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

Executive Summary Report and Recommendations

Responding to Interpersonal Violence: Are you safe?

Clinical Senate of Western Australia

24 March 2017

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Executive Summary

The first meeting of the Clinical Senate of Western Australia for 2017 was held on 24 March at the University Club of WA.

The topic for debate was "Responding to Interpersonal Violence: Are you safe?

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

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

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

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

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

The opening session

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

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

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

Through her story telling the importance of "family" and what makes up the family became evident. As clinicians we were asked to consider who is involved in both protecting and

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

supporting the perpetrator and the victim. Marie was also able to broaden our understanding of spread and impact of family violence and what impact it will have on the widened “family” unit.

Ms Tanya Basile, Deputy Chair of the Clinical Senate, introduced the topic for debate calling on senators to consider how clinicians at the coal face can detect, manage and provide appropriate care in the setting of interpersonal violence. How we can identify IPV within our healthcare facilities, respond to this sensitively and manage disclosures of interpersonal violence using evidence based approaches, whilst keeping our patients and our staff safe. The aim is to develop policy recommendations designed to improve the detection of interpersonal violence within health care facilities, and to improve the response and management of outcomes for patients and support our staff.

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

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

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

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

In addressing the issue of are you safe? Ms Basile highlighted that violence is increasingly spilling into our hospitals reporting a 33% increased use of Emergency Departments by those experiencing IPV. In 2016, one tertiary site reported 2521 Code Blacks related to IPV of which 45% were in the ED.

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

Ms Basile called on participants to consider how to best identify IPV within our healthcare facilities, manage it using evidence based approaches, and ensure that we keep our patients and our staff safe. She asked Senators to consider practical solutions that could be implemented across WA Health.

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

In addressing the topic of the day, Prof Geelhoed echoed Ms Basile stating that identifying, and addressing IPV is unfortunately an increasing reality of being a healthcare professional. He acknowledged the broad range of agencies and services in attendance and concluded

“Collectively, we have more of a chance of finding real solutions to both protect our staff and importantly our patients”.

The opening talk to set the scene was presented by Superintendent Kim Massam from WA Police. He shared his department’s perspective on responding to IPV speaking to the impact of Interpersonal Violence on WA Police and opportunities for change. Superintendent Massam stated he has oversight of 700 staff servicing one quarter of the metropolitan area. He reported IPV is core work for him as both an officer and as a leader of his staff. This debate truly is a call to action!

He reported that in 2015-2016 WA Police attended 59,408 (162.7/day) incidents of Domestic Violence (DV) and that DV makes up 30-40% of their work. He reported it a well-known fact that many women do not report this therefore; this is only the tip of the iceberg in relation to this issue. Many seek advice or support from family members, friends or community services. It is estimated that 74% of women have confided in someone about violence experienced while only 20% had reported it to police[2].

Superintendent Massam dedicated his talk to one of the victims; Jane whom he stated exemplified the struggle at hand.

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

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

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

Superintendent Massam stressed the importance of the first contact and how management is critical to the victim’s response. If as police officers and health professionals we carry preconceived prejudices into our interactions with a victim, then our ability to assist them is diminished. It is the adaptive change and the challenge to change the hearts and minds of all our front line service delivery people to actually care and portray that on each and every contact that is the true challenge. He stated when we do increase victim safety we have an opportunity to stop the violence however, when we get it wrong the outcomes are often catastrophic, and

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[2] Australian Bureau of Statistics (ABS), *Personal safety survey Australia 2012*, op. cit.

our victims become voiceless. Superintendent Massam stated the challenge for you is when victims come through the front door of your health service; we simply cannot miss that opportunity.

Again returning to Jane's case he stated that one year ago he received a call from a doctor at Royal Perth Hospital who was crying on the phone. This doctor had finally realised what was happening to Jane. Superintendent Massam stated he was still very concerned for Jane and he worried that there would not be a positive outcome for her due to the cycle of abuse. I am here today to remind you that it is really important to take every opportunity at every occasion to put this together, to do some research, to read the play and to be the very best first responder. Make sure the people you work with and work for, as well as those who work under you, are doing the same so we never have another story like Jane.

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

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

Lastly, there should be a system of communication and reporting that ensures relevant information is shared between agencies. Superintendent Massam stated this was particularly important at a time when some healthcare is being privatised. All Health Boards need to see this as a whole of health issue. The victims of violence will present anywhere. It is important everyone is doing it the same. WA Police also rely heavily on training and processes to deliver services.

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

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

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

Ms Simmons described Family Domestic Violence (FDV) as an abuse of power within intimate relationships, or within relationships of trust and/or dependency, which causes the victim to live in fear of the abuser. In WA Health, the policy definition is broader than intimate partner violence and encompasses extended family relationships, older people and same sex partnerships, between siblings, from adolescents to parents or from family carers to a relative or a relative with a disability. This captures the diversity and complex nature of abuse in the community.

The combined health, administration and social welfare costs of violence against women are estimated to be $21.7 billion a year, with projections suggesting that if no further action is taken

to prevent violence against women, costs will accumulate to $323.4 billion over a thirty year period (2014-15 to 2044-45)[3]. Aboriginal women are 35 times more likely to be hospitalised due to family violence related assaults than non-Aboriginal women.

She overviewed the Department for Chid Protection and Family Support (CPFS) which operates 17 Districts across the state, and provides after hours responses through Crisis Care and the Men's and Women's Domestic Violence helplines. They are responsible for responding to referrals where FDV is the presenting concern or is found to be present when investigating alleged neglect, sexual and/or physical abuse and emotional abuse. The Family and Domestic Violence Unit (FDVU) is responsible for 'internal' child protection family and domestic violence policy, practice development and guidance; and coordinating a central and regional across government approach to FDV strategic planning, policy development and implementation.

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

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

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

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

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

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

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

[3] Price Waterhouse Coopers (2015) 'A high price to pay: the economic case for preventing violence against women', report prepared for Our Watch and the Victorian Health Promotion Foundation (VicHealth).

at risk; we should instead focus on the perpetrator. It is critical that we focus on the mother and the child as a unit. Screening and assessment is critical.

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

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

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

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

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

The final presentation was delivered by Ms Jenny O’Callaghan, Co-Director, Women’s Health, Genetics and Mental Health, Women and Newborn Health Service who spoke on Responding to Family and Domestic Violence in WA Health.

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

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

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

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

In addressing what might be done, Ms O'Callaghan presented a program from Victoria Strengthening Hospital Responses to Family Violence (SHRFV) which has been evaluated and is working. She stated there are six key elements to the program and executive sponsorship is critical success. The six key elements include the following: create cross hospital leadership and momentum; laying a foundation through policy, procedures and guidelines; changing culture; building capacity and capability; building partnerships and connections with the wider community and the family violence sector; and building the evidence base.

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

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

Plenary

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

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

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

In summarising the responses to the open ended questions Ms Brennan stated that both elicited quite similar feedback and responses were collated and themed together. The main themes were: holistic care; coordination of services; staff training; funding, culturally competence care and FDV as a health issue and the importance of screening. ; She shared several specific accounts. Highlighted in the responses were mental health services, services provided by WA Health in the community; and emergency departments.

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

Ms Roia Atmar next shared her very personal story and journey through IPV. Her story articulates how she was verbally, emotionally and physically abused over many years. The abuse was often followed by remorse, apologies and the promise of it not happening again. Whenever she attended medical appointments her husband would attend with her, speak on her behalf and the medical professionals would speak directly to him. The signs of abuse were not identified as he was careful not to leave visible signs and lied about the most serious injury which resulted in a significant hospital stay. The length of stay provided an opportunity for staff to ask the right questions and open the door for Roia to seek help.

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

Through Roia's story participants were reminded of the role each clinician can play in assisting victims. Highlighted was the importance of creating a safe space for disclosure and the need for a multiagency response.

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

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

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

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

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

Key messages were:

- The question is the challenge! How do we raise it - clinicians need to have the skills around asking the question.
- Lack of universal screening.
- Consider targeting secondary points for detection - advertising to families etc.
- Limited mandatory reporting.
- Issues with partner presence when screening – allow for one on one time with patient.
- Specific concerns were raised for people with disabilities and older people.
- Early detection -Risk factors – must be identified by clinicians up front.

- Specific issues related to Aboriginals and family violence- there must be a different approach with understanding that it might impact the entire family.
- Treatment by responders (racism and victimisation).

Specific issues related to staff:

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

Key summary points:

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

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

The afternoon session consisted of two concurrent workshops. Senators developed policy recommendations directed at both the System Manager and Health Service Boards designed to improve detection and management of IPV in patients attending WA Health facilities and to support staff to manage IPV. The recommendations are attached to this report.

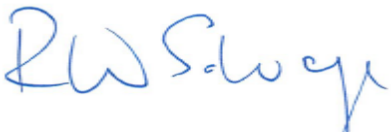
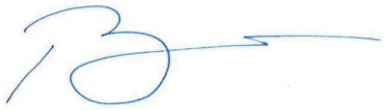
In conclusion, hospitals are in a unique position to play a significant role in driving social change that reduces the occurrence of family violence. The hospital system is an early contact point for many people who have experienced family and domestic violence. Staff are able to make an early diagnosis.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

The Clinical Senate recommendations align with the World Health Organizations Health Response. The recent appointment of The Hon Minister Simone McGurk to a family violence portfolio presents a unique opportunity to implement the key outcomes from the

debate. The Health Consumers' Council aims to convene a community forum to progress a consumer-centred approach to service design.

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

Sincerely

Professor Julie Quinlivan	Mr Wayne Salvage	Ms Pip Brennan
Chair	Executive Sponsor	Executive Sponsor
Clinical Senate of Western Australia	Chief Executive North Metropolitan Health Service	Executive Director Health Consumers' Council WA

Responding to Interpersonal Violence – Are you safe?
Clinical Senate Recommendations

That the System Manager:

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

That Health Service Boards:

1. Work in partnership with Aboriginal people within their catchment area to develop and co-design domestic violence programs.

2. Consider a policy in line with evidence based practice to implement mandated domestic violence screening for high risk patients such as pregnant women, people with disability, indigenous patients, mental health patients, frequent emergency department attenders, patients with significant drug and alcohol dependency, and patients with cultural and linguistic diversity.

3. Consider creating a new position or else formally allocate to an existing employee responsibility for education and training of staff in interpersonal violence in order to:
    - Raise awareness
    - Promote and effect cultural change
    - Optimise screening and intervention strategies
    - Coordinate data collation and research activities

4. Acknowledge interpersonal violence is an important issue impacting upon staff and develop internal policy that enables
    - Reporting of instances of interpersonal violence occurring towards staff members and patients and records measures to document the impact of cumulative stress on staff due to abuse or aggression
    - Provides ongoing training in recognising and managing interpersonal violence through the use of communication and de-escalation skills, and educates staff about understanding the causes for patient behaviours;
    - Provides proactive support mechanisms for staff who experience interpersonal violence in the workplace through such processes as formal debriefing process and team based supports post event (immediate response teams - EAP based)
    - Prioritises security responses for staff and patient safety.
5. Develop a care pathway for managing interpersonal violence across the patient lifespan that gives staff clarity about tools and resources available.
6. Develop a pathway for referral of individuals at risk of or experiencing interpersonal violence based on WA Health guidelines and WAPHA Health Pathways, and update this pathway every two years.

Executive Sponsors, Presenters & Expert Witnesses

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

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