information and the tick boxes and the information that you are required to enter potentially, how does family violence compare with, say - you would ordinarily be asking someone if they smoke, for example, or drink alcohol or use drugs, those sorts of things. How is family violence treated relative to those sorts of factors that might impact upon health?

MS WATSON: I think that question is best answered by a doctor because it is actually the doctor's role to tick those boxes. As a clinician in terms of having this family violence training it's helped with my overall approach in asking and identifying women who are at risk of family violence. But I wouldn't be able to tell you compared to, say, smoking or asthma or pelvic pain whether family

violence is treated as a diagnosis the same as a physical health complaint.

MS DAVIDSON: Ms Dunlop, can I ask you that question in relation to systems that you have in place for I think you refer to them as co-morbidity issues. So what sort of things are recorded as co-morbidities and is there a requirement to check for those?

MS DUNLOP: Again, as part of a regular history taking clinicians will ask patients a whole variety of things, and things such as high blood pressure, diabetes, do you smoke, how much do you drink are routinely recorded. What we would like to see is that family violence be part of that routine. I think we have already heard this morning that a big step of that is to actually train the clinicians to be confident to ask and, more importantly, know what to do if it is disclosed. So the two go hand in hand.

What we don't want is a tick box, and we have heard this morning that that's not ideal. It is about training the clinicians to ask that question the same as they would around smoking or high blood pressure and other known factors, mental health issues.

MS DAVIDSON: In terms of the Royal Women's you have some services such as social work. So what sort of services are available for women who have disclosed family violence?

MS DUNLOP: We do have a social work department and we do have the assistance of Inner Melbourne Legal on-site several days a week as well. But, again, the social work department is predominantly a Monday to Friday service. We do have some on-call social workers, but it's certainly

not a 24/7 service.

MS DAVIDSON: What about relationships with family violence service providers or other specialist service providers to whom you may refer for women who have disclosed family violence?

MS DUNLOP: Particularly through the social work department they have relationships and contacts. Clearly women come from different geographical areas. So each of the services are slightly different in each of those areas. So it's the social work department that need to know if I'm out in the west or if I'm from a rural region what services are available to that particular woman in her area. They are really the linchpin of hooking up women into those sectors.

What we do know is that, although particularly during antenatal care we have a fantastic opportunity to work with women and families for their longer term health, but it still is a finite period of time and that it's not the hospital's role to continually case manage a woman for years and years, for example, in that we do need to work with the community agencies to provide that ongoing support to women and families.

MS DAVIDSON: Ms Watson, what about the situation where a woman discloses family violence? Does it impact on discharge policies, for example, in the hospital? How do you deal with that situation? I think Commissioner Faulkner asked that question in relation to the other panel members about things like discharge policies and taking family violence into account.

MS WATSON: We have had women who have had social admissions because of family violence. With the nature of our

emergency department we do, like I said, have a lot of people going home and being discharged. There's business hours and after hours. We are a 24-hour a day service. So we are the front door of the hospital. If a woman was to present with family violence, yes, there are discharge times and discharge planning. I guess, in that concept it's about immediate safety.

The woman is central to all decision making. I can offer services, discuss them, tell her that it's a legitimate health concern or even acknowledge that what she's actually going through is family violence, because it was said earlier today that some women don't even know that the abuse that they are going through is considered family violence.

It's up to the woman if she takes on that referral, if she does want to go home to the environment. So she is central to all of the decision making. I guess, as a health care professional, the woman is the best person to assess her level of risk. It's not so much about disclosures and referrals and collecting data on whether the referrals meet the disclosures; but the woman knows that - we know that women attempt to leave up to eight times from a violent partner before she actually decides to leave. So if she was to see me that day and I was to discuss what our services provide, that we do have women's social support, that we do have legal service involved, that you can go five days a fortnight and receive specialised care, because I'm not a family violence expert but I do have a duty of care for her safety, it would be up to her. She might not be ready that day, but she needs to know that the hospital is a

safe place to disclose family violence and that we are a 24-hour a day service and that she can come back at any time.

MS DAVIDSON: Ms Gyorki, can I just get you to finally comment on your experience of observing women who have disclosed family violence and the sort of services that are able to be offered.

MS GYORKI: It's critical to be able to provide that wraparound care to these women. As both Amy and Lisa have said, there are a number of services on-site. From our perspective, from the legal perspective, we see a lot of women who are just coming with a number of questions, the answers to which will hopefully inform their decision as to whether to leave or not; so around child support, around who's going to have time with the kids and what that's going to look like, childbirth maintenance, property, separation, divorce, intervention orders, financial assistance for victims of crime. It's often a fairly formulaic response for a lot of the women that we see and they are just trying to arm themselves with that information so that they can make an informed decision as to whether or not to leave that relationship.

We try to provide that in a really holistic way. We work closely with the social work department as much as we can, and obviously with the clients' consent to do that. But we know that women who are chronically abused are going to have difficulty either Googling a legal service or going into a legal service; whereas going into a hospital, a 24-hour environment, where they know they can receive support is a much safer environment for them and it's not necessarily advertised on the outside of the

hospital that there is a legal service in there. So we are providing them with an opportunity to receive that legal intervention in a safer environment than they would otherwise be able to at a legal service that has a shop front, for example.

MS DAVIDSON: Do the Commissioners have any questions?

COMMISSIONER NEAVE: No, we don't.

MS DAVIDSON: Thank you. If the witnesses could be excused and we will adjourn until 2 o'clock.

COMMISSIONER NEAVE: Thank you very much indeed for your evidence.

<(THE WITNESSES WITHDREW)

LUNCHEON ADJOURNMENT

UPON RESUMING AT 2.00 PM:

MS DAVIDSON: Commissioners, the next witness is Bernadette Anne Harrison, who is the Maternal and Child Health Coordinator from the City of Greater Dandenong.

<BERNADETTE ANNE HARRISON, affirmed and examined:

MS DAVIDSON: Ms Harrison, have you made a statement for the Royal Commission in this matter?

MS HARRISON: I have.

MS DAVIDSON: Are you able to confirm that it is true and correct?

MS HARRISON: I can.

MS DAVIDSON: You are a maternal and child health nurse, trained as a nurse. You are currently in a role as a coordinator. Can you explain what your role involves at the City of Greater Dandenong?

MS HARRISON: I'm the Maternal and Child Health Coordinator for the City of Greater Dandenong, and that is managing the service for maternal and child health, which has maternal and child health nurses, early parenting support officers, business support and also research programs, including the right@home, which has maternal and child health nurses and a social worker, and Bridging the Gap, which is involving maternal and child health nurses.

MS DAVIDSON: In terms of the maternal and child health service, can you explain the difference between the universal service and the enhanced service, and what each of those involve?

MS HARRISON: Yes. The maternal and child health universal service is a service that promotes child health and development, and supports families with children from nought to six years. We offer key ages and stages, from

when the baby is born, with 10 key ages and stages, including a home visit within the first two weeks. Then we have a key age and stage at two weeks, four weeks, eight weeks, four months, eight months, 12 months, 18 months, two years, and three and a half.

That goes through a number of health-promotion activities. It also looks at the child health and development. It also engages in a parent evaluation development screen, which the parents are asked to complete 10 questions about the development of their children, which is from fine motor, gross motor and how they see their child developing.

From the PEDS, which it's referred to, if there are any significant issues, that's picked up through a scoring of the PEDS. We then go on to a secondary screening called the Brigance. From the Brigance it highlights three areas of gross motor, language - and from there we refer on. It will be a referral on to paediatricians, GPs or any allied health services.

Throughout the universal program we offer new parent groups, and other sleep and settling services, and depending on the local needs of that community, as within the City of Greater Dandenong, we have peer educators that actually take culturally diverse groups in those parenting groups. Because of the cultural diversity we have a "Cooking for your Baby" group, which extends in sharing our ideas about the nutrition and food for children and families, and we work with those different communities. That may be different in every council, but generally every universal program will have a new parent group.

Then for the enhanced program, the enhanced sits

alongside the universal program, where we offer an additional 15 hours of service in home to the families, or in rural communities there's an additional 17 hours. That's working with the most vulnerable families that have been referred from the universal. In the City of Greater Dandenong we are a little bit different, and I think there are another two councils that actually accept referrals straight into the enhanced service from hospitals, GPs or other services because of the vulnerability and we want to make sure that families don't fall through the gap.

That enhanced service is different in every council because of the community needs again. In the City of Greater Dandenong we have maternal and child health nurses, we also have early parenting support officers, and they work with the families intensively for the additional 15 hours, where then they will refer back to the universal to be linked into that for ongoing support. But, if any crisis then reappears, they will then be referred back into the enhanced service.

MS DAVIDSON: You have identified that for the enhanced program you are able to take direct referrals from hospitals into that program, but does it still start at after birth?

MS HARRISON: Yes. Both the universal and the enhanced program starts after we receive the birth notification, and by the birth act we are given the birth notification per council to actually follow up and offer the service. There is a program called the right@home that starts in the antenatal. That's a research project. But from the universal and enhanced we start at the receipt of that birth notification.

MS DAVIDSON: You talked about the ability in your area to

refer straight from hospital into the enhanced program but that in other areas the woman might go first to the universal service and then get referred from there. What do you see as being the difficulties for that referral process?

MS HARRISON: In regards to being in the universal program - so if I take myself back when I was a maternal and child health nurse in the universal program - first you have to do a home visit, and the home visit goes through picking up all the family details, personal details and just ensuring that from delivery that the mother/child, feeding relationship, that the family have supports and who is around to support that family.

Then the two-week could be within the next two weeks after the home visit. However, sometimes because of increased birth notifications or the ability of - whether the families are available for the appointment, that may be a little bit longer, but generally it's that timeframe. That it may take some time, it may be the second or third or fourth visit, that things are being disclosed or that as a practitioner you are actually identifying some concerns you might have in that relationship within the family.

So with a referral coming straight from any services, particularly the hospitals, you can have a conversation not only in the maternity but quite often social workers from the hospital will discuss the issues with the enhanced team, and by that we can link in a lot quicker into the enhanced rather than waiting for a universal nurse to actually refer in, which may be quite delayed.

MS DAVIDSON: From your perspective, what are the consequences of potentially having one nurse have, say, three visits and then a referral to a new nurse to do an enhanced program?

MS HARRISON: I think one of the most important things in maternal and child health is building a trusting relationship and building that rapport with the families. In a lot of services you can go through a number of practitioners. But in linking in as soon as we can, if there are issues and we have built that trusting relationship, then we can actually work more closely with the families.

MS DAVIDSON: You have talked about in your statement the right@home program. Does that enable an even earlier intervention?

MS HARRISON: Yes. The right@home program is a research project that has been delivered in the City of Greater Dandenong by ARACY, and it's two maternal and child health nurses and a social worker. That right@home program starts around the 26/28 weeks gestation for that mother. Then one to two and even on some occasions if we can get in at that time we can offer three home visits to that family until the birth of their child. That's going through where the parent is at at that moment and then the parent's attunement and responsivity to the impending birth. It's also about establishing that relationship and just identifying some of the family issues that may be obvious or that the family would like to talk to prior to the delivery of their child.

MS DAVIDSON: In terms of the right@home program what sorts of benefits are you seeing from that program?

MS HARRISON: Just last week we actually had the philanthropic fund holders, ARACY, Sharon Goldfield from the Centre for Community Child Health come out for a presentation with the right@home. I think one of the most powerful demonstrations is that we had three families there and what they raised was that, No. 1, the relationship of the practitioner, and in a lot of cases where maternal and child health you may have a number of practitioners that you are seeing over the course of the four, five, six years in maternal and child health, in right@home you have the continuity of care with the same practitioners.

It's building the parents' confidence. It's actually supporting the parents to demonstrate that the children are great learners from a very early age and that any significant stresses can be highlighted, can be discussed to actually then refer to other agencies if need be.

MS DAVIDSON: In your experience, if it wasn't for that sort of right@home program what would that vulnerable family 's experience of the service potentially involve in terms of the number of people that they might have to see?

MS HARRISON: In comparison to the universal service, the right@home offers 25 visits from the antenatal period of 26 to 28 to two years of age. The universal service offers 10 key ages and stages from a home visit to three and half. So potentially we have a far higher relationship and far higher contact with families in the right@home, which is an in-home service. The universal service is - the first visit is offered in the home and subsequent visits the majority of time are actually offered in the health centres. Right@home is offered in

the home. So it's the practitioners that are going into the home that are actually working with both the mother and family or other family that may be living in that residence and all being part of raising the children.

In the centres for maternal and child health, particularly I guess in the City of Greater Dandenong we have extended families that do come in. So it may generally just be the mother encouraging for fathers to participate, but a lot of the time it's actually the extended families. Because of our cultural diversity a lot of the families are living with extended families.

So the differences between the universal and right@home is, I guess, from a continuity of care that very similar practitioners - although I must say in the City of Greater Dandenong we have a relatively stable nurse relationship within the different regions, but of course there are times that they do change. But right@home, it's the same practitioners that follow the families right through till two years of age.

MS DAVIDSON: What does that mean for the outcomes for that family?

MS HARRISON: I guess I keep stating that the trusting relationships, that we build rapport, and from the trusting relationships, if there are any issues - and I think what was raised at the forum last week was families were saying with that trust with the professional then they are able to disclose all sorts of anxieties and issues they may have with their child, with what was happening with them on a psychosocial basis and being able to then work through with that family how to support them, and looking at a strengths based focus and approach. So

what is it that the families can really bring to that practice to actually really develop and potentially for the best outcome for their child or children.

MS DAVIDSON: Can I just perhaps get you to address two aspects of that program, firstly the idea of starting in the antenatal period. What is your view about whether or not that's a useful thing for families to start earlier than birth?

MS HARRISON: The antenatal period is a really important time for maternal and child health to link in. I will go back. When I first started in maternal and child health 18 years ago we actually used to visit the hospitals, and in visiting the hospitals you would go in and you would meet or you would introduce yourselves to the families in the hospitals and explain the service.

A lot of families are not aware of maternal and child health, particularly in our community. I guess in the broader sense a lot people are aware of maternal and child health. But it is actually explaining what maternal and child health is about, making it appropriate for them, working with the families, because I think a lot of our work is done in post-delivery where families are not aware.

So in the City of Greater Dandenong we have a very high culturally diverse community. They have never known a preventative program such as maternal and child health. So we are needing to actually have that conversation with them to try to make the service relevant for them. In working with them in the antenatal program we can actually work alongside of them, explaining what the service is and setting up supports if needed in that

antenatal period.

It also highlights the fact that in waiting until the birth notification, if there are any major issues, the universal service of maternal and child health, it's not mandated that you attend. It's a free universal service that people can choose. They can choose to decline it, they can choose to attend. So if families have significant issues, if we link in earlier then we can actually follow them through and support them prior to the birth and then after the birth. So it's making sure that families don't fall through the gaps.

MS DAVIDSON: The second aspect that appears significant or different from the other maternal and child health nurse services from the right@home program is the idea of working with the broader family. You have talked in your statement about working with fathers. Historically, have maternal and child health - we know the name says "maternal and child health". Historically, have maternal and child health nurses had a significant involvement with the fathers?

MS HARRISON: No. I guess the name suggests maternal and child health. The focus has been on that relationship because several years ago the emphasis was put on the mother/child relationship because of the infantmental health research that was showing that once the attachment and bonding was made that was a very strong bond, and also I think the service itself indicates that it's a 9 to 5 service and generally a lot of fathers work. So the involvement in the past has not been focused at fathers.

However, I would suggest over the last five years there has been a rethink about involving fathers. It's

important because children need to have that relationship with their fathers, and I think in moving forward I think we in maternal and child health need to actually start to rethink about what our service is and who our services are actually supporting. Although we are supporting the family at large and, yes, the mother and the child are the focus, the mother, father and child should be the focus in maternal and child health.

It's also from our training that the focus is about the family. However, it's more on that mother/child diad that we actually focus on. But I think as we move forward - and I think a lot of services, a lot of people have talked that we are moving slowly towards that, but it is a slow evolvement of involving more fathers.

There's a lot of programs now that we encourage fathers to attend. CPR nights, we get a lot of involvement of fathers. A lot of our other programs, particularly in the City of Greater Dandenong, for both the family and children services and youth services, a lot of programs now are focusing at involvement of fathers.

MS DAVIDSON: Can I move perhaps to the role that maternal and child health nurses have been playing in relation to identification of family violence. Can I ask you perhaps your experience as a maternal and child health nurse of incorporating family violence questions and enquiry as part of your practice?

MS HARRISON: As a maternal and child health - I think I celebrated when our framework actually changed several years ago and it was posed that as maternal and child health nurses we actually ask four questions about family violence. Prior to that there was no formalised

statements and it was the professional's judgment that you would be picking up with mothers when you were talking about the family and home what was actually going on with relationships. So when you would speak about - I will use an example that I remember starting as a new graduate, that you would be asking mum, "What part does dad play? He can help you at night too for feeding," that there would be a shy away of some mothers and you would start to think, "What's going on there?"

Then it was one visit after another that as, again, you build trust and rapport that the mother would then realise that the role of maternal and child health about preventative health and about health promotion, that we were a resource that if anything was to be declared that they could come back.

On a number of times mothers would actually push their prams with their babies, have been in very violent relationships, and then of course the course of actions in the practice would unfold. I think with the four questions of maternal and child health today - would you like me to state the four questions?

MS DAVIDSON: Yes.

MS HARRISON: I just want to make it clear.

MS DAVIDSON: At paragraph 48?

MS HARRISON: Yes. So the four questions that we ask today - and this is at the four-week key age and stage. However, I think that at any stage of professional judgment that we can actually ask it when we know it is safe to ask. So the four questions that we ask in a conversational style - and as I was a lecturer for maternal and child health for a couple of years I used to actually speak to the students

and say, "If you do it as a conversational style, families will get to know that this is part of our role and this would actually encourage families to identify we must know something about it and we could support." That's been my case as a maternal and child health nurse.

But the four questions are: are you in any way worried about the safety of yourself or your children; are you afraid of someone in your family; has anyone in your household ever pushed, hit, kicked, punched or otherwise hurt you; would you like help with this now?

We have had training in CRAF. CRAF is the Common Risk Assessment Framework, and all maternal and child health nurses have actually had training in that. There's three parts of the framework in which there is an identifying component, there is a preliminary assessment and then there is a comprehensive assessment. Maternal and child health sits at that identifying assessment, that we identify and then we refer on.

However, in the case of having a mother disclose - and most times it is a mother that discloses - the impact I think people need a clearer understanding is the impact it has on the nurse and our service. In maternal and child health our service delivery of the key ages and stages for most of the key ages and stages are half an hour. We have a number of criteria to actually work through with the families. For a home visit and three and a half we have 45 minutes to an hour. So when we have back-to-back appointments starting at 9 o'clock in the morning going until 11.30, administration, and then restarting again at 1 or 1.30 for ongoing appointments, when someone comes in and discloses,

the impact or the ramifications on the ongoing appointments and the rest of the day is quite significant.

I will actually demonstrate with an example that happened in Springvale less than two months ago. One of the nurses had a mother that actually arrived for her 2 o'clock appointment. This mother had waited two days because she had a scheduled appointment. The mother walked in in a very distressed state. The mother had very poor English and the nurse had to phone in for an interpreter. The mother was explaining that she didn't want to go home and she was actually starting to pick up objects to try and harm herself because she wanted to die.

When the interpreter arrived - at the same time the nurse was trying to contact services but at the same time sent an email to the leadership team saying she needed assistance - only because we had said that we were out on mobile, so she sent an email. So our enhanced team leader took up that call and was there within about 10 minutes.

This mother had had significant issues in the family home where the father was a gambler and had absconded. Strangers had come into the house, had ransacked and had taken - recovered the debts, and had also held a gun at the mother's head and the three-year-old's head, with an 18-month-old child.

From that scenario we called the Crisis Assessment Team and we called Child Protection. On both occasions we were told to take the mother to the hospital. We were told Child Protection was not available and that we should get the family to go to the hospital. At that stage I became involved and we called the police, and the

police identified and informed us that they weren't available to take the children, because the ambulance could only take the mother.

During this time - so we were from 2 o'clock to 5 o'clock at this stage, and this is a centre which is a family centre, so there's child care, there's kindergarten, there's a number of people, and we had a number of issues we were trying to work through.

I actually spoke to Child Protection. I actually spoke to the CAT team, all of which they said they are not available. Maternal and child health then - and this is a common instance, that we become a holding bay until someone can actually respond to our call.

In a number of cases and in my personal experience, in that holding phase a lot of mothers will say, "I'm out of here." They will actually just surrender and they will walk out with all encouraging them to say until a service actually turns up. In the end we had an ambulance, we had four policemen, we had two team leaders, because it was getting significant. The children were so distressed. We had another team leader that came in and we were entertaining the children because no-one could help us. This mother was escalating to a point where she was grabbing things. She wanted to die. She wanted to hurt herself significantly.

Finally, when the ambulance arrived we were able to calm her down, and a police regional officer ended up coming and we identified then - and this was about 6 o'clock - 6-6.30, I think it was - that there was a family member that could come and pick up the children, and then that mother could actually be taken to the local

hospital to be assessed.

The reason why I tell that story is the impact on maternal and child health universal service is from 2.30 through until 4.30 we had half-hour appointments. We had another two rooms in that facility where we had ongoing appointments. So we had up to three to four families waiting to actually see other maternal and child health nurses. We ended up rescheduling a number of appointments for the nurse involved with this case.

But what it demonstrates is time. What it demonstrates is we need more flexibility. I think that the impact it has on families - the impact it has on professionals is quite significant when you get those sorts of significant cases.

MS DAVIDSON: What would you like to see in terms of the system responding to those sorts of incidents?

MS HARRISON: An integrated collaborative partnership for all services. I know a number of us, and I think - and I'm going to quote Frank Oberklaid, because we talk about silo services and I think that we still work in silo services. I think we are all very separate. When an issue like that happens, it's maternal and child health. Someone comes in, you hand over, and then there's no partnership, there's no collaboration in which we can actually share - with privacy as a real issue when we are trying to share information.

Maternal and child health are mandated to actually report any child protection issues. So on that platform we bring in Child Protection, but it's not always the other way, that if we ring up to find out where the progress of the family, they don't actually share that

information.

So I would like an integrated outreach model where, if a situation like that happens, you can actually call an immediate response team and that immediate response team would be then released to come and either support the nurse or then have a discussion and handover, and then take the family to a safe spot to actually work through as a collaborative team. When I talk about that, I'm talking about maternal and child health, I'm talking about family violence workers, it might be housing workers, early parenting support officers - anyone to actually help that family at that time in that crisis.

MS DAVIDSON: You talked about if you phone up you don't find any information about that family after that incident. Would that family normally come back to you and continue in the service?

MS HARRISON: Yes, once the crisis has been worked through, unless the family or the mother and the children have actually been sent to a family refuge for a period of time, but generally families do come back and generally families have that relationship that they will continue with the nurse that actually supported them.

As communities actually discuss things, that once families have that understanding of what we do in maternal and child health, I think they actually appreciate the service and the support and guidance we actually give them when they do return.

MS DAVIDSON: How important is it for you as the service that's continuing to provide a service to have information relating to what has happened to them following that incident?

MS HARRISON: It's paramount. It's paramount in the fact of supporting that family and also referring to the appropriate services. We all have our roles and responsibilities to follow through and to support families. However, when it comes to having more information there's a lot of follow-up that we do for maternal and child health to try and keep the families engaged, because on a universal platform is the best platform that we can actually work with families, and it's free, it's accessible. If we can refer and link in services and have the most current information there to work with, we then know that they are getting the best.

I think with a lot of services, particularly in family violence, when we are looking at the services out in the communities we need to have, for want of a better word, a mapping exercise to make sure all services are kept current because they change so often. Maternal and child health know the most immediate ones, but there are many other services in the community that sometimes you only become aware of by default or by referral from another service. So I think it's really important that we try and exercise a mapping responsive chart to make sure that every community have their own local services that they can actually refer to as current.

MS DAVIDSON: You have also talked in your witness statement about your vision of a maternal and child health outreach service. Can I get you to expand on that?

MS HARRISON: Yes. I have had this idea for probably 12 months, 18 months. In the City of Greater Dandenong we are very lucky to be able to look at innovation and ideas about how we actually best service our community for the

potential outcomes of our children and families. So the vision I have is the enhanced service is - we have a criteria we need to follow with enhanced of how they actually are referred into the service, and I think we have potential to actually diversify more.

However, a lot of councils have nurses, parenting officers, some have psychologists. My vision for a community outreach to actually supersede enhanced is to have a central - taking on a little bit of the immediate response team, looking at the community outreach where it's a seamless platform from universal to a community outreach. You have a professional platform where you can actually call on a number of professionals. You will have maternal and child health nurses, early parenting support officers, housing, Indigenous workers, lactation consultants, youth workers, Child FIRST representatives, that we could actually, once we get a referral into the enhanced service, that whatever the needs of that family are we would then be able to pull on those resources appropriately and then work with the families until they are actually established and we have them referring into wherever they need to be.

Even bringing in kindergartens and child care, having representatives there - and playgroups. Playgroups are a great forum where we can actually work with families. So if we have a core group of people that we can actually call on to actually work within the community, work with the families in their homes or in any venue that is safe to do so, to actually work with them and support them on that platform.

With the enhanced service at the moment with

15 hours it's quite contained. We have the flexibility, but again it's that time constraint and funding, because funding is an issue within maternal and child health and enhanced. So with that community really drawing on the community professionals to work with those families. I see it as being quite a seamless program, that if you get a referral from any service, antenatally or even post-delivery, that they go straight within the community outreach, they are still linked within the universal platform, but you have a multitude of other universal and/or secondary services working together appropriately for that family.

MS DAVIDSON: Are you talking about those services effectively coming in to provide services to the family rather than the family going to each of those services in different places, the services actually being the ones that would come in - - -

MS HARRISON: Correct.

MS DAVIDSON: Just finally, in terms of funding, you identified an issue about funding for enhanced maternal and child health - - -

MS HARRISON: Yes.

MS DAVIDSON: That doesn't necessarily take into account the different makeup of the communities. Is that - - -

MS HARRISON: No. In the City of Greater Dandenong we are a very vulnerable community, where we have cultural complexities, we have a high level of family violence, drug and alcohol, mental health issues. If we want to give the same service as our neighbouring councils we need to do a lot more groundwork and making the service relevant for these families that have, particularly from

our cultural diverse families, not known about maternal and child health. So we have to make it relevant for them to then be able to work through.

We are working with interpreters every day. We have group consultations with interpreters as in we have an interpreter for a whole session and then we go through individual appointments. But to actually make that service relevant and to actually support the families, the timing - I would say double the time we need to actually support those families and give them the quality that other councils would give.

I think within the schools, and I think we've said it in the statement, the Gonski scheme that actually take into consideration the social issues in families and the complexities that's more of a level funding measure.

MS DAVIDSON: I have no further questions for Ms Harrison. Any questions from the Commission?

COMMISSIONER NEAVE: Yes, I have a question, and I was reflecting on what you were saying there. I understand that some of the funding for maternal and child health nurses comes from the local government body.

MS HARRISON: Yes.

COMMISSIONER NEAVE: But some comes centrally from the state government.

MS HARRISON: Yes, that's right.

COMMISSIONER NEAVE: Do you know whether the state government funding takes account of the areas of disadvantage so that councils that have a higher proportion of people with problems or that are more ethnically mixed or whatever it might be, does the funding reflect those differences in local government areas?

MS HARRISON: I think there is - I must say I don't know the details, but I think there is some reflection of some funding. But at the same time with the local government to the state funding there's quite an imbalance. It's supposed to be a 50:50 split, but I know in the City of Greater Dandenong it probably comes to more of a 65, 70 split with local government.

COMMISSIONER NEAVE: Do you mean that local government is providing the 70 and the state government - - -

MS HARRISON: Yes.

COMMISSIONER NEAVE: Yes, I see. Can I ask you about the enhanced service. Do you get funded for a number of places for families that need the enhanced service; is that how it works?

MS HARRISON: Actually the funding comes from the number of cases that are closed. But each year, depending on - the state government will set criteria for each council, and for each council we have a number of case closures that we have to meet per year, which then reflects the amount of funding we receive. The funding is actually set on the Family Tax Benefit A .

COMMISSIONER NEAVE: So it does reflect to some extent the structure of the families in that area. Is it enough for you in your area? Do you get enough to cover the sorts of families that meet those criteria?

MS HARRISON: No.

COMMISSIONER NEAVE: What do you do then? You just take them in and deal with them? We have heard quite a bit about this from other witnesses.

MS HARRISON: I guess from maternal and child health we do everything possible to support the family until we can

actually link them into other services. Of course there's not enough money for anything. But I guess we try and run enhanced so there is no cost to council because of the cost we have to the universal program. But I'm sure that there are times that we actually - the council does pay because we are trying to support the families as much as we can until we get the appropriate services in place.

COMMISSIONER NEAVE: So the council doesn't fund the enhanced, this is a top-up or something of the universal service?

MS HARRISON: Yes, and generally in the City of Greater Dandenong we would probably use the universal platform to actually support that family and enhanced to try to support the family as much as we can.

COMMISSIONER NEAVE: Good. Thank you.

MS DAVIDSON: I would ask that Ms Harrison be excused.

COMMISSIONER NEAVE: Thank you very much, Ms Harrison.

MS HARRISON: Thank you.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: Commissioners, the next witness is Meghan O'Brien. If she could please come forward.

<MEGHAN JANE O'BRIEN, sworn and examined :

MR MOSHINSKY: Ms O'Brien, could you please outline to the Commission your current position and give a brief overview of your professional background?

MS O'BRIEN: Yes. The current position I'm employed at is a team leader in the Social Work Department at St Vincent's Hospital, and I'm also a PhD candidate at the University of Melbourne.

MR MOSHINSKY: Have you prepared a witness statement for the Royal Commission?

MS O'BRIEN: Yes, I have.

MR MOSHINSKY: Are the contents of your statement true and correct?

MS O'BRIEN: Yes.

MR MOSHINSKY: You deal in your statement with a particular project at St Vincent's Hospital to do with elder abuse.

MS O'BRIEN: Yes.

MR MOSHINSKY: Before we get into that, we have had some evidence about elder abuse already in the Commission, but could you just outline very briefly what do we mean when we talk about elder abuse?

MS O'BRIEN: Elder abuse is obviously under the domain of family violence. The term "elder abuse" certainly here in Victoria, there's five main types of elder abuse. Obviously the five main types are physical, psychological, sexual, neglect and financial. Within the definition of "elder abuse" which is adopted here in Victoria and certainly a number of states across Australia the notion is very much - it's around a person that has a known relationship that is causing harm to an older person. So there is a connection or a relationship between the older person and the person or the perpetrator causing that harm.

MR MOSHINSKY: The project at St Vincent's went through a number of stages and it started with a pilot.

MS O'BRIEN: Yes.

MR MOSHINSKY: What led to the pilot happening?

MS O'BRIEN: For those who don't know, St Vincent's Hospital Melbourne is a hospital that obviously has very much a social commitment to our vulnerable population and those who are socially disadvantaged. So back in 2005 we were in a fortunate position at that time that we recognised

that elder abuse was something that we were actually seeing within our patient population, so we had an academic researcher that was actually based at St Vincent's Hospital at the time, so the Social Work Department and the University of Melbourne worked together on a pilot program or pilot project in 2005, and what that included was including 166 staff across the organisation and actually getting them to talk about their experience of elder abuse and to talk also about their confidence in terms of knowing - if they were comfortable in knowing how to act on elder abuse if they actually suspected it.

That pilot study occurred over about a 12-month period. It was a very significant study in that just over 53 per cent of staff certainly identified that they suspected elder abuse, but only seven per cent of staff actually had the confidence or knowledge in terms of actually putting an implementation - implementing an intervention plan. So that pilot study and the findings from that pilot study led to an article that is part of my witness statement, and that very much talks around the hospital being a window of opportunity based on that pilot study.

The results of that pilot study then enabled St Vincent's Social Work Department and the University of Melbourne to apply to the Australian Research Council to get funding for someone to take on a PhD obviously in the area of elder abuse, within St Vincent's Hospital, and that was myself.

MR MOSHINSKY: So you then did some research on the issue; is that what happened next after the pilot?

MS O'BRIEN: Yes, the scholarship or the ARC linkage project

started in 2009. That was obviously at the same time as the Victorian publication with respect to age came out. So it was obviously very much a hot topic by then in terms of elder abuse having more of a profile.

I was also very fortunate at the time that I was given or successful in receiving a travelling scholarship from the Victorian Department of Health, and that enabled me to go to the United Kingdom for three weeks and actually observe and go to many of the hospitals, talk to policy makers, go to conferences and things like that. So I was very much able to look at the safeguarding approach that was actually occurring in the United Kingdom at the time. That study tour very much happened early on when I commenced my PhD studies. Do you want me to talk about the different phases?

MR MOSHINSKY: What happened next in terms of the project, because ultimately it gets rolled out?

MS O'BRIEN: Yes.

MR MOSHINSKY: Is that the next thing that happens?

MS O'BRIEN: Yes. Obviously the learnings that I brought back from the UK very much enabled us to commence my PhD, and ultimately my PhD focuses on supporting hospital clinicians, medical staff, nursing staff and allied health staff, if they suspect elder abuse, having the competence, confidence and knowledge how to act on suspected elder abuse.

So part of my PhD and the aims and methodology was very much around identifying barriers for staff, finding out what the issues were for staff in terms of why they weren't acting on elder abuse, establishing a pathway and, importantly, establishing a dedicated or unique

hospital education package. So my PhD included the development of an education package for hospital staff and also the evaluation of that package.

One thing we certainly recognised early on with my PhD studies was, for myself to be able to educate hospital staff, we needed a hospital policy. So alongside my PhD studies there was a high-level governance group which was actually set up within the organisation, and that was a steering group that worked on our hospital policy. Our hospital policy doesn't refer to elder abuse in the title. The title of it is "Vulnerable older people". So this was a steering group that worked on a policy for over 18 months, and this coincided obviously with my PhD studies at the same time.

MR MOSHINSKY: Can we turn then to the implementation phase. Can you give us a bit of a picture of how it was rolled out?

MS O'BRIEN: Yes. As I said, my PhD studies was very much working alongside what we were actually implementing at St Vincent's. So what we recognised was within a hospital setting it was very important that we recognise that all staff shouldn't necessarily have the expectation that they need to be able to act or respond to elder abuse. It was very much recognised that there were core groups within our organisation, particularly the social work staff and the key coordination staff in our emergency department, that needed the skills and knowledge to actually act on elder abuse. So my education package was very much geared or steered towards those group of clinicians.

Part of what I needed to do also was develop a competency framework, which I did. I developed a training

DVD. So it's a training DVD that has five case scenarios in it. The methodology I actually used in relation to the education was a pre- and post-test design. Also part of my PhD studies included myself doing some baseline data, some focus groups, interviews with staff. So all of that information, also including obviously what was happening with the evidence and the literature that was happening both within Australia and internationally, and my study tour, very much then informed our implementation which was occurring at St Vincent's, and we recognised that it was important to have a governance structure, and the governance structure obviously has a number of different elements, one being education and training, which was my PhD studies. It very much involved having executive support. It very much involved having data collection, having a risk management framework and policies and processes.

So the policy we have within St Vincent's also has a model of care. So what that means is that we are able to give clinicians a step-by-step guide to - if they suspect elder abuse for patients coming into our health service, they know how to respond to that.

MR MOSHINSKY: Is the broad model that across a wide number of staff members they need to be able to ask the question if it's appropriate and know who to refer to, but there are some specialised people who know how to then deal with it further?

MS O'BRIEN: Yes. Certainly at the moment what we have certainly found within our organisation, which is consistent with the literature and evidence, is that elder abuse particularly, like family violence, can be very

overwhelming for health professionals. We know that it's not necessarily something that staff witness within a hospital setting. So these are patients that are coming into our health service - and we can talk about the data, but what we do know is that, once patients are coming into our health service, the ability to actually act on elder abuse and ask those patients those questions requires a high degree of clinical expertise and knowledge in terms of actually how to act on that.

So certainly at the moment within our organisation it's very much - it's a strong view that social work certainly and the care coordination staff, as I said, from our emergency department program certainly are the key staff who are actually implementing or acting on suspected elder abuse and family violence within our organisation.

MR MOSHINSKY: But other health professionals might refer a patient to them?

MS O'BRIEN: Absolutely. The model of care clearly is that if - what we are trying to do is get awareness raising out there, so all staff across the whole organisation know that there is a model of care, and certainly what we do is actually encourage any staff to actually do what's called vulnerable older persons notification. So if any staff across the organisation believe that an older person is at risk, that they do a notification and then we manage that within our own organisation in terms of who are the best staff, most appropriate staff, to actually get involved in terms of doing an assessment and care plan.

MR MOSHINSKY: How long has the program been now implemented for? When did its implementation happen?

MS O'BRIEN: Our policy, our vulnerable older persons policy, was actually endorsed in March 2013, but we have been collecting data since December 2012. So the education that - part of what I do, the education itself has been happening for about the last three years. So that's - my PhD studies are sort of at the final stage, but very much part of what I do in terms of my role within the Social Work Department is ongoing education to staff within the organisation.

MR MOSHINSKY: In your statement at paragraph 49 you set out some of the data that's been gained so far.

MS O'BRIEN: Yes.

MR MOSHINSKY: Can you indicate to the Commission what some of the interesting and important findings have been from the data so far?

MS O'BRIEN: Yes. What I might just make reference to is, as I said, what we have been asking staff to do is if they do suspect elder abuse to do these notifications. What we were able to do is get ethics approval within our organisation and we are able to do some analysis of the actual data or documentation of patients' histories. So what we have been able to find from the audit, and this is for a period from December 2012 to March 2014, that what we know within our own organisation that our patients, predominantly 75 per cent of those are female; we know that patients are generally between 76 to 84 years of age, which is consistent obviously with other data across Victoria; 71 per cent of our patients were born in another country; and 45 per cent of those required an interpreter.

What we have been able to do also within our data for our notifications is actually look at the different

types of abuse that's been suspected. Obviously of interest is financial abuse was 54 per cent, psychological/emotional abuse was 44 per cent.

What we have also found within our patient groups and our notifications, which is obviously consistent with the literature, in many of our patient situations, that there is often more than one abuse actually happening at any one time. So we have been able to also look at that data.

What we also were able to do is actually look at things such as who the person of concern or who the perpetrator was, and certainly in our case, which again consistent with the literature, in 47 per cent of our cases was the son; and 22 per cent, the spouse or partner.

One thing that we also look very closely at is the risk or the triggers associated with some of the situations that we deal with. So our model is very much based on a prevention model. So it's about not causing more harm to the older person. So what we can actually do or what we have done is actually look at the risk factors, what is it that is actually happening in that situation. So we are able to actually get a sense of these patients in terms of mental health issues, how many of these situations there were issues around dementia or cognitive impairment, substance abuse issues, history of family violence.

What we also know from the data is that 60 per cent of our notifications, it was the older person themselves that actually disclosed to the health professional. So that's quite contrary to what the evidence actually says. I think that's - the catchphrase

that you started with in terms of a "window of opportunity", and that's what we believe, that while patients, older patients, are in our health service, that they are obviously feeling safe and they are disclosing that information directly to health professionals.

COMMISSIONER NEAVE: Could I just clarify one point. In paragraph 50.8 you list risk factors, and it is not clear which ones of these apply to the victim and which ones of them apply to the abuser. I presume the dementia/cognitive impairment is the victim, but some of the others might apply to - or do you not differentiate?

MS O'BRIEN: We have. Yes, we've - there's actually just over 50 categories that we have actually looked at within our data, but, yes, certainly the risk factors that you can see in this situation do mostly apply to the person of concern or the person causing harm. But, yes, obviously we also know from the evidence and the literature that older people are high users of hospitals and we know that obviously the issue of dementia is increasing. So we felt that was a significant risk factor in the scenario, and that's why it's actually been included in the witness statement.

COMMISSIONER NEAVE: So the risk factor might apply to either - the other factors you mention? For instance, history of family violence might well be a reference to the alleged abuser, whereas the dementia and cognitive impairment relates to the alleged victim?

MS O'BRIEN: Possibly, yes.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: One point you make in the statement is that I think your work has shown that the time close to

discharge is when a person is most likely to disclose. Could you just explain that?

MS O'BRIEN: Yes. Certainly what we found is that there's certainly been - the evidence is telling us a story, and what we know from these stories is that it's often at the time of discharge, when patients are more likely to feel more vulnerable or at risk, when often social workers are talking to patients regarding their discharge, and it's certainly overwhelmingly an issue usually at the time of discharge where patients actually feel that they need to disclose. So that's something that we are certainly finding with our patient cohort within our organisation.

MR MOSHINSKY: There have been some questions you will have heard today, or you may not have heard, the questions around whether hospital practices may have changed around discharge if family violence is apparent. In terms of the hospital you are working at, is there any change to practice around discharge if elder abuse is disclosed?

MS O'BRIEN: Yes, there is. What we have certainly done is, depending on, within a hospital setting, if they are in an acute hospital bed and if that means that the patient no longer has acute medical issues, for example, and we need to have some ongoing assessment, that might include, for example, that they might need a cognitive assessment, so access to a neuro psyche or geriatrician, what we are able to do and certainly got support within our organisation, that many of these people or patients we are able to move to our subacute environment.

Absolutely the data is telling us in terms of what the practice implications are. So, yes, I would say absolutely our practice and our hospital does reflect, and

part of what we do is also risk assessment. So part of that is also determining the risk to the patient if they would return home. But saying that also we obviously have situations where we have got patients over 65 who are competent and very much their choice, their wish is to return to a situation.

So in some situations discharge may not stop, but what we may do is actually just implement a revised care plan based on the risk or what that older person actually wants and what the risk factors are. Obviously you have to take into consideration whether an older person is actually returning to an environment where that person of concern or the perpetrator is actually living. So all of that comes into consideration at the time of discharge.

MR MOSHINSKY: At the end of your statement you give us a case study.

MS O'BRIEN: Yes.

MR MOSHINSKY: Could you just talk us through that case study just so we can see an example of how this works in practice?

MS O'BRIEN: Yes. The case study that I have utilised within my witness statement just describes the situation. So Mrs B is an 83-year-old female from a CALD background. She is widowed, lives in her own home with her 52-year-old son, who is in receipt of a disability pension due to mental health issues, and Mrs B has a medical history that includes heart disease and diabetes. She presents to the emergency department due to severe pain following a fall at home. She is diagnosed with a fractured hip. Her son presents in the emergency department as stressed and said in passing to staff that he'd left his mother alone for

most of the day. Mrs B had limited contact with her local doctor.

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

So this is a scenario where quite typically in this case the unit social worker would be expected to do a notification within our organisation because the older person had actually disclosed. So this is not confirmed abuse. Obviously this is suspected abuse.

At the time of discharge from the rehab unit Mrs B required supervision and support with tasks such as showering and dressing, and she was very much insistent on returning home. So in this particular situation obviously what we would be doing and obviously something we would consider is very much around that patient's capacity to make decisions for herself, was she making informed decisions, and part of what we did in this situation was actually do a cognitive assessment during her admission and we certainly recognised there were no issues in relation to her memory or ability to make decisions. So very much in line with our organisation's policy of

empowerment and self-determination, the team supported Mrs B's right to return home and community services were organised.

Certainly her son was very upset about this on the grounds that he felt that he was having issues in relation to accessing her finances. Certainly what we did - and this is the benefit of what a hospital can offer. We have staff on site, so certainly in this situation and in many of our cases we are able to have case conferences, family meetings, actually having treating teams involved. We are able to look at a comprehensive care plan at discharge, given the patient's care needs.

Following consent from Mrs B, referral was made to our aged care assessment team and she was discharged home on one of our transition care packages. Certainly what this meant was that Mrs B was able to be safely discharged home with ongoing support and case management to assist her.

So that's a scenario of how we might consider a patient's situation within our organisation.

MR MOSHINSKY: Can I ask you just one last question. This program is focused on elder abuse. Based on your academic work and your experience of this program, do you think it has potential applicability to family violence more generally?

MS O'BRIEN: Absolutely, and that's certainly something we are looking at within our own organisation. So St Vincent's Hospital Melbourne is part of a national organisation, St Vincent's Health Australia. So very much our philosophy, our ethos, our values within our organisation

is absolutely a social commitment to vulnerable people, socially disadvantaged, justice. So family violence is absolutely something that's on our agenda within our national organisation, and it's certainly something we are looking at.

Family violence is absolutely something we do see, particularly in our emergency department. So we know that our governance model in relation to elder abuse has given us, I suppose, the tools to develop a model of care, look at data, do all of that, and, importantly, it actually gives a framework for staff to actually act on it. So we absolutely believe that what we are doing at St Vincent's in relation to elder abuse can be replicated in relation to family violence in terms of the same models and learnings.

MR MOSHINSKY: Thank you. Do the Commissioners - - -

DEPUTY COMMISSIONER FAULKNER: I just wouldn't mind following up just to ask, if you were to conceptualise the system applying to a different form of family violence, is there a gap in that transition care package? Where would you find that for intimate partner violence, for example? That's clearly an aged care arrangement.

MS O'BRIEN: Absolutely. The benefit of hospitals, what we do have particularly for our older patients, because that's predominantly who our hospital users are, we do have a number of ambulatory and community services, transition care being one of them, which is a national program. But certainly within our own organisation we do have a number of HARP programs, so depending on the risk and depending on the particular situation, hospitals do have access to time-limited case management, brokerage funds.

But, yes, certainly in situations of family violence we are also reliant on the service system, the community services out there, for other patients who present to our hospital.

COMMISSIONER NEAVE: I have a question. We have heard a little bit before about the issue of recording of information about family violence. I wonder how that's handled at St Vincent's?

MS O'BRIEN: Yes. I was very fortunate, part of my study tour, that's something that they are very advanced with in relation to the UK in terms of their documentation and even their computerised notifications. So part of what we have been looking at is certainly - and it's been something that health professionals do struggle with ethically in terms of how they do document, and that's something in terms of the data audit, something we have been looking at in terms of even the language that staff should actually use.

So all of those things we have been looking at, and we do have guidelines for staff around all of that. Part of that is also very consistent with the legislation that governs hospitals in relation to confidentiality, duty of care, privacy, all those types of things.

But what we are able to do, very fortunately, is, as I said, documentation, we have a shared hospital system, which is a little bit different to also what happens in the community. So what that means is all staff in all our programs, whether that's inpatients, community, all have access to the same information. So that's of great benefit because what we are finding is many of these patients are coming in and going across units, wards,

programs. But, yes, we were very fortunate that we were able to take some learnings from the UK in relation to our documentation.

COMMISSIONER NEAVE: Have you experienced any difficulties in relation to the communication of that information externally? Suppose, for example, you were wanting to ensure that Mrs B's bank manager didn't let the son draw out all of her money, for example. There's some difficulties there, aren't there?

MS O'BRIEN: There is. Again, I suppose what we very much have to do at the time, and I think the difference - one of the main differences with elder abuse, which is different to family violence when you are dealing with adults, is very much around what is the cognition of that older person. So, with the greatest of respect and listening to their wishes and what they are wanting, part of that does come into it. So certainly there are situations where we have older people who are at risk and they, because of their cognition or dementia, can't make their decisions for themselves. So in some situations we do have to go down legal pathways if there are scenarios, and obviously, yes, we can't contact banks necessarily because of privacy, but, yes, certainly there are situations where if the harm or the abuse to that person is so significant that we have got the options of going to VCAT for administration and things like that if needed. But it's absolutely about what that older person wants or what their wishes are.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: If the witness could please be excused, and if we could perhaps now have a very short adjournment of, say, five minutes.

COMMISSIONER NEAVE: Thank you very much, Ms O'Brien.

<(THE WITNESS WITHDREW)

(Short adjournment.)

MR MOSHINSKY: Commissioners, the next witness is Lorna McNamara. If she could please be sworn in.

<LORNA DOROTHY McNAMARA, affirmed and examined:

MR MOSHINSKY: Ms McNamara, could you please tell the Commission what your current position is and give also just a brief overview of your professional background?

MS McNAMARA: I'm the Acting Director of the Child Protection Wellbeing and Violence Prevention and Response Team with New South Wales Kids and Families, which is part of New South Wales Health. My background is in disability, mental health, and drug and alcohol nursing, and I'm an honorary associate with Sydney University.

MR MOSHINSKY: Apart from the acting role, you are also the Director of the Education Centre Against Violence?

MS McNAMARA: Yes, I am.

MR MOSHINSKY: That's known as ECAV?

MS McNAMARA: Yes.

MR MOSHINSKY: Have you prepared a statement for the Royal Commission?

MS McNAMARA: I have.

MR MOSHINSKY: Are the contents true and correct?

MS McNAMARA: They are.

MR MOSHINSKY: I was wondering whether you could outline for the Commission a bit about ECAV, when was it established, what does it do?

MS McNAMARA: ECAV was established in around 1985. It commenced at the time that New South Wales began to respond to child sexual assault and adult sexual assault

as a health system, and with the opening of the first sexual assault service at Westmead. It commenced with two trainers and since that time has gone on to take on domestic and family violence, child abuse and neglect and also Aboriginal family health.

MR MOSHINSKY: Approximately how many staff does ECAV have?

MS McNAMARA: At the moment ECAV would have around 24 full-time staff, that includes some administration, and around 50 contractors.

MR MOSHINSKY: ECAV is part of the Department of Health?

MS McNAMARA: It is, and it's a statewide service. So it operates across the service. It goes across the state training and providing supervision and support and resources.

MR MOSHINSKY: What sort of training does ECAV provide?

MS McNAMARA: So we offer training from community development, particularly in Aboriginal communities and in culturally and linguistically diverse communities, through to one-, two-, three-, four- and five-day professional development for health workers, for NGOs and for other workers, for example, other government agencies often attend that training, through to qualifications through the VET sector, Certificate IV - Advanced Diploma, Graduate Certificate in the Medical and Forensic Examination of Adult Sexual Assault, through to postgraduate qualifications at the Sydney University and the New South Wales Institute of Psychiatry.

MR MOSHINSKY: So ECAV provides training both for government workers as well as non-government organisation workers?

MS McNAMARA: Yes. I think we are quite unusual in that regard. Most government agencies that have learning and

development target their workforce alone. We have always had the brief to train health workers, other government departments and the NGO sector as well.

MR MOSHINSKY: In the family violence space who are the people that you train, you as in ECAV?

MS McNAMARA: Really just about everyone who is interested in attending the training. So we would train nurses, social workers, psychologists. We would have doctors attending - that includes medical doctors, GPs, psychiatrists, forensic specialists - for some of that training. We have also provided training to Victims Services, which is part of the justice department, the Department of Public Prosecutions. We have shared training with Family and Community Services, so delivered with them; and then broadly the NGO sector. There's quite a number of those services that provide family and domestic violence support, support to children as well and around sexual assault as well.

MR MOSHINSKY: In your statement at paragraph 30 there's a section dealing with ECAV's training philosophy and general approach. Could you speak briefly to that issue? What's the general approach to training that ECAV takes?

MS McNAMARA: We really are aimed at trying to focus on prevention, early intervention or high-quality responses to anyone that's been affected by physical or sexual violence or emotional abuse and neglect; anywhere that they come through the health services or our interagency partners. So we're really focused on a trauma-informed response, but that also includes current safety assessment and cultural safety.

MR MOSHINSKY: Over the next pages of your statement you refer

to different types of training, for example, for front-line workers, management training and also specialist training for champions. Can you briefly outline what the differences are and how you approach that?

MS McNAMARA: Firstly, we train specialist workforces. So we are the - we train the mandated training for sexual assault counsellors in sexual assault services and the mandated training for child protection counsellors; also for Aboriginal family health workers that work with Aboriginal communities around family violence, sexual assault and child abuse; and we are also involved in the training of medical and forensic specialists or doctors and sexual assault nurse examiners around responding in a medical and forensic way to sexual assault.

We also train front-line staff and we train across the health system. So anyone who has been involved in this sector would know that financing this is always difficult and we tend to offer models that target specific workforces, so front-line workers and what they might need to know compared to someone who would be giving a more therapeutic response and needing to know more about therapeutic models and complex trauma symptomatology, through to management that may need to understand investigative processes and/or governance structures or application of policy and audit or evaluation. So we have different levels of training.

MR MOSHINSKY: In paragraph 43 of your statement you identify what you describe as two common failures. One is one-off training; another is Train the Trainer, something that's been referred to in evidence today, which you will have

heard. Could you speak to those two issues?

MS McNAMARA: I should clarify one-off training is fine if you are getting training in an area of expertise that you know and it's actually providing additional information. That can be quite useful. But, if you are training a workforce in an area that they are completely unfamiliar with, one-off training tends not to be held over time because the dynamics within their own workplaces will take precedence and it will lose its influence over time. Could you just ask that question again, please?

MR MOSHINSKY: The Train the Trainer.

MS McNAMARA: The Train the Trainer model has the same application. If a midwife is going to teach other midwives about a new strategy or a new application within midwifery, that's great. But, again, if you are training, for example, mental health workers on how to understand domestic and family violence, which is outside of their paradigm, then that's not helpful.

So what I have seen historically is you will have a mental health worker - I'm just choosing mental health but it could be drug and alcohol - you might give them a three-day training on understanding domestic family violence and then they are meant to go out and train other mental health workers. You cannot give a worker 10 or 20 years of experience in a three-day program, and what happens over time is the common ideas and beliefs that are already circulating in the workplace end up being reinforced. So we are not actually changing behaviour. But it is a very cheap option often and an option that organisations tend to opt for.

MR MOSHINSKY: Speaking about financial matters, do people who

attend training have to pay or is it provided for free?

MS McNAMARA: If we are funded, and we are funded for certain target groups, that training is free, and that includes training delivered in Sydney or training that we deliver across the state. We run around 200 workshops a year. For health workers the average cost is $80 no matter how long the program is. So a one- to a five-day program. For other professionals who are in government that's around $120, and for private practitioners it's $100 a day. So still a very subsidised training rate.

MR MOSHINSKY: In your statement at paragraph 52 you have listed a number of different courses that relate to domestic violence. Just a couple of specific questions. For example, in 51.2 you refer to domestic violence routine screening facilitators training. Who would do that type of training course?

MS McNAMARA: New South Wales implemented a domestic violence routine screening program in 2001 following quite a lot of research and evaluation, and the - - -

MR MOSHINSKY: Can I just interrupt you at that point. Could you just explain to the Commission what the routine screening for domestic violence covers, like who has to be screened?

MS McNAMARA: Okay. Domestic violence routine screening covers - it's for women, and it's for young women from 16 up through to mid-70s. Anyone coming through - there's four major streams, so it was mental health, drug and alcohol, antenatal and early childhood.

So the screening - there's quite a process with this. So there's a number of tools. There's a protocol, there are forms and then there what's called a Z-card,

which I have here, that any woman that's screened receives as they leave. It's kept discrete, so it looks a little bit like a tampon box so that it won't interest a partner, and it has low literacy, easy-to-understand information. That comes in 12 languages as well.

MR MOSHINSKY: Thank you. I'm sorry, I interrupted you. So the question was domestic violence routine screening facilitators training, who would attend that course?

MS McNAMARA: We deliver this program, and we couldn't possibly deliver that to everyone across the state in those four streams. So every local health district has a domestic violence coordinator or coordinator and training position that are involved in managing or supporting domestic violence responses within their LHD.

They would attend and nominate people within those four streams that they see as champions to also attend this training, some of which we deliver in Sydney and others that we deliver across the state. That's a one-day training. With that they receive a training package and they are taken through how to respond and support workers delivering the routine screening program.

Along with that we have a DVD resource, which I have submitted, called "Safer Lives, Better health", and that has a DV routine screening scenario in that so workers can see how that is undertaken.

MR MOSHINSKY: LHD - is that local health district?

MS McNAMARA: It is.

MR MOSHINSKY: Did you say that each local health district has a domestic violence coordinator?

MS McNAMARA: Either a coordinator or a trainer, yes.

MR MOSHINSKY: Could I then take up the point that you make

starting at paragraph 60, which is different paradigms in different sectors. Would you be able to speak to that issue?

MS McNAMARA: Yes. When there's a critical incident often training is pulled out as the first response to addressing the critical incident and resolving problems within the sector. There's a lot of rhetoric about collaborative practice and integrated practice, all of it really important. But the realities are it's very difficult to train someone in the context that they understand.

So, for example, domestic violence workers are trained, as we have heard earlier today, to listen to their clients, to believe what their clients are saying, to validate what they say and then to support them in their response. Mental health workers are trained to assess the form of thought, the content of the thought and perhaps not always believe what that client is saying. Drug and alcohol workers are often trained also to be cautious whether a client is manipulating or lying around securing substances, including alcohol or drugs.

So assisting workers to come out of one paradigm into another is quite complex and difficult, and we are asking them to hold multiple paradigms when we are asking workers to address both domestic violence, mental health and drug and alcohol issues. To do that successfully we really need to be facilitating that training with people who understand those areas incredibly well and can answer issues for those workers and unpack common ideas and beliefs that exist within those workplaces. Then that becomes a very useful and very effective training process for them.

MR MOSHINSKY: At paragraph 77 you say that, "In New South Wales we really have two systems that operate: the child protection system that's child focused; the domestic violence network that's adult focused. There needs to be a greater interrelationship between the two." Then you go on to say in paragraph 78, "From my perspective, domestic violence is a central structure within which other forms of abuse will be found." Could you speak to that concept, please?

MS McNAMARA: Yes. There's a lot of - where you find domestic family violence generally you will also find quite high rates of adult sexual assaults. So I think statistically we are around about 25 per cent. I would suggest that if you are working with clients and there's trust built you will get higher levels of disclosure around that. Also child sexual assault - - -

COMMISSIONER NEAVE: Sorry, do you mean by that that 25 per cent of people who have suffered from family violence - - -

MS McNAMARA: Women, yes.

COMMISSIONER NEAVE: Women who have suffered from family violence have also experienced sexual assault, that's really a higher figure?

MS McNAMARA: Yes.

MR MOSHINSKY: Within the context of the family violence, do you mean?

MS McNAMARA: In the context of the family violence. Again, if I go back to that resource "Safer Lives, Better Health", we had six adult survivors of domestic violence talk and five of those six all talked about sexual violence. But that will not be spoken about unless actually asked for.

That's something that even when someone discloses domestic violence they often will not disclose sexual violence, unless specifically enquired.

Also child abuse, so physical abuse, neglect. Sometimes that neglect is associated with the fact that there may be mental health and drug and alcohol issues, and mental health and drug and alcohol issues are often an outcome or an impact of being victimised by abuse. So if a woman is very depressed it is also very hard for her sometimes to care for her children. But we also have higher rates of sexualised and sexually harmful behaviours for children and young people coming out of domestic violence. So that's another area that really does need a response.

MR MOSHINSKY: In paragraph 80 you refer to the "It Stops Here" domestic violence response system, and you have attached as LM-3 a copy of that program. Is that New South Wales's recent multi-disciplinary approach to high-risk cases?

MS McNAMARA: It is, and very similar I think to your RAMPs process in Victoria.

MR MOSHINSKY: Then in the last section of your statement at paragraph 86 and following you outline some of the benefits of ECAV being located within government. I was wondering if you could speak to that, please?

MS McNAMARA: ECAV has the benefit, in being in government, in being in health, of participating in policy development both within health and across the health sector, but also with interagencies. I believe that because we are in government we are able to have conversations about limitations and problems that may be occurring within service and across other agencies that if we were an

external provider I don't think we would be privy to.

So it enables us, one, to identify where gaps are in service provision both within health, as I explained between, say, mental health provision and sexual assault provision, as well as working across agencies such as police, Family and Community Services, which is a statutory child protection system, Victims Services, et cetera.

ECAV is involved as a partner with the joint investigative response teams for child abuse, so with FaCS, police and with Health. ECAV partners with those other two agencies to deliver the training to that front-line workforce. So we are working constantly on improving and addressing and identifying gaps within that system.

But it also enables us, because we are involved in child protection, to understand where the gaps are in issues around domestic family violence and sexual assault provisions. So we have a chance to look across that. Of course we do a lot of work in the Aboriginal sector and we are able to identify those issues as well.

MR MOSHINSKY: Thank you.

MS McNAMARA: So it's more about influence, I would say, rather than anything else.

MR MOSHINSKY: Thank you. Do the Commissioners have any questions?

DEPUTY COMMISSIONER FAULKNER: I just want to check some history. Did ECAV develop from the health system or from the child protection system? Where did it come from?

MS McNAMARA: It came from the health system. So Health began to deliver sexual assault services. We have around 55

sexual assault services in New South Wales. They are all Health-funded and come out of mainly hospitals, and they provide - not all 55; about 30 provide - medical and forensic services as well to adult and child victims of sexual assault.

DEPUTY COMMISSIONER FAULKNER: With that genesis then, when you move into family violence, is there a very different focus in terms of the use of forensic and more clinical interventions?

MS McNAMARA: At this stage we are not really doing forensics with domestic family violence. Police are still very involved with that. We do the forensics for sexual assault for victims, and some areas, some services do it for domestic violence, but generally that is a police responsibility at this stage in New South Wales.

The dynamics are similar, power and control, and so in that way it links very well. But service provision from New South Wales Health is much more limited around domestic family violence. Though we do routine screening and we have social work in some areas, we don't have, other than one or two, specific domestic violence services. That's more the NGO sector and Housing.

DEPUTY COMMISSIONER FAULKNER: Thank you.

COMMISSIONER NEAVE: Can I just pick up on the routine screening. So this is something which is required when a person presents themselves to one of those services; have I understood that correctly?

MS McNAMARA: That's right.

COMMISSIONER NEAVE: And that's done by some sort of health department directive, or is that - - -

MS McNAMARA: That's right, it's part of the policy and

procedures. So domestic violence routine screening is part of that. It's taken quite a while to build up engagement around this. But we have ongoing training. So it is not just a one-off training. There is ongoing training, a yearly forum that people attend, so they are able to keep developing their skills. We have I think over 80 per cent compliance with antenatal services that have really found this very effective and useful, and over 70 per cent with drug and alcohol.

Our screening rates in mental health have dropped, and they have dropped because we have had a change in the tool. It was separated from their main assessment tool, and I really need to stress the tools that are used and how they are embedded within systems really have an influence on how effective some of these processes are. So we will need to come back and do some work on that.

But we also audit this with a snapshot every year. That's really important. There is feedback into the sector and we can monitor how it is going.

MR MOSHINSKY: I think you gave the percentages for antenatal. Do you know the percentage for early childhood?

MS McNAMARA: Early childhood is just under 50 per cent, and one of the critical issues there is home visiting. So we have a student doing a PhD now on home visiting. So for some of those nurses they are concerned if they are going into the home and screening where there's domestic violence. So we have found those rates have dropped. So we are working on that now as well.

DEPUTY COMMISSIONER FAULKNER: Sorry, can I just confirm do you know the disclosure rate, then?

MS McNAMARA: The disclosure rate across the whole system is about 5.5 per cent. This is in the 2013 snapshot. We haven't collated the 2014. For mental health it's around 18 per cent. For drug and alcohol it's around 23 per cent, which we would anticipate in those two areas. We are looking at indicators in both mental health and drug and alcohol.

Antenatal is lower but because we know domestic violence often starts at the antenatal period they are seen as a critical group to screen so that we can have that early intervention.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MR MOSHINSKY: If there are no further questions, could the witness please be excused.

COMMISSIONER NEAVE: Thank you very much.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: Commissioners, the next witness is Frances Diver. If she could please come forward.

<FRANCES MARIE DIVER, affirmed and examined:

MR MOSHINSKY: Ms Diver, could you please indicate to the Commission your current position and outline your professional background?

MS DIVER: Sure. I'm currently the Deputy Secretary in the Department of Health and Human Services, one of several deputy secretaries, with responsibility for a division that's called Health Service Performance and Programs. My role is essentially the interface between the department and the public health services in terms of their performance, their funding, planning. I also have responsibility for regulation of private hospitals, responsibility for ambulance services and a range of

policy and program areas as well.

MR MOSHINSKY: You have prepared a statement for the Commission?

MS DIVER: I have.

MR MOSHINSKY: Are the contents true and correct?

MS DIVER: That's correct.

MR MOSHINSKY: I think you have been in the hearing all day?

MS DIVER: I have.

MR MOSHINSKY: As you will have seen, one of the overarching themes of the evidence today is the potential role of the health system in addressing family violence. I think you take up that issue in various places in your statement, but including at paragraph 82 you refer to health professionals being uniquely placed. Could you just speak to that issue? First of all, what role do you see the health system potentially playing in relation to family violence?

MS DIVER: The health system is an incredibly broad system that has a range of services, and perhaps it's worth just describing that at the start. So when we talk about the health system we are talking about hospitals, and then there's public hospitals, and in Victoria public hospitals pretty much mostly owned and governed and managed by the government. We have a private hospital system, which is obviously run privately but in which the state government has a role in regulating. Then there's a very large community and primary care sector, which is primarily general practice but also a number of other community and primary care practitioners, which is mostly funded by the Commonwealth Government through MBS. So it's a very large sector. So the public health sector, for example, is

80,000 workers, just to give you a sense of the size of the sector.

So individuals in the community obviously have a lot of contact with the health sector, and in fact most of the contact that consumers have would be with general practitioners rather than with hospitals. So general practitioners have a very important role to play in working with consumers on their health issues and particularly in a continuity of care sense because general practitioners will be working with individual consumers over a long period of time.

Hospitals also have a unique place in the system and obviously a critical place in the system in times of crisis or in times of illness, but hospitals mostly have a kind of brief intervention with an individual in a time of crisis. But there are some services in hospitals or health services more broadly that have an ongoing relationship or a longer term relationship, so, for example, mental health services where, at the most serious end of the scale, those with enduring mental illness will have a long-term relationship with a mental health service.

Another area that has a particular role to play, and people have referred to it today, is in maternity services and antenatal services. So there's sort of touch points for consumers and the health system, and there is kind of a continuity of care relationship through general practice, and then there's points of intersection between hospitals and individual consumers.

The other point to make is that of course clinicians have a particular relationship with individual

consumers. It's a high-trust relationship where consumers have a lot of faith in their individual health practitioners and there is often a kind of close and trusting relationship. It's in that context that the health professionals or the health providers have an opportunity to play a role in working with people who are affected by family violence because it's in that context that consumers may in fact reveal or disclose that they are at risk or affected by family violence.

MR MOSHINSKY: Thank you. That's very helpful, that overview. So given that overview, and acknowledging the complexity in the very many different parts of the system, at a conceptual level what are the ways that you see the health system potentially assisting to either identify or respond to family violence?

MS DIVER: I think in the context of identification of family violence and providing opportunities for individuals to disclose that they have been affected by family violence, traditionally in the past what we have seen is that an individual clinician will assess an individual for whatever the presenting issue is in a general practice, in an emergency department, in an antenatal clinic, in a mental health clinic. The clinician is then assessing that patient in the fullness of the circumstances of that patient. So it's the clinical presentation, what's the issue - is it a broken arm, is it a mental health issue, is it a routine antenatal visit - but also what are the social circumstances that that patient is operating within. So we would call that the psychosocial factors.

It is fair to say that the hospital system or the health system has had a traditionally kind of medical

orientation, a medical model. Over the last 10 to 20 years that's broadened to be a much broader social model.

So kind of at first take what you would say is that an individual clinician is required to assess a patient in front of them in their full context. I think what we have then identified is that in fact, without adequate training and without an adequate understanding of the role of family violence on affecting health outcomes and broadly social attitudes and community culture around family violence, perhaps that hasn't been done in such a fulsome way. I think that I see an opportunity now for improving the way health professionals are equipped to facilitate conversations and assessment around the impact of family violence on health outcomes.

MR MOSHINSKY: If I could focus for the moment on hospitals, and I will come back to GPs later, you have given some of an outline of the structure in Victoria between the private and public hospitals. Could you expand a bit on the division of responsibility between the Department of Health and Human Services on the one hand and individual public hospitals? So to what extent does the department have a role in working out what is actually done in hospitals, what are the respective areas of responsibility?

MS DIVER: Sure. In Victoria perhaps particularly, a particularly developed model that's been rolled out across Australia, but a real separation between what's the kind of department or the ministry function and what's the role of an individual health service. So the department has a particular role in policy development, planning, funding,

accountability, sometimes referred to as a system manager role or system leadership role. So that's the role of the health department. So how do we do that? So we may come up with statewide plans for particular service streams or overall a framework for priorities for service delivery. We may come up with policies, so elder abuse policies or vulnerable children policies or maternity policies.

We do funding, so funding of services, as well as responsibility for the performance and the formal accountability arrangements for health services, which is really where the department has a very formal but collaborative and close relationship with health services in terms of holding them to account for the services that they have been funded for and ensuring that they are delivered according to the standards set by government.

There are number of ways in which the standards are set, and there's probably two things that are worth mentioning. So one is at a quality and safety level, there are national standards for hospitals and health services. Those national standards - all health services are required to be accredited against the national standards, and there are 10 national standards, including partnering with performance, governance, clinical deterioration, just by way of example. So that's a kind of a standard setting body that assures me, assures us, that hospitals are meeting the quality and safety standards set by the national commission for quality and safety in health care.

Then from the state government, the state government priorities and policies, but in particular the state government priorities, are reflected in a document

that's agreed annually between a board of a health service and the minister, the Minister for Health, and that document essentially lays out what the government's priorities are, what the health services' priorities are, what funding is going to be provided and what some of the key performance indicators are, and that's an agreement that's negotiated annually and signed by the minister and the board chair.

That's the document that we really use as the basis for our formal accountability arrangements with health services, and we have a formal performance monitoring framework that involves a range of assessments against the actions that have been identified in the statement of priorities, that agreement, as well as the KPIs and their financial performance.

MR MOSHINSKY: Does that model, which I think might be referred to as a system leadership model - I think you referred to that phrase - where the department is, I take it from your answer, mainly looking at policies and funding and outcomes in terms of services provided, does that mean that the department has only limited capacity to effect change, for example, initiatives relating to family violence of the type that we have been discussing today? Does the department have much scope to actually effect change under that model?

MS DIVER: I would say it has significant opportunity to influence and effect change so that the sector is able to deliver on what it is that the government's priority is. When I'm talking about those annual agreements I'm talking about the public health services. So it's slightly different for the private hospitals, and very different

for general practitioners; so if we stick back with the hospitals, or the health services. So, yes, the government, the minister, working through the department, has significant opportunity to influence what health services - what they consider to be a priority. So we will convey to services what the priorities are for them and provide them with perhaps policy, perhaps funding and formally monitor what it is that those health services should be doing.

The divide is also - I have probably talked a lot about what the role of the department is. Then there is the role of the health services. So health services are governed by boards. Boards in the main are appointed by the minister and by the government. Those boards are really reflecting - they are there to implement the government's priorities, but really as a reflection of the community as well and representing the community's interests. Those boards are then held accountable by the minister for what's going on in the service. So the service responsibility is actually about service delivery, and - - -

MR MOSHINSKY: Can I just interrupt you. Could you just explain what you mean when you are referring to health services? Are you talking about regional?

MS DIVER: So a health service is an entity. So, for example, The Alfred, Alfred Health is an entity, or Melbourne Health is an entity, and within those entities they run hospitals, but they also might run a number of other services as well - community health, centres against sexual assault, aged care services. So the health services is a broad term for the entity, and part of the

entity is a hospital.

MR MOSHINSKY: I see.

COMMISSIONER NEAVE: Just to give an example, would it be possible under this process for the department to set, I will use the word, objective - that may not be the correct terminology - of reducing childhood obesity or reducing family violence, and then saying to the service providers, "This is one of the government's priorities, and we want you to do this, and your KPIs will include some KPI to do with that particular objective"?

MS DIVER: Yes, that's correct. In fact that's happened. In '14/15, in the statement of priorities there was an item - it was a non-mandatory, but there was an item that said health services should take some actions addressing vulnerable communities, for example, elder abuse, and that was nominated in the statement of priorities as an area of action that a health service might undertake some action. So we can see St Vincent's will have a very good response, because you can see that St Vincent's has done quite a lot of work in elder abuse.

In '15/16 statement of priorities we have included as a mandatory item that health services need to take action to implement programs to address and respond to family violence. So that's an action area. It's mandatory. So we have said health services must do something about it. They will put in their - so we have said that's one of the areas. Health services will then list their actions, and then we will monitor their actions during the year, halfway through the year, I think it's in our quarter 3 performance sort of round of meetings health services will bring to those meetings what they

have done or report by exception if they haven't been achieving those - what the actions that they said they were going to do, and then at the end of the year health services are required to report against those actions in their annual report.

So they are actions and they are priorities. They are not necessarily in relation to family violence at this stage hard KPIs.

COMMISSIONER NEAVE: You could, however, could you not, introduce routine screening for family violence or ask the service providers to do that?

MS DIVER: If that was what we determined to be the most appropriate response and we all agreed that mandatory screening using a particular tool was best practice, then we could include that in the statement of priorities and require health services to do that. I think there's probably a couple of things to say around that. One is that of course we would want to have health services respond to family violence in a more comprehensive way than just do mandatory screening.

COMMISSIONER NEAVE: Of course. That was just an example.

MS DIVER: As an example, by way of example. So a la Kaiser Permanente that says there is actually a package that needs to be implemented, then that's what we would be interested in doing.

DEPUTY COMMISSIONER FAULKNER: Can I just clarify, Ms Diver. But that means that you don't prescribe that; you ask them to take action about family violence without prescribing it and then they come up with the ideas?

MS DIVER: Correct. What's important to understand is that there's already a whole lot of action happening out in

health services. Health services are, and I think I have submitted that as part of my witness statement, a collection of activities. So not all health services are at the same place. Some of them are members of integrated family violence networks; some aren't. Some are members through primary care partnerships. So there is a whole kind of range of activities that are occurring in health services.

But the piece of work that the department has funded at the Royal Women's Hospital - at the Women's Hospital, which is about strengthening hospitals' response to family violence, is really about having a lead agency take a lead role, develop - so they undertook a pilot, did some training. There was an evaluation of that training. The evaluation is not quite finalised yet. Out of the evaluation the Women's learnt quite a lot about what is effective in terms of implementing responses to family violence, particularly in the screening process.

The Women's Hospital is now developing a toolkit that is about to be - they are about to undertake consultation with other health services to say, "Hey, does this work for you? Is this an appropriate kind of toolkit?" Then we would produce the toolkit, and we anticipate that's a toolkit that we would use to spread best practice across the system and enable health services to then adapt their own local circumstances using the information in the toolkit.

COMMISSIONER NEAVE: Just a follow-up question. Who is responsible for generating the ideas? For example, you might go away and look at world practices, as we had evidence this morning, and decide that this should include

a series of elements. Does the department take responsibility for the generation of ideas - I understand that it doesn't impose them on the local areas - or does it adopt a sort of "let many flowers bloom" policy, leave it to the service providers to come up with some ideas as to how to go about achieving an outcome?

MS DIVER: You probably won't be surprised to hear me say it is both. So there is both generation of ideas from government, and government policy priorities. There is generation of ideas in the department. I should say that the department works not just with the bureaucrats locked up on their own but of course the department is working with the sector. So much of the work of the department is informed by ministerial advisory committees or sector reference groups. Then of course there's clinical leadership at the health service level.

It's probably worth saying that one of the - so the department would say and I would say that one of the strengths of our system is the nature of our devolved governance that allows local autonomy and allows innovation to occur out in the sector. The more you mandate from the centre and impose on services, the less innovation you get. So it's a balance, obviously, but we think an important part of our system is allowing that kind of flexibility and innovation.

So family violence has obviously become a priority of government, so elder abuse, we put guidelines out a few years ago, family violence has obviously become a particular policy priority of government. The Women's is taking a leadership role, and we encourage and support that. Then we will facilitate the rollout of that across

the sector, and we would facilitate that in a number of ways. So we make it a priority. It's in the statement of priorities. We talk about it in our policy and funding guidelines. We follow up the actions to see if services are actually doing what they said they were going to do, and we may also fund particular initiatives. So dedicated funding obviously has significant influence as well.

DEPUTY COMMISSIONER FAULKNER: Can I just say when people put forward their ideas about what they might do, does the department critique that in any way, because it's quite possible that some initiatives that are put forward are window-dressing? Do you critique that and ask for more?

MS DIVER: I think what we try and do is link services together. So where we have a service that's got very good practice, then we will link that with a service that's perhaps struggling in the area. Another area where there is an opportunity for sort of auditing or checking what services are doing is the national accreditation standards.

So the national accreditation standards that I referred to earlier from the National Commission on Safety and Quality in Health Care, just call it the national commission for now, those 10 standards are now up for review, and one of the standards relates to partnering with consumers and consumer-centred care.

Included in the review of those standards is a new standard related to ensuring that there is appropriate screening for vulnerable groups. That's one sentence in a national standard, but those standards are about to be released for consultation and there is an expectation that that will allow - if that goes through the process and is

endorsed, then that allows - makes sure that services who are required to meet that standard can demonstrate that they have got appropriate screening, appropriate services that are kind of responding to consumers' needs, and then in the accreditation process, which is essentially site visits by accreditors, will be able to assess health services performance in that area; so that what may look like window-dressing then through an accreditation visit actually gets revealed as - it is either revealed as window-dressing or not. So that's kind of one audit process.

But, really, it's the connection of services to partnering with other agencies, both peer agencies, so a good performer with a less well-informed performer, but also the requirement for health services to be partnering with community based and - with specialist family violence services. So there is a holding to each other account in terms of what the actual processes are.

So it's not that hospitals do this in isolation. Hospitals aren't necessarily family violence experts, but they obviously need to be expert at enquiring and responding to family violence, and linking people with family violence services. So outside the individual kind of patient care there's a need for partnering, and so we would - I would expect the head of the Royal Women's Social Work Department to be part of an integrated family violence network, and the family violence services and police and community services and the hospital are all meeting separately and there's a feedback loop in terms of what their practice is.

MR MOSHINSKY: Can I take up some of the points that were made

by the first panel this morning, the panel of four. You will recall that one of the strong themes from a number of the members of the panel was that when implementing new programs the training should almost be last, that it was very important, they indicated, to have the systems, the policies and the infrastructure in place and then do the training. Can I invite you to comment on that as a general approach?

MS DIVER: Sure. That's really about change management in relation to any change in an organisation and a change in clinical practice. So there is a bunch of elements that you need. In particular you need to have that a priority, so it is a priority by somebody, whether it's government or the board. You need to have executive sponsorship, so there needs to be very clear senior executive sponsorship.

In a hospital setting you need clinical leadership. Mostly clinicians aren't going to get on board unless there is a kind of clinical champion. You need appropriate protocols and procedures for managing the patient pathways or the referral networks both within the hospital and externally to the external partners.

Then you need to equip clinicians to be able to actually do the enquiry and have an agreement amongst clinicians about, "So who are we targeting?" It's not just one individual clinician that has decided that this is their life work and they are going to do it and the other clinicians aren't, but actually agreement on how is that being rolled out across the hospital, who are the patients that are being targeted for screening and what is the appropriate response when that occurs.

So you need to have all of those things in place

before you start the training. So a good example - when people have referred to social work being a five-day service, a good example is there are social workers on call after hours. If there is an enquiry in an emergency department and there is an issue that needs to be resolved, then social work is on call and that's part of the role of social work to be on call and respond to that after hours. So it is making sure the systems and processes are in place. That's not an unusual change management process in hospitals.

I think the work that the Women's is doing in developing the toolkit to help hospitals strengthen their response to family violence is really all about that. It's about what is the package, and to then make sure that hospitals don't have to re-invent the wheel every time they go to do it but that there are resources that are available to support them about this is what the protocol could look like, this is what the screening tool could look like, this is what the medical records notes could look like, this is how they organise their social work resources, this is how they do their service mapping with their kind of specialist family violence services. Then services will take that and adapt it slightly differently.

So I imagine St Vincent's would, if they were to deal more broadly with family violence than elder abuse, use some of the processes that have been successful for them in elder abuse, and that will work for St Vincent's. So it is allowing services to adapt it to their local environment. If you allow the flexibility of services to adapt it to their local environment, they are more likely to take ownership of it, and actually embed it, own it,

live it and actually implement it, rather than it being a circular from the department.

MR MOSHINSKY: Another point that was made by a number of the members of that panel was that where programs have been run we haven't evaluated for women's outcomes. You will recall the number of times that was mentioned.

MS DIVER: Yes.

MR MOSHINSKY: Can you comment on that in terms of programs and evaluations that have happened?

MS DIVER: Yes. So the search for health outcomes is a great art, and we are not there yet. So measuring health outcomes is a very complex area. We are quite good at measuring activity and outputs, and we are not bad at measuring - sort of having surrogate measures of quality. But, really, patient reported outcomes is a relatively new area of practice, and there's a lot of interest in actually developing patient reported outcomes.

I think it's fair to say that at this stage what we have got is small-scale evaluation programs of individual pilots within a health care setting that tell us that there's more work to be done. But I think so far from the evidence that I can see we haven't actually got a consistent - we haven't got consensus on what's the most appropriate practice.

For example, the World Health Organization is still saying - their advice is still that universal screening is not appropriate in a health care setting and that there has been no evidence shown - none of the evidence shows that there is an overall benefit in terms of reducing the burden of family violence and impacting on health outcomes. That doesn't mean to say that we don't

do screening. It's just that universal screening is not appropriate.

So then the next question is: what are the areas that we should be targeting screening to? For example, antenatal clinics have been identified as a possible area because it's known that that's when family violence often - that's an area in which family violence can start. So - I think I have lost track of your first question now.

MR MOSHINSKY: The point was that, in terms of programs that have been run and evaluated, so far there don't seem to be actual women's outcomes coming out of those evaluations?

MS DIVER: Correct.

MR MOSHINSKY: Another topic that was discussed in the panel this morning was around data, and we have touched on it in your evidence already. Can I go back to that topic of data and data systems. Just in terms of the structure in Victoria, who decides what data is kept? Is that a department decision or a health service decision or a hospital decision?

MS DIVER: If we are going to talk about data, I might just go back to in Victoria, because our services are individual entities and have a history of an individual entity, they have not been kind of a single system. So New South Wales used to be a single system. So single - so they would have a single ICT system, single data system. In Victoria what we have got is lots of different entities who have different systems. So their ICT infrastructure is different in each entity.

However - and individual services will collect their own data in ways that they see as appropriate for them. So they may collect more data. But a subset of

that data, minimum datasets are required to be submitted to the department. Those minimum datasets are according to both national and state guidelines. So the big dataset, which is the Victorian Admitted Episodes Dataset, which is really about inpatient care, there are national classification and coding standards and in fact international standards that guide that data collection.

MR MOSHINSKY: So I take it from what you are saying there are minimum datasets both at the state level and at the Commonwealth level?

MS DIVER: Correct.

MR MOSHINSKY: So the department can require certain minimum data to be kept by hospitals?

MS DIVER: Correct.

MR MOSHINSKY: To take a particular example of relevance here, as I understand it currently there's no requirement to record if someone discloses a history of family violence or present family violence as a patient in a hospital. Is that right?

MS DIVER: So the minimum datasets that come into the department, there is in fact opportunity to record family violence. So the emergency department dataset is a dataset that is filled in by clinicians and emergency departments. It has a number of fields for diagnosis, for example, and in the fields that are related to injury, so there's been an injury, then there's subsequent fields in that dataset that would relate to what's the cause of the injury. So what's the location, what was the activity, for example, so was it a football field or was it a car accident or was there human intent, so there are human intent fields and subsets within those fields that relate

to family violence.

So the purpose of those fields is about injury surveillance. It's not - the purpose of those fields is not about individual patient care. The purpose of those is about the minimum dataset that comes into the department and for injury surveillance. So that's in the emergency department dataset.

It's probably fair to say that there's - so there's an opportunity to record it; that doesn't mean it's always recorded. So, first up, we already know that there is an underreporting - so people are not necessarily disclosing to health care professionals. Then there's are health care professionals actually recording it. Then is it being recorded in the dataset. So there is kind of a number of areas. So we know the data. So the data says about a thousand cases a year in Victorian public hospital emergency departments are related to family violence. We think that's significant underreporting. But that's the data we have.

There's also the admitted dataset. The admitted dataset operates according to international and national coding standards, and it's a very complex dataset. Each patient record has up to 40 diagnostic - kind of capacity for 40 diagnoses. So there's primary diagnosis and secondary diagnosis and contributing factors. In that dataset there are fields that cover external causes, and that's where family violence can be recorded.

So we do have information in the admitted dataset that tells us about family violence. But, again, we think it is underrecorded. That's a dataset that is probably more developed because that dataset in fact drives funding

for hospitals. But the external causes are not an element that drives funding for individual diagnostic related groups or individual categories of patients.

MR MOSHINSKY: Can I just interrupt, for that group, the patients who are admitted to hospital, does that dataset just capture the principal reason that they have been admitted or does it also capture comorbidities?

MS DIVER: It captures comorbidities, so that's the 40 fields essentially, and family violence is considered an external cause. So it's in there, but it doesn't contribute to the hospital funding, I suppose, if that's where we are going.

One of the things that we have looked at is is there a difference in cost. So, without getting too complicated, the diagnostic groups or the casemix funding for individual patients is really a reflection - the payments that are made to hospital are based on the cost in the hospital, and we have looked at episodes where family violence has been identified with similar cases where family violence hasn't been identified and we haven't identified any difference in cost.

I have to say it's significantly underreported. But, intuitively, that's not surprising because in fact the costs related to family violence are not borne by hospitals. They are mostly borne by specialist family violence services. So there's a small additional cost, there would be some social work input, and occasionally there would be an extended length of stay. But mostly the costs for the system for family violence are in fact for specialist family violence services.

That's where there is a direct impact from family violence, so an injury, for example. But of course

there's many indirect health costs associated with family violence - exacerbation of chronic illnesses or where there is undisclosed family violence and there is an exacerbation of a mental health issue or a drug and alcohol issue.

MR MOSHINSKY: Would you see utility in capturing that data even though it may not be linked to cost or funding?

MS DIVER: Data and health care is a very complex area, and to implement new data systems we really need to be very careful about what's the intention of collecting the data, and there's a number of levels at which we want to collect data. So we need data for the clinicians, who are dealing with patients - have the referrals been made, what's been documented in the medical record - and, really, for the purposes of coordinating the care for the individual patient. So that's kind of one area of data. That's mostly - really, responsibility for that sits at a health service level within their own data systems.

Then there's the issue of data collection for monitoring trends, costs, evaluation purposes, what's the prevalence. So there's a couple of options of how you might collect that data. So you might impose more data collection on health services to report into these minimum datasets and then have to audit and do follow-up and change ICT systems and do a whole lot of things. That's one way of doing it, and the cost benefit would need to be assessed.

But there's also opportunities for data linkage as a mechanism to get that information as well. So that is de-identified hospital data being linked with de-identified family services, specialist family violence

service data. So kind of data linkage is another opportunity where you might actually get that data in a more cost-effective way.

Then the last issue of course is using snapshots or surveys or registries or individual data collection, sort of deep dives into a particular area, and that might provide more rich data in fact that you can use to kind of apply the lessons out of that data more broadly.

MR MOSHINSKY: One of the aspects that you referred to was notes kept by the doctor, for example, to inform further care of the patient. Ms Watson, from the Royal Women's, who gave evidence later in the morning, talked about the benefits of having knowledge that perhaps a patient has previously disclosed family violence on an earlier occasion. Is whether that sort of recording should occur something that's for the health service to decide rather than the department?

MS DIVER: I think my reference to that is something that occurs at a health service level, and obviously - it's clear that having medical records that are consistent and provide history and continuity to support continuity of care are very important, and in particular not only within the hospital, because that's a fairly limited, short episode in someone's life, but in fact the connection back to general practice, because general practice is in fact where most of health care occurs.

So what we are all interested in is electronic medical records in some form. Whilst we are progressively rolling out electronic medical records and hospitals are gradually implementing electronic medical records, probably the most interesting part perhaps from the Royal

Commission's point of view will be the personally controlled electronic health record, which is really being driven by the Commonwealth and is much more about general practice but also with connections into hospitals.

So at the moment the - that's called the Personally Controlled Electronic Health Record, or PCEHR. About 10 per cent of Victorians have opted into that system, and that's really a repository for health providers to put information into a central repository that different providers can access information.

In the medium to long term, that is probably what we are all looking for in terms of having information that's accessible by a number of health providers to ensure continuity of care.

MR MOSHINSKY: Can I move to another topic - - -

DEPUTY COMMISSIONER FAULKNER: Can I just ask a follow-up, please. Ms Diver, one of the things that you could need data collection for is to assess whether or not you are treating the condition that's presenting or the context that's presenting in the right setting. In the past there have been identifiers for Indigeneity to collect information so that you understand better how that population is being served. I'm just wondering what your response might be to something like that that says that probably family violence technically is an ambulatory condition, it should be treated outside the hospital, and having an idea of how much of what's coming to you is in fact in that bucket would also be useful, I think, but I would like your comment on that.

MS DIVER: First of all what I would say about the identification of Aboriginal and Torres Strait Islander

people in hospitals, there's an insensitive payment essentially, there's a loading on the - a 30 per cent loading on the inpatient payment, basically. That's there for two reasons. It's there because we know that the cost of caring for Aboriginal and Torres Strait Islanders is higher than the cost of non-Aboriginal and Torres Strait Islanders, and that's because that population has poorer health and they tend to have longer length of stay, more investigations and require more support.

But it's also there to ensure there is an absolute incentive to get the identification of Aboriginal and Torres Strait Islander people because of the significant gap in health outcomes for Aboriginal and Torres Strait Islander people. So there is a kind of clear policy intent and definitely a cost to services that we need to ensure that we pay services so that they can cover the cost of services.

When you move to family violence, so I guess should we put a loading onto the - if we are thinking about using that system, so what if we put a loading onto the casemix payment for family violence. It's an interesting idea. But one of the issues that we have got is that we haven't got any evidence that the cost of delivering an episode of care to somebody who has been affected by family violence is more than somebody who hasn't been affected by family violence. So the actual cost - so broken arm or an injury for somebody related to falling off a horse, whatever it is, or an accident, an accidental injury versus family violence, there doesn't appear to be from the data that we have so far any evidence that there is a greater cost for family

violence - for people affected by family violence. That's because most of the cost is actually borne by specialist family violence services. Small cost on hospitals, but very small compared to the cost that's borne by the specialist services.

So in terms of payments for hospital's care, not sure that quite works. But in terms of understanding what the prevalence is and what the overall impact, so what's the burden on hospitals in terms of the number of people that are affected by family violence, that's a different issue. So there's kind of payment for the individual episode, probably doesn't work. But in terms of understanding is it a thousand presentations a year to emergency departments or is it 10,000 or 50,000 and what are the trends, they are much more - that is really important information to have, and I think there's a couple of ways of getting at it. One is the data linkage work with family violence services, and another is kind of new data collections in health services, and the cost benefit of each would need to be assessed.

DEPUTY COMMISSIONER FAULKNER: Thank you.

COMMISSIONER NEAVE: Could I just explore that a little further. Is not the reason that the cost of care might be the same that people who come in with a broken arm and a history of family violence are treated for their broken arm and not for the additional matters, the additional complications that might arise? I understand that you might then refer them elsewhere, but if we were to engage clinicians in identifying, providing support and all of those sorts of things, then the difference might become more apparent? It's a bit circular, isn't it?

MS DIVER: Sort of. But in the context of the cost of an episode of care in a hospital, the cost of a social worker assessment and referral is likely to be relatively small in the context of the overall cost of their care. So a $10,000 episode of care for one episode in hospital, and to put social work resources into that, yes, there's some cost but it's not particularly significant cost. But there is significant cost for the services that that service is going to refer to.

I think there are costs in hospitals in relation to establishing systems for identifying and responding to family violence. So that's kind of a sort of a slightly different issue, and we might pay hospitals in a different way for that. So not all funding for hospitals occurs through casemix, and particularly a change management process, for example, or embedding, for example, the Women's toolkit into hospitals, there's significant work that's required for change management, embedding it in clinical practice, feedback loops, local data collection, training. So if that was something that we were going to roll out across hospitals, then we would fund them perhaps in a dedicated fashion for that for a period of time to allow that to be embedded into clinical practice.

DEPUTY COMMISSIONER FAULKNER: One of the things that I might posit is to say that, for example, it only costs the same because that's all you give people with family violence problems. So if you look at the evidence that's been led about the need for enhanced antenatal care, enhanced maternity care, at the moment what happens is people don't get anything enhanced and so therefore it costs the same. So that's the other argument that I would like considered

as well.

MS DIVER: Sure. Antenatal care is an ambulatory setting. It is a little bit different from the case mix system for inpatient care. Antenatal care I think is a really interesting environment in which we can really probably push the system to do things quite differently. We have heard evidence today from other witnesses about bringing the legal service in and bringing other services into the hospital setting, which for some people that will be really important and helpful, and there are obviously costs associated with that that need to be reflected in the cost of antenatal care.

But there's also an argument that says actually antenatal care should be occurring in a community based setting where in fact you have all those services surrounding - - -

DEPUTY COMMISSIONER FAULKNER: I'm happy to concede the point. So let's go to maternity and say a lot of evidence has been led about premature babies, for example. I just wonder if people are recognising the connection between prematurity and then things like complications - if you took all that into account, whether it would in fact display something else. I didn't mean to stop you, but I'm just looking for a comment on the hypothesis that perhaps we are missing some of the costs of care because we are not identifying that the source of some of the complications is in fact violence.

MS DIVER: Yes, I agree that's possible, particularly because it's indirect. So prematurity would be a good example of what the physical presenting symptom is, early labour, whatever it is that is leading to the prematurity, but in

fact there might be family violence occurring at home; or there might be an infection or there might be something else, but there might be family violence and an infection. There is causation and correlation. Yes, there is certainly the possibility and definitely the possibility that that is affecting pregnancy care or the cost of neonatal care.

I guess what I'm trying to also say is that the cost of antenatal care - so if we have more social workers, more drug and alcohol workers, more mental health workers involved in antenatal care, that's a good thing for those that need it and we should do that, and in some places that needs to be in a tertiary setting like a hospital and there is cost involved in that, and the costs of that are reflected in the cost weights, and so hospitals are paid for that in an antenatal setting.

But there is also an opportunity to have the clinical antenatal care occur in a community based setting. A good example of that would be the Koori maternity services. So the department has funded Koori maternity services so that the clinical care occurs in an Aboriginal controlled organisation mostly or in at least a Koori health care setting so that you are putting the clinical care surrounding the social care as well. So there's just two ways of looking at it, and we need both would be the answer.

MR MOSHINSKY: One of the points that's been made in evidence today about other systems is that there seems to be a coordinator role in different regions. I think the evidence from this morning was that each district health board in New Zealand had I think a family violence

coordinator. We have just heard that each local health board in New South Wales has either a coordinator or a specialised trainer. Do we have any equivalent in Victoria?

MS DIVER: We don't have named coordinators in the same way. But, from where I sit, the head of social work would be that role. Do we need a dedicated role? Particularly in the roll-out of a new approach in hospitals, the Strengthening Hospital Responses, then that would be a possibility.

The other point to make with the district health boards in New Zealand of course is that's a single level of government. That incorporates primary care and hospital care. One of the things that I haven't talked about is primary health networks. So general practice, more than 5,000 GPs, more than 30 million episodes of care in general practice every year in Victoria, and there's a need to kind of coordinate that and provide more than just medical care in a primary care setting.

The Commonwealth is newly establishing primary health networks across Australia. There will be six primary health networks in Victoria. There is probably an opportunity for primary health networks to also have a role in making sure that primary care is able to assess, respond and connect to the specialist service system for family violence.

So I think that health services, there needs to be a role or somebody in the health service needs to be accountable for what the health service system is for that individual hospital system to respond to family violence. So my first take would be that would be social work, but

in some services that might be the emergency department care coordinator or it might be a midwifery position in the antenatal clinic. So we need to have that identified if we are to roll out the Strengthening Hospital Responses to Family Violence.

I would also say that there's probably a significant opportunity for primary health networks to consider that kind of approach to ensure that the very disparate service delivery that occurs in primary care has some way of coordinating and enhancing their response.

MR MOSHINSKY: In terms of the health services, whether it was a good idea to have a family violence coordinator, would that be something that the department would sort of buy into or would that be just a matter for the health service, in your view?

MS DIVER: How it might happen in the next little while is we will look at the work of the Women's in the toolkit that supports the roll-out of an approach to identifying and responding to family violence. Some services will say, "Yes, we already have a social worker who is already nominated to be the kind of person that responds to and coordinates family violence," and that's what they will do. So there is a kind of nomination process and then there is a funding process.

Mostly we would say this is for health services to organise who is the best person in their organisation to be the person to coordinate the response to family violence in their service. That's kind of responding at an organisational level as opposed to responding on a clinical level to individual referral cases.

MR MOSHINSKY: We had evidence this afternoon about the New

South Wales ECAV model where training is to a considerable extent done by government. Is there any equivalent in Victoria and what observations would you make about the benefits of that system?

MS DIVER: So there is some training that's funded and sponsored by the department, and there would be some undertaken by the department as well. But it is probably fair to say that the department has a much more distributed model for training. We may fund a lead agency to undertake training or health services would organise their own training. I think the elder abuse training was run by Victoria University. So the department funds Victoria University, who then trains 7,000 people across the state.

So we don't have a centralised model in the way New South Wales has a centralised model. I noted that that model applies across both public and private or public and non-government organisations. Probably Victoria would say that doesn't necessarily have to be from the centre, but I do note that New South Wales witness also commented on the capacity to influence policy because they are located within the health department.

That's interesting, and I guess that's also about how the department interacts with the sector in terms of where they get their policy advice from to inform what policies would occur. So there's a little bit about working with the sector to make sure that the policies that government are going to put together are informed by best practice. Does that mean that we have to have training units sitting in the Department of Health and Human Services? I'm not sure that's the only way. It's

one way. It's working for New South Wales. Could it work for us? Possibly. But there are other ways of doing it as well. Probably a distributed model fits more with the model of service delivery in Victoria where the department holds a kind of planning, policy, funding role and the sector holds much more of a delivery role.

MR MOSHINSKY: I just want to ask you a couple of questions about the Strengthening Hospital Responses to Family Violence project that you have referred to, and I think you have a copy available to you of the draft evaluation report, otherwise we can pass one forward. Can you just explain what stage the evaluation is up to? Is this a draft report or is it a final report?

MS DIVER: This is a draft report from Our Watch, which was the organisation that was undertaking the evaluation. Our Watch is planning to - I think their plan they have told us is the timeline is September this year, plans to finalise the evaluation report. This is really Our Watch's draft final that's come into the department for commentary. So, from our point of view, we have only recently seen it. It's draft and there are a number of issues with it, and I expect there to be changes to the document before it's finalised.

MR MOSHINSKY: Did you have any personal involvement in the actual conduct of this project?

MS DIVER: No, not personally.

MR MOSHINSKY: I'm conscious of the time. There's a limit to how much I will go into at the moment. You are familiar with the document, though. One of the points that might be made is that it doesn't appear that all the systems and policies were actually in place at the beginning of the

project.

MS DIVER: Absolutely.

MR MOSHINSKY: Which doesn't seem to fit with perhaps the model that you indicated earlier was best practice.

MS DIVER: Correct. Maybe let me explain. There was some funding made available through the Office for Women which was part of a national partnership on family violence. That money was made available to the Women's and Bendigo to do some training. It was initially framed around prevention but then shifted to be around identification and response.

So the two services looked at the literature and undertook some training, and this evaluation has really evaluated that training. The lessons learned out of that I think now feed into - not that I think - the lessons learned are now shaping the way the Women's will put together a kit that would be rolled out across the system. So that was one piece of work.

Subsequently earlier this year or late last year the then Department of Health funded the Royal Women's to take a leadership role in taking lessons learned from that small pilot to develop something that could be rolled out across the state, and that's where a much more comprehensive approach is being taken. It's about, "What's the protocol? What is the screening tool? Who are we targeting? How do we do the training? What's the system? What's the service mapping?"

So I would describe this as a first draft of an evaluation of a small pilot that was really just the beginnings of a piece of work around training, and out of that process identified a whole range of issues that need

to be addressed if we are going to put together a response that is truly strengthening the hospital response to family violence.

MR MOSHINSKY: Can I raise the more general point with you that was raised. It's come up quite a lot during the public hearings, the number of pilots there seem to be, and also the point that Kelsey Hegarty made this morning that there seems to be a lot of duplication with projects. Can you speak to that general issue?

MS DIVER: I think that's a fair criticism of quite a lot of work in the sector, that at times what appears to be duplication and lots of pilots, that is partly a feature of this devolved system where people do their own thing. That sometimes feels like duplication and waste, and sometimes it is. But sometimes that's actually about innovation and people adapting systems for their own context, I guess. So that's a general comment about duplication and small pilots.

Probably what I would say is this was a small pilot. There are some lessons learned. I'm not interested in now just telling health services to go and re-invent this. What we do is we pick a lead agency, like the Women's, and they develop something that's consistent, a toolkit that can then be rolled out across the system. That's not a pilot. That's what we are going to do.

The language of "pilot" - so, yes, I agree there are pilots, and this was a pilot and there's some findings. But one of the benefits of the health system is that it is large and when we decide to do something we really decide to do it and we have capacity to roll that out. That's what we anticipate to happen with the

development of the new kit by the Women's.

MR MOSHINSKY: The last topic I wanted to raise with you is the general issue across the health system of the department's role in assessing what the demand is for different types of services and planning to ensure there are adequate health services available. I understand that sort of planning is part of the department's role.

A number of the issues that have come up through the evidence and the public hearings concern, for example, CAT teams and whether there is sufficient availability. There's been a lot of evidence that there isn't. Mental health services, there's been quite a deal of evidence that's insufficient. Can you comment on what planning there is particularly around those issues to see that there are sufficient services available to meet demand?

MS DIVER: Certainly the department has a strong role in planning at a statewide level and at a clinical stream level, so across the whole of the public sector and public/private, and then there might be a mental health plan or a maternity plan. Those plans often set out future directions, both in a policy sense and in kind of service volume or service capacity sense. Sometimes those service plans lead to a shifting of resources across the system, and sometimes those plans lead to capital development.

So a growth corridor is a really good example. If you pick Werribee as a big growth corridor, the department would work with Mercy Hospital Werribee to look at what their capacity is, what the demands are, what the future population projections are, and out of that process would ultimately come some capital plans, because that is

what has occurred, and that might say, "We need some more maternity capacity. We need some more mental health capacity." Then those capital developments would be funded by government and then, over time, that would be opened as new capacity. So there's a process in place for dealing with that. That's kind of very big planning, big capital developments.

In terms of year on year planning, so there's certainly bids to government for growth funding. Every year in Victoria for at least the last 10 years the health budget has increased every year, and that's been based on both population growth, age and complexity costs and initiatives that allow the system to grow to better meet consumer demand. So that ensures that the health department has funds to distribute to services to meet growth according to the budget parameters and the kind of policy outcomes that the government is seeking.

One of the issues is then how does the health department allocate that funding to services. Is it Werribee or is it Dandenong? We use both population projections, service capacity and service performance to determine the allocation of resources to the different entities, to the different health services, so that they can meet their objectives.

Then the way we fund services is we also try to give services maximum flexibility so that they can reconfigure services to best meet their needs. Mental health is a really good example of where there might be inpatient capacity, community teams, emergency department teams and non-government organisations. So there's growth in the whole of the mental health budget, but there might

be reconfiguration across different streams within the mental health service system. So if you are working in one part of the system you might see that there is a change in service, but you are not necessarily seeing that there is a growth in another part of the service.

So that's how it works, recognising - having said all of that - that obviously health services are working within a capped budget. It's not uncapped. So the budget is capped by the government's capacity to fund. Whilst I have said that funding has increased every year, demand has also increased every year. Is it exactly matched? No. Are there areas that are in greater need? Yes. How do services respond to that? Through a process of prioritisation, of ensuring that they can provide services for those most in need and improve outcomes and try and improve outcomes for the foremost patients.

MR MOSHINSKY: In those areas that I mention, mental health and the CAT teams in particular, is there really a shortfall of service to meet demand?

MS DIVER: Many people would say that, yes.

MR MOSHINSKY: Commissioners, those are my questions.

DEPUTY COMMISSIONER FAULKNER: Is there easy evidence to get of that shortfall in terms of CAT call-outs that are not responded to or mental health service waiting lists? Is there some dimensioning of that that would help us know whether that's growing or whether it's been relatively stagnant?

MS DIVER: I might have to take that on notice and go back to my mental health colleagues to see if we can dimension that.

DEPUTY COMMISSIONER FAULKNER: We are interested in drug and

alcohol as well.

MS DIVER: Yes. It's most evident in mental health, but it applies across the whole system where the kind of state funded mental health system that looks after the most serious psychiatric illnesses, so the 60,000 or the couple of per cent of the population - so there's a range of services for those people. There's quite a lot of work that's been going on to reconfigure CAT teams into general teams, and how mental health interfaces with emergency departments, and how mental health services work with police and other services.

So I think it's fair to say there's a lot of expectation around that end of the service. But that end of the service is kind of the pointy end of the triangle. There's a lot of mental health service that's in fact mostly funded by the Commonwealth through general practice and other community based agencies. So, whilst the mental health state budget might be growing each year - and it has - what we can't see is what's the level of service provision sort of further down the triangle and is that placing additional pressure on the sort of state funded system.

I do think there has been sort of changes in the way services are configuring their CAT teams, was the traditional one, crisis assessment teams and their continuing care teams, and the way they interface with the non-government sector. So there has been quite a lot of reform in that area which makes the position quite murky to actually understand have we got a shrinking of services or have we got an increase in demand, and is that increase in demand related to the broader service system

not kind of picking up their share of the work and not adequately responding or not being in a position to respond to that care.

General practice is a good example where much mental health care would occur in general practice and through general counselling services, but are GPs in a position to deal with that. Whilst they may not be in a position to deal with that for whatever reason - funding models, expertise, training, access to services - do we really want to push people into the sort of mental health system, specialist system, is that in fact the most appropriate response, because you want to keep people in the right level of care to meet their needs. But, in terms of being able to dimension the kind of potentially increased - or the service gap for mental health, I would have to get back to you on that.

DEPUTY COMMISSIONER FAULKNER: So mental health and drug and alcohol are the two that people have asserted constantly that at the point where an intervention is appropriate, maybe at a court day, the magistrates will say, "We want to order some mental health services or drug and alcohol," and people are told they will wait 10 months. So that's what we are looking for.

MS DIVER: I understand what you are looking for.

MR MOSHINSKY: If there are no further questions, may the witness be excused?

COMMISSIONER NEAVE: Thank you. Thank you very much, Ms Diver.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: That concludes the evidence for today.

ADJOURNED UNTIL THURSDAY, 13 AUGUST 2015 AT 9.30 AM