ST VINCENT'S HEALTH AUSTRALIA

UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

St Vincent's Health Australia

Submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Family, Domestic and Sexual Violence

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Table of Contents

1 INTRODUCTION

St Vincent's Health Australia, as a provider of health and wrap-around services to people who have experienced family and domestic abuse and violence, believes that hospitals can play a key role in delivering improvements in the family and domestic violence system.

This submission will reflect the experiences and practices of St Vincent's hospitals and domestic and family violence support services, as well as sharing data, including from during the ongoing COVID-19 pandemic. We will discuss the role that hospitals can play in not only identifying family and domestic abuse and violence, but also in assessing risk and providing interventions and support to improve a victim's ongoing safety after discharge from hospital. As St Vincent's Health Australia has outlined previously in its submission[1] to the Royal Commission into Family Violence, it is crucial to mention that in addition to addressing the immediate health needs of a victim or person at risk, improved identification within hospital settings, with the appropriate follow-up and referral to specialist services, can significantly increase the number of victims or people at risk who receive support.

Considering the health impacts associated with family and domestic abuse and violence, victims frequently interact with the health system – both in primary and acute care settings. For example, an estimated 38% of women who present to Emergency Departments (EDs) have experienced physical abuse in their lifetime (based on analysis of 18 different studies). Another study found that between 65% and 85% of women attending EDs experienced emotional abuse[2].

There are also a range of factors that increase a woman's vulnerability to family violence and for which she may access health services, including in hospital settings. In particular:

- Pregnancy – the prevalence and intensity of violence has been shown to escalate during pregnancy, and many women report violence occurring for the first time during pregnancy.
- Mental health issues – there is a strong association between mental illness and experiencing family violence, and prevalence of lifetime physical and sexual abuse among women attending mental health services has been found to be higher than in any other health setting.
- Alcohol and other drug use – women who are victims of family violence are more likely to have a drug or alcohol problem, and women with a partner with a substance abuse problem are also more likely to experience abuse[3].

While this is the case, it may be that victims of family and domestic abuse and violence can experience difficulties when accessing health services. This may include discomfort with disclosing abuse and violence in the healthcare environment, inappropriate responses by health professionals and a lack of patient confidence in the outcomes following a disclosure.

At the heart of the St Vincent's approach to responding to family and domestic abuse and violence is a trauma-informed care approach. Trauma-informed care is a strengths based framework for service delivery whereby health professionals are aware of the impact trauma has on people and how service provision can reduce the impact of trauma and contribute to recovery. Trauma-informed principles improve patient experience, increase staff confidence, contribute to service efficiencies and create safer environments.

Within St Vincent's Health Australia, it has been found that trauma is a common factor among vulnerable groups of focus across the organisation.

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[1] St Vincent's Health Australia submission to Royal Commission into Family Violence. 1 June 2015.

[2] Spangaro & Ruane (2014).

[3] Spangaro & Ruane (2014).

This submission is grounded in St Vincent Health's trauma-informed care approach and our experience working with vulnerable communities.

1.1 DEFINITIONS

Within this submission, the term 'victims' is used to describe people who have experienced family and domestic abuse and violence. However, it is not our intention to victimise people.

In some sections, the submission refers to 'women', who comprise the majority of people who experience family violence.

St Vincent's also recognises that there are different manifestations of family and domestic abuse and violence, including non-physical and sexual violence such as emotional, social and financial and other forms.

1.2 ABOUT ST VINCENT'S HEALTH AUSTRALIA

St Vincent's Health Australia has been providing health care in Australia for more than 160 years, since our first hospital was established in Sydney in 1857 by the Sisters of Charity.

Today, St Vincent's Health Australia is the nation's largest not-for-profit health and aged care provider. We operate six public hospitals, 10 private hospitals and 20 aged care facilities in Queensland, New South Wales and Victoria. Along with three co-located research institutes – the Victor Chang Cardiac Research Institute, the Garvan Institute of Medical Research, and St Vincent's Institute of Medical Research – we work in close partnership with other research bodies, universities, and health care providers.

We are a clinical and education leader with a national and international reputation in medical research. Our areas of expertise include heart lung transplantation; bone marrow transplantation; cardiology; neurosurgery; cancer; clinical genomics; HIV medicine; palliative care; respiratory medicine; mental health; drug and alcohol services; aged psychiatry; homeless health; and prisoner health.

St Vincent's Health Australia employs around 20,650 staff and operates more than 3,000 hospital beds and 2,400 residential aged care places. In our hospitals, we provide more than 1 million episodes of care for patients each year.

St Vincent's Health Australia provides compassionate healthcare to all people. Our Mission, to bring God's love to those in need through the healing ministry of Jesus, underpins who we are and calls us to a special commitment to people from vulnerable and marginalised backgrounds. The following sections will provide an overview of the services available for victims of family, domestic and sexual violence at St Vincent's Health Australia facilities.

1.3 ST VINCENT'S HOSPITAL MELBOURNE

St Vincent's Hospital Melbourne (SVHM) is a tertiary public healthcare service. SVHM provide a range of services, including acute medical and surgical services, emergency and critical care, aged care, diagnostics, rehabilitation, allied health, mental health, palliative care and residential care. SVHM work with a vast network of collaborative partners to deliver high quality treatment and person-centred care, teaching, education and research. There are more than 5,000 staff and 880 beds in daily use across SVHM's services.

Responding to family, domestic and sexual violence

The Assessment, Liaison & Early Referral Team (ALERT) is a Complex Care Service that was established in 2000 as part of the Victorian Government's Hospital Demand Strategy to improve health outcomes and reduce demand on Emergency Department (ED). ALERT provides an integrated service aimed at reducing hospital demand, and providing coordinated care that bridges the interface between acute hospital ED and the community. ALERT particularly targets patients with complex psychosocial and medical needs, including frequent presenters or those at high risk of re-presentation, people experiencing homelessness, family violence or disability, and any patient requiring discharge planning from ED. Care coordination and discharge planning are a critical part of the ALERT team role. The multidisciplinary nature of the ALERT team is a unique strength and this currently includes staff with backgrounds and experience in nursing, social work, physiotherapy, occupational therapy, mental health nursing, dietetics, and addiction medicine[4]. A case study of ALERT's response to family and domestic violence is provided at appendix one.

As part of the St Vincent's Health Australia 'Big Data' project, supported by the Inclusive Health Program (see section 1.7), administrative health data from all acute emergency department (ED) and acute inpatient electronic files at SVHM was collected from 2008 to 2017 to identify victims of family violence. It was found that over the 10 years, an average of 111 patients (250 attendances) in ED and 64 inpatients (144 admissions) each year were identified as being for victims of family violence using these case definitions.

Within the family violence cohort, many had at least one other vulnerability including 30-39% with a mental health issue, 24-32% who had a drug and/or alcohol issue, 14-18% who were homeless, and 10-12% who were Aboriginal and Torres Strait Islander.

Table 1. Additional vulnerabilities identified in family violence cohort (SVHM, 2008-2017)

Additional vulnerability within family violence cohort	ED	Inpt
Mental Health	30%	39%
Drug and Alcohol	24%	32%
Homeless	14%	18%
Aboriginal and Torres Strait Islander	10%	12%
Prisoner	5%	5%

While 250 ED attendances and 144 inpatient admissions were identified for people who were victims of family violence every year over these 10 years, when compared with national data this is a clear underestimation. According to Pointer and Kreisfeld (2012), "every three hours a woman is admitted to hospital as a result of family violence"[5]. Indeed, the Australian Institute of Health and Welfare's 2016 report on the burden of disease for women, identified domestic violence as 'the number one contributor to morbidity and mortality for women between 16 and 45'. For Aboriginal and Torres Strait Islander women, family violence contributes to 60% morbidity and mortality.

Further, many victims of family violence do not declare violence as the source of their injuries and even when it is clear that family violence is the cause of an ED admission, this patient group often leave as soon as they are medically able. In the SVHM data, 32% of the family violence cohort were identified as leaving ED before being fully assessed compared to 18% of the SVHM general population. St Vincent's respects that a person experiencing family violence may not be ready to disclose or take action. We recognise that systems can contribute to an improved patient experience

[4] Wood, L., Vallesi, S., Martin, K., Lester, L., Zaretzky, K., Flatau, P., Gazey, A (2017). St Vincent's Hospital Melbourne Homelessness Programs Evaluation Report. An evaluation of ALERT, CHOPS, The Cottage and Prague House. Centre for Social Impact: University of Western Australia, Perth, Western Australia.

[5] Pointer S & Kreisfeld R (2012) Hospitalised interpersonal violence and perpetrator coding, Australia, 2002–05, Injury research and statistics series no. 77. Cat. no. INJCAT 153, AIHW, Canberra.

and that staff can have improved confidence in responding. As such, SVHM's governance, coordination and response group and notification system assist staff to monitor the presenting issues regardless of the person's entry point to hospital. This will be further expanded upon in section two.

As part of an organisational-wide response to family and domestic violence, SVHM has also been participating in the Strengthening Hospitals Response to Family Violence (SHRFV) program. This includes the '*Family Violence Across the Lifespan*' training offered to all health disciplines and non-clinical staff, with the purpose of strengthening staff's ability to offer sensitive 'first-line' support and to ensure that clinicians can provide safer spaces for patients and colleagues to discuss past or current family violence. SHRFV training has resulted in an increase in staff confidence to assess and provide family violence reports, consultations and referrals, and to provide better outcomes for our patient's welfare[6].

1.4 ST VINCENT'S HEALTH NETWORK SYDNEY

St Vincent's Health Network Sydney (SVHNS) comprises of St Vincent's Hospital Sydney Limited as the affiliated health organisation in respect of four recognised establishments under the Health Services Act 1997 (NSW) (Health Services Act). Under the Health Services Act, St Vincent's Hospital Sydney Limited, is treated as a Network for the purposes of the National Health Reform Agreement in respect of the three recognised establishments: St Vincent's Hospital, Darlinghurst; Sacred Heart Health Service, Darlinghurst; St Joseph's Hospital, Auburn; and St Vincent's Correctional Health, Parklea.

The Network is part of an integrated network of clinical services that aim to ensure timely access to appropriate care for all residents in New South Wales. The facilities of the St Vincent's Health Network Sydney are located in the geographical boundaries of the South Eastern Sydney and Western Sydney Local Health Districts. Collaborative arrangements have been established to ensure provision of clinical services to the communities located in these Local Health Districts.

Responding to family, domestic and sexual violence

St Vincent's Hospital Sydney (SVHS) has a dedicated Domestic and Family Violence Service which provides a comprehensive crisis response, counselling, case management with a trauma-informed and person-centred approach. A highly experienced, dedicated clinical specialist senior social worker leads and is the Manager for this service. The Domestic and Family Violence Service is part of the hospital's Social Work Department, which provides a 24/7 crisis response to domestic and family violence predominantly through the Emergency Department but across the SVHS campus.

SVHS was part of the innovative 2017 NSW Health trial study of the Domestic and Family Violence (DFV) screening of women in Emergency. SVHS was the sole metropolitan site chosen along with two rural sites. This study was the front runner for the ongoing development of trialling screening in NSW Health in Emergency Departments. This evolving research is informing the need for change and for comprehensive integrated forensic DFV services in Health.

SVHS is about to commence a clinical trial of DFV screening within its Emergency Department for all persons aged 16 and over in response to the identified need for the hospital's demographic and patient population. This project is a collaborative project led by Medical, Nursing and Social Work staff within SVHS' Emergency Department.

[6] St Vincent's Hospital Melbourne Quality Account 2018-2019.

SVHS is represented on a number of sector meetings responding to family and domestic violence, including:

- NSW Health Prevention and Response to Violence Abuse and Neglect (PARVAN) Senior Executives Steering Committee meeting (Tier2/3).
- NSW Health PARVAN Senior Managers meeting.
- Community of Practice: VAN Stream - PARVAN Senior Executives and Senior Managers.
- NSW Health 'Design Working Group' VDAC Design Working Group.
- NSW Ministry of Health 'Integrated Domestic and Family Violence Crisis Response Specialist Working Group'.

1.5 ST VINCENT'S PRIVATE HOSPITALS

St Vincent's operates 10 private hospitals throughout Queensland, New South Wales and Victoria. As part of how St Vincent's responds to family and domestic violence, all staff employed within the private hospitals undertake a domestic violence awareness training module. This course enables health, allied health, and frontline workers to confidently recognise signs of domestic and family violence, respond with appropriate care, and refer people experiencing or at risk of domestic and family violence to appropriate support services.

Further, staff working in our maternity services (available at St Vincent's Private Hospital, Fitzroy; St Vincent's Private Hospital, Toowoomba; and St Vincent's Private Hospital Northside), paediatric wards and private Emergency Departments are required to do more specialised face-to-face training in clinical response to domestic and family violence every three years. The maternity units also offer pre-natal screening to all women for risk of post-natal depression and family and domestic violence because, as noted earlier, pregnancy is a known key risk factor for domestic violence beginning or escalating.

Referrals to family violence support services are provided for pregnant women who are identified as at risk of intimate partner violence. It is noted that participation in any support is always voluntary nevertheless the pre-natal screening allows staff to be prepared to provide appropriate support and care when the woman comes in to deliver her baby. Mandatory reporting requirements are followed if there is a reasonable concern for the safety of the newborn in this situation.

1.6 OPEN SUPPORT

Open Support is a community service organisation committed to addressing the unmet and changing needs of the most vulnerable in our community since 1990.

Open Support plays a vital role in the St Vincent's Clinic (a facility of St Vincent's Health Australia) and St Vincent Health Australia's commitment to social responsibility. Since 1995, Open Support has supported more than 1,900 families (women and children) affected by domestic and family violence.

With a holistic approach, Open Support provides 24/7 crisis and transitional accommodation, and specialised domestic and family violence case management support to women and children, from the point of crisis through to recovery.

Open Support has developed a particular focus on vulnerable culturally diverse communities who face additional barriers to safety and support, offering:

- dedicated support to families from culturally diverse (CALD) backgrounds; and
- specialised support to these families and to women on temporary visas.

In the past two years, more than 80% of the families Open Support has assisted with crisis accommodation and 100% of families accessing transitional accommodation are on temporary visas, with no access to income, healthcare, housing or government support. These women and children have limited exit pathways from crisis accommodation and often need full financial support for periods of up to three years.

Open Support's Domestic Violence Manager is regularly consulted as a subject matter expert by peak bodies, and more recently the media. She is also a representative on the Domestic Violence NSW Community of Practice and Advocacy Group for Women on Temporary Visas Experiencing Violence.

Further information will be provided in section two of this submission.

1.7 ST VINCENT'S HEALTH AUSTRALIA'S INCLUSIVE HEALTH PROGRAM

In line with St Vincent's Health Australia's Mission of bringing the healing ministry of Jesus to all we serve, along with Catholic Social Teaching principles, the Inclusive Health Program (IHP) aims to address the impacts of poverty, marginalisation, or vulnerability of access to healthcare services. It reflects a focus on the preferential option for people who are disadvantaged and vulnerable in service delivery, and a commitment to addressing social determinants of health and limited access to healthcare. Our priority populations are people who are homeless, people experiencing issues with substance use, people living with mental illness, people in prison, and members of the Aboriginal and Torres Strait Islander community. We also focus on refugees, asylum seekers, and those escaping family and domestic violence.

Through the IHP, St Vincent's Health Australia has invested in several projects in the area of family and domestic violence, including Elder Abuse, Health Justice Partnerships, and Domestic Violence screening in ED. One example of this is provided below.

Domestic Violence Screening in Emergency Department (SVHNS)

Emergency Departments around the country see the aftermath of family violence, and are one of the most crucial places, not only for the treatment of victims, but also providing a window of opportunity for the screening and reporting of incidents of domestic violence. Without effective screening for domestic violence in our EDs, the identification rate sits as low as around 2%, while the prevalence of patients experiencing family violence is estimated at around 38%.

As a part of its overarching Mission, St Vincent's Hospital recognised the urgent need to drastically improve the rates of identification of women experiencing domestic violence. In 2017 the hospital participated in a multi-site project to test the feasibility of screening for domestic violence in NSW Hospital Emergency Departments, launching an initiative to increase staff confidence around enquiring about, identifying, and reporting incidents of domestic violence to women and children, and to offer specialist services and hope to this vulnerable group to improve their safety, health and wellbeing.

Every woman aged 16-45 who presented to the SVHNS Emergency Department in Darlinghurst during this period was asked questions about domestic violence, regardless of the reason for their presentation[7]. Every woman who disclosed domestic violence through screening was offered acute care and support such as housing, advocacy, child care, legal advice or police reporting along with a dedicated social work service, and longer term needs such as counselling, case work and other

[7] NSW Health domestic violence screening and response in NSW Emergency Departments: Feasibility Study. NSW Government, August 2019.

referrals. More than 700 women participated and 106 disclosed domestic violence from a current or former partner. Without the proper screening, studies have shown that up to 72% of women who attend an ED after an incident of abuse are not identified as victims of domestic violence.

This project was jointly funded by the NSW Ministry of Health and SVHA's Inclusive Health Program to increase the efficacy and equity in services provided to victims of domestic and family violence, to provide an evidence base for advocacy, and to influence public policy affecting the health needs of this particularly vulnerable group of people. The Ministry of Health intends to make specific recommendations as a result of this project.

2 RESPONSES TO TERMS OF REFERENCE

This submission draws on the experiences from within St Vincent's Health Australia's services, and particularly responds to terms of reference (c), (d), (f), (h), (i) and (j). A summary of recommendations can also be found in section three.

c) The level and impact of coordination, accountability for, and access to services and policy responses across the Commonwealth, state and territory governments, local governments, non government and community organisations, and business.

Coordination and collaboration

St Vincent's acknowledges the connected and positive relationships that occur across government, and the appropriate sharing of information. However, we note that in some instances the services (whether government agencies or non-government organisations) can be siloed with different roles that support victims and their children. In order to best support victims, it is critical that services remain connected and do not operate in isolation from one another.

One example of effective coordination is in New South Wales, where Safety Action Meetings (SAMs) are being implemented across the state. Safety Action Meetings are regular meetings of local service providers that aim to prevent or reduce serious threats to the safety of domestic violence victims and their children through targeted information sharing. Members share information to develop tailored, time-specific Safety Action Plans for victims at serious threat and their children. SAMs are attended by government and non-government service providers working with domestic violence victims and perpetrators in the local area, and are chaired by a senior police officer[8].

Recommendations:

- Governments should consider mechanisms for strengthening frontline coordination between health services, police and specialist family violence services. St Vincent's Health Australia suggests that Safety Action Meetings provide a useful model for further consideration in other states and territories, where appropriate.
- That the role of hospitals in responding to family violence (beyond identification) - including providing risk assessment, safety planning and first line responses - is recognised and supported in government policy and practice guides.

[8] Safety Action Meeting Manual. NSW Government, August 2014.

Access to Centrelink

The large cohorts of disadvantaged and vulnerable patients cared for at St Vincent's public hospitals in Sydney and Melbourne are frequent users of public hospital services and are commonly reliant on income support payments and other services managed by Services Australia (eg: Centrelink). In addition to their caseload of vulnerable patients, both hospitals also care for individuals who, because of the nature of their illness or the reason for their presentation, often require access to other Centrelink payments, for example, Sickness Allowance, or for their loved ones to apply for (or make adjustments to, or change their circumstances around) the Carer Payment. This includes people who are identified as experiencing family or domestic violence.

Access to adequate income and housing is essential in keeping people experiencing family and domestic violence safe, making Centrelink a life-saving service for this cohort. Delays to accessing appropriate financial service or accommodation can not only cause frustration and distress, it can also result in missed opportunities to support people to a safer setting. Hospital services assign senior social workers to support people who have experienced family and domestic violence, as their experiences of trauma require a thoughtful and skilled response to ensure optimal outcomes. Centrelink services should consider the need for a trauma-informed response by using appropriately skilled and senior staff, and facilitating prompt follow-up by hospital social workers should escalation be required. Face-to-face contact can be especially effective for engaging with hard-to reach populations with experiences of trauma, as demonstrated by the Oasis community Centrelink clinic.

In the past, Centrelink has provided tailored services to support the hospitals in their care of this diverse group of patients/clients in recognition of their often complex needs. For example, at St Vincent's Hospital Melbourne, in the past that took the form of Centrelink providing a liaison service which made on-site visits. A Centrelink employee would attend the hospital once a week to see patients face-to-face on the ward with appointments being made via a booking system. At St Vincent's Hospital Sydney, Centrelink once provided a regular visiting service via Centrelink Engagement Officers. There were a number of benefits of dedicated Centrelink support, however, unfortunately Centrelink no longer provides either hospital with a dedicated or direct support service.

As such, both hospitals largely rely on Centrelink's general phone and online gateways which create challenges for staff and patients in the form of lengthy wait times and unnecessarily prolonged delays in the resolution of issues. This takes our staff away from their clinical duties and can lead to unnecessary extended hospital stays.

Recommendations:

- Trial the establishment of regular pop-up Centrelink clinics in public hospitals with large cohorts of vulnerable patients, to enable patients and hospital social workers to see a Centrelink officer in person (eg: the Salvation Army's Oasis community Centrelink clinic).
- Trial a direct phone line for hospital social workers to senior Centrelink officers making representations on behalf of high-risk and vulnerable patients with specialised Centrelink advisors/subject experts (eg: family violence, homelessness, health, aged care) to liaise with.
- Centrelink to provide regular training and education sessions for hospital social workers on its range of payments, eligibility requirements, and their application processes.
- Establish a pilot program in conjunction with state health departments that aims to expedite Centrelink payment applications for inpatients to avoid discharge delays.

d) The way that health, housing, access to services, including legal services, and women's economic independence impact on the ability of women to escape domestic violence.

Social Workers

Social workers within health services play a critical role in responding to victims of family and domestic violence. For example, within St Vincent's Hospital Sydney there is an embedded 24/7 comprehensive approach to domestic and family violence where all domestic and family violence cases are referred to social workers. The on-call social worker is trained in crisis domestic and family violence response and conducts a domestic violence safety assessment and planning using a DV safety assessment tool. Referrals may then be made to St Vincent's on-site DFV service for ongoing counselling, case management, court preparation and other matters.

Accommodation

One area of concern for St Vincent's is the shortfall of appropriate accommodation (short and long-term) for women who are victims of family and domestic violence. In a number of instances, women may not want to be housed in emergency accommodation with men or in homeless shelters (where domestic and family violence is not the primary reason for accessing this housing), as this may be traumatising or they may have concerns with safety. Further, women with children have few options available to them as access can be a challenge. Connected services would address this issue by enhancing safety, for example through Housing Officers being able to attend via virtual in-reaching appointments at the time of crisis.

The Domestic Violence Line prioritises crisis accommodation but preferably if Housing Officers were available at the time of need then secure and stable housing, preferably long-term, purpose-built and with comprehensive services available could be allocated. This change of approach would work to keep women and children safer. It would also afford women the dignity and recognition of their acute need for comprehensive assessment for multiple services and support potentially including: legal, health, financial, accommodation, education and employment assistance. The uncertainty surrounding suitable housing influences many women's decisions as to why they may return to violent partners due to housing insecurity[9].

Recommendations:

- Explore opportunities to, where appropriate, develop safe houses / refuges in close vicinity to public hospitals responding to family and domestic violence, allowing easy and responsive access to crisis and temporary accommodation that have dedicated family violence, housing and legal workers.
- Develop a one-stop-shop approach for a comprehensive response to family, domestic and sexual violence. For example, this could include embedding a legal service into health services for comprehensive assistance when a person presents or is available for consultation when the person attends for counselling in person or via telehealth. Housing security could also be part of this innovation.

[9] Australia's National Research Organisation for Women's Safety.(2019) Domestic and Family Violence, housing insecurity and homelessness: Research synthesis (2nd Ed.; ANROWS Insights, 07/2019).Sydney, NSW: ANROWS

f) The adequacy of the qualitative and quantitative evidence base around the prevalence of domestic and family violence and how to overcome limitations in the collection of nationally consistent and timely qualitative and quantitative data including, but not limited to, court, police, hospitalisation and housing.

Screening and Support

The first stage of a response to family violence is identification (unless family violence has already been disclosed). Screening is an evidence-based process of directly asking questions about current or previous abuse and/or safety concerns at home. In health settings, screening can either be:

- routine (or universal) – where all women presenting to a particular service are asked a standardised set of questions (regardless of indicators of violence); or
- targeted – where women are selected for screening based on a professional's judgement where there are indicators of family violence present.

As identified in section one of this submission, St Vincent's Health Australia's public hospitals currently collects data to identify victims of family violence. For example, nursing staff at SVHM ask the question "When you go home, do you feel safe?" on admission which may then lead to a second, more thorough, assessment for ALERT or Social Work.

It is critical that in conjunction with screening practices that there are appropriate coordinated responses to the screening which provide a comprehensive service to improve women's and children's safety, and access to effective services and support.

The NSW Ministry of Health provided funding to St Vincent's Health Network Sydney's (SVHNS) for involvement in a NSW state-wide project that occurred across three sites, to trial a screening tool for domestic violence in ED. The SVHA Inclusive Health Program provided additional resources to ensure identified patients were provided with follow up support from hospital social workers. In this study, all women aged 16-45 who came into ED (triaged 1-4) were eligible to be asked to complete a brief Domestic Violence Screening Tool'[10] over a six-month period. Pre-screening, SVHNS' ED identified approximately 2% of patients as experiencing domestic violence, a figure close to that found in similar settings without screening[11]. Through screening, however, this study identified prevalence of 18% among women alone[12] . Importantly, however, only 13% of the women eligible for screening were able to participate due to a lack of privacy from partners (33%), other family members (22%), or other patients (32%), in addition to the practical issues for the nurses trying to fit screening into tight schedules (p6).

Even with these limitations, if the proportion of family violence identified in the SVHNS study was translated to the figures identified in the SVHM Big Data analysis (as outlined in section 1.3), the numbers would be closer to 4,500 ED attendances and 2,592 inpatient admissions every year at SVHM.

St Vincent's Health Australia believes there is strong evidence to support routine screening in health services. Further, to support enhanced screening (both routine and targeted), more hospital staff need to be educated to improve their competence and confidence in responding to family violence, and trained in using screening tools and questions. If more cases of family violence are identified additional social work (or other specialist) capacity would be required to undertake more comprehensive risk assessment and safety planning, and provide appropriate follow-up and referral to specialist family violence services.

[10] Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A (2003), HITS: A Short Domestic Violence Screening Tool for Use in a Family, Fam Med 1998;30(7):508-12.)
[11] Boyle A, Robinson S, & Atkinson P (2004). Domestic violence in emergency medicine patients, *Emerg Med J*;21(1):9–13
[12] Prevention and Response to Violence, Abuse and Neglect, 2019

Recommendations:

- Introduce universal family and domestic violence screening across all Emergency Departments, where it can be done safely and with appropriately trained staff.
- Introduce 'safe rooms' in Emergency Departments where people can be assessed in a safe place and while other services (such as police or accommodation) can be arranged.
- Support education and training for appropriate hospital staff to improve their competence and confidence in responding to family violence, and trained in using screening tools and questions.
- Data should be collected to reflect all victims of domestic and family violence (including children), rather than the counting of singular domestic violence incidents.

h) The experiences of all women, including Aboriginal and Torres Strait Islander women, rural women, culturally and linguistically diverse women, LGBTQI women, women with a disability, and women on temporary visas.

Domestic and family violence affects all women

St Vincent's acknowledges that family and domestic violence affects all women across the life span and it cuts across all socio-economic and cultural groups. As a result, responses from governments and other organisations need to be responsive to the diversity of victims of family and domestic abuse and violence, and hold women as central to its processes to inform policy change.

In 2013, SVHM implemented a hospital-wide policy, model of care and education framework to respond to elder abuse (a form of family violence). Elder Abuse can be defined as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person."[13] According to SVHM data collected between 2013 and 2018, it was found that of elder abuse notifications:

- 58% were female and 42% were male (not always gender specific).
- More than half (51%) were over 80 years old.
- 68% were born outside of Australia.
- 1% were of Aboriginal and Torres Strait Islander background.
- 43% required an interpreter.

The types of abuse were categorised as:

- Psychological = 58%
- Financial = 51%
- Physical = 38%
- Neglect = 22%
- Sexual = 2%
- Multiple types of abuse = 50%

[13] World Health Organisation

- Older person disclosed abuse = 52%

The alleged perpetrator was an immediate family member in 74% of cases.

The framework was developed as part of the PhD research of St Vincent's Hospital Melbourne Senior Social Worker, Meghan O'Brien and supported by an Australian Research Council Linkage grant in collaboration with the University of Melbourne. The key features of the model are:

- High-level governance arrangements: a senior Vulnerable Older People Coordination and Response Group has been established. Members of the group review all data relating to suspected cases, and also advises on policy and continuous improvement.
- A model of care which supports staff to identify pathways for intervention and escalation based on risk, patient choice, and safety planning.
- Data collection and notification – All cases of confirmed, witnessed or suspected elder abuse are notified to the coordination and response group. The data informs process improvement and workforce training.
- Education – the framework is underpinned by three tiers of competency training for hospital staff:
    - Level 1 – Awareness raising for all hospital staff who do not receive Level 2 and 3 training.
    - Level 2 – Education for managers.
    - Level 3 – Education for clinicians undertaking assessments and providing interventions for vulnerable older people.

Between 2013 and 2018, SVHM collected Vulnerable Older Persons notifications (ie: people aged 65 years and over). During this time, 565 notifications were made as set out in Table 2.

Table 2. Vulnerable Older Persons (SVHM, 2013-2018)

Year	Notifications
2013	35
2014	70
2015	82
2016	148
2017	131
2018	99

Further, SVHM collected family violence notifications across the lifespan from 2019 onwards, and in 2019 there were 306 notifications, of which 173 notifications were about patients aged under 65 years of age and 133 were about patients aged 65 years and over – see Table 3 below.

Table 3. Family notifications across the lifespan (SVHM, 2019-2020)

Year	Notifications (patients under 65 years)	Notifications (patients 65 years and over)
2019	173	133
2020 (until 30 June)	170	74

Further, both St Vincent's Hospital Sydney and St Vincent's Hospital Melbourne are involved in Health Justice Partnerships which provide legal assistance and advice to staff and patients within an

acute care setting. This commenced in January 2016 at St Vincent's Hospital Melbourne with the Justice Connect Seniors Law & Seniors Rights Victoria establishing Australia's first Health Justice Partnership (HJP) for vulnerable older people at risk of abuse in a hospital setting. In 2017, a Health Justice Partnership (HJP) was established between St Vincent's Health Network, Sydney (SVHNS) and Justice Connect, a community legal centre, to improve our response to the issue of elder abuse in society. This Health Justice Partnership service has recently been extended as part of a project to the Murrumbidgee Local Health District (LHD) at Griffith and Wagga Wagga. It is recognised that access to legal advice is even more challenging in rural and remote areas for complex issues such as elder abuse. A case study is provided at appendix two.

St Vincent's Health Australia also recognises that family and domestic violence is gendered in that women and girls experience family and domestic abuse and violence in higher proportions than men. However, it is not solely gendered, as research shows same-sex domestic abuse and violence is often greater in proportion than opposite gender relationships, while transgender people experience the highest rates across the board of domestic and family abuse and violence.

For example, the *Calling It What It Really Is* report[14] states that "54.7% of all participants reported that they had previously been in one or more emotionally abusive relationship, while 34.8% reported that they had been abused sexually or physically by a previous partner."

Temporary Visas

Women on temporary visas often face a number of specific and compounding barriers to escaping domestic violence and accessing support for themselves and their children.

As identified in section one, more than 80% of Open Support's available bed nights have been occupied by families without access to income, healthcare, housing or government support because of their temporary visa status. These clients have limited exit pathways from crisis accommodation and often need full financial support for periods of up to three years.

Open Support's experience shows that the issue is on the rise: over the past 12 months, the number of women and children on temporary visas receiving assistance from Open Support has increased by 53%.

Open Support's experience with this cohort highlights the following barriers:

- Inability to access housing;
- Inability to access healthcare;
- Inability to access income;
- Challenges in accessing crisis accommodation;
- Risk, fear and threats of deportation and separation from their children;
- Lack of culturally safe and accessible services and free interpreting services;
- Limited social networks and access to support, lack of understanding of their rights; and
- Limited information provided in their respective language (English as a second language).

Recommendations:

- The provision of suitable, safe and accessible accommodation options for women and children, including those on temporary visas, who are leaving abusive homes.
- Regardless of visa type or status, every person experiencing domestic and family violence should access:
    - social security including Centrelink, and Medicare (enabling suitable access to healthcare and flexible financial support packages to attend to immediate needs); and

[14] Calling It What It Really Is: A Report into Lesbian, Gay, Bisexual, Transgender, Gender Diverse, Intersex and Queer Experiences of Domestic and Family Violence. UNSW. New South Wales, Australia, 2014.

    - the Family Violence provisions under the Migration Regulations.
- When developing policy reform, governments should engage with, and reflect the lived experiences of, victims of family and domestic violence.
- Governments support further work with Aboriginal and Torres Strait Islander and CALD communities to develop guidance for health services in how to appropriately support people to access support services.
- Governments support a review of resourcing, training and cultural competency within support services to meet the needs of Aboriginal and CALD people experiencing family violence.
- That the best practice elder abuse framework at St Vincent's Hospital Melbourne be adopted more broadly in hospitals for responding to family violence.
- Each state and territory should consider appointing an Ageing and Disability Commissioner.
- Dedicated outreach family and domestic abuse and violence services should be provided for LGBTIQ communities, along with training for health and other support workers in identifying same-sex domestic violence and abuse.

i) The impact of natural disasters and other significant events such as COVID-19, including health requirements such as staying at home, on the prevalence of domestic violence and provision of support services.

A link between natural disasters and an increase in family and domestic violence has long been established by international research[15].

One of the first such studies on such a link in Australia examined the aftermath of the 2009 Black Saturday bushfires and found there had been a reported increase in domestic abuse in bushfire-affected communities, with some women disclosing the crisis had triggered violence including in male partners who'd never before been abusive.[16] [17]Another study found women who were living in regions more severely affected by the fires experienced higher levels of violence than those in less severely affected areas.[18]

Community service providers and government authorities also reported on an uptick in family and domestic violence in the wake of the Australian 2019-20 bushfire season.[19]

Lisa Gibbs, a public health researcher who leads community resilience research at the Centre for Disaster Management and Public Safety at the University of Melbourne, gave testimony before the Royal Commission into National Natural Disaster Arrangements, set up to examine the 2019-20 Australian bushfires, and attributed the increase in domestic violence after a natural disaster to "people are dealing with change of income, change of accommodation, relationship breakdown because of the strain of what's going on…all of these factors undermine people's capacity to deal with what's happening".

From the beginning of the COVID-19 pandemic in Australia, police, community service providers, and health authorities have all reported increased levels of family and domestic violence, a situation

[15] Anastario, Shehab, & Lawry, 2009; Clemens, Hietala, Rytter, Schmidt, & Reese, 1999; Enarson, 1999; Fothergill, 1999; Houghton, 2009b; Jenkins & Phillips, 2008b; Schumacher et al., 2010

[16] https://ajem.infoservices.com.au/items/AJEM-28-02-09

[17] https://www.npr.org/sections/health-shots/2020/07/07/814490120/the-fire-the-virus-the-violence-australia-and-the-lessons-of-natural-disasters

[18] https://www.cambridge.org/core/journals/bjpsych-open/article/interpersonal-violence-and-mental-health-outcomes-following-disaster/FE519D59C68BCE944AE4A88884A157C5#fndtn-information

[19] https://www.theaustralian.com.au/nation/politics/bushfires-agencies-report-postnatural-disaster-spike-in-domestic-violence-incidents/news-story/ea822344afac37cb4796ff3e4735759b

exacerbated by 'stay at home' orders, social isolation and other factors such as loss of employment, financial stress, and increased alcohol use.

It's worth noting that this is not a purely Australian phenomenon, as evidenced by the United Nations Secretary-General António Guterres' citing a sharp rise in domestic violence worldwide amid global coronavirus lockdowns as being behind his call for governments to make addressing the issue a key part of their pandemic response.[20]

In NSW, the state's Victims Services department announced in May 2020 an increase in both male and female victims turning to front-line support after domestic violence. Its report found there were 9809 referrals through the government's Safer Pathways program for female domestic and family violence victims in March, an increase of 11 per cent from the same period last year. For males there was an increase of almost 9 per cent.[21]

Women's Safety NSW attributed a 56 per cent increase in family and domestic violence client caseload to a surge in new clients during the pandemic period.[22]

Between March and April 2020, 14 per cent of family violence calls to Victoria Police were attributed to circumstances surrounding the coronavirus.[23]

Monash University surveyed 166 family violence victim support practitioners across Victoria during a four-week period from the end of April into May. It found almost 60 per cent of practitioners said the COVID-19 pandemic had increased the frequency of violence against women; half of respondents said the severity of violence had increased; the number of first-time family violence reports had gone up for 42 per cent of practitioners surveyed; and practitioners themselves were struggling working from home, which was "wreaking havoc" on their boundaries and mental health.[24]

St Vincent's Health Australia's hospitals have not been immune from similar experiences during the COVID-19 pandemic.

Data from St Vincent's Hospital Melbourne show the hospital – which was already experiencing a sharp year-on-year increase in admissions related to family violence for the months of January and February – experienced double the number of total admissions as a result of family violence in the month of March in early stage of the pandemic.

As Table 4 on the following page indicates, the percentage of admissions related to family violence – as a total of all admissions to the hospital – increased from 0.5 per cent to 1.0 per cent in March.

While presentations and admissions decreased in April – as they did for all public hospitals in Australia because of stay-at-home orders leading to fewer people requiring acute health care – the number of family violence-related admissions was still larger than for the same month in 2019.

[20] https://www.npr.org/sections/coronavirus-live-updates/2020/04/06/827908402/global-lockdowns-resulting-in-horrifying-surge-in-domestic-violence-u-n-warns
[21] https://www.smh.com.au/national/nsw/domestic-violence-victims-seeking-help-rises-10-per-cent-after-covid-19-lockdown-20200501-p54oxt.html
[22] https://www.abc.net.au/news/2020-06-06/nsw-government-meets-with-domestic-violence-groups-amid-warning/12296018?nw=0
[23] https://www.abc.net.au/news/2020-05-09/victoria-family-violence-cases-double-at-melbourne-hospital/12227594
[24] https://www.theage.com.au/national/victoria/new-reports-of-family-violence-spike-in-covid-19-lockdown-study-finds-20200607-p55096.html

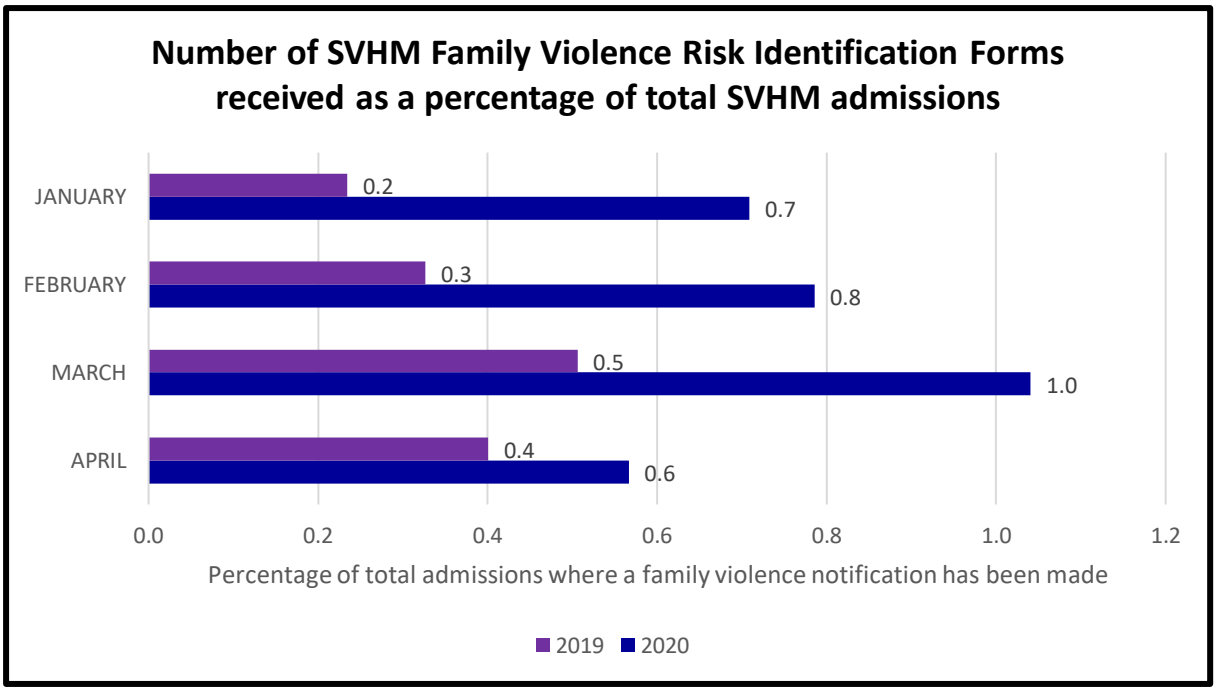

Table 4 Number of SVHM Family Violence Risk Identification Forms received as a percentage of total SVHM admissions

Subjective data to date at St Vincent's Hospital Melbourne suggests that rising financial stress had exacerbated domestic violence during the pandemic, especially with adult children returning home after losing their jobs and creating a pressure-cooker environment. It also noted an increase in physical injuries among the victims.

Among the cases identified, the hospital's view was that financial abuse was also rising and young children were being used by some perpetrators to inflict emotional abuse over the child's mother.

As in Melbourne, much higher numbers of patients experiencing family and domestic violence have been identified at St Vincent's Hospital Sydney's Domestic and Family Violence Service during the pandemic.

In May 2020, when the pandemic was at its height in Sydney, referrals to the service more than doubled, from just over 20 cases for the same month in 2019, to 43.

As presentations declined during the pandemic – combined with stay-at-home orders and people being unwilling to travel to hospital out of fear of contracting COVID-19 – St Vincent's Sydney's Domestic and Family Violence Service moved primarily to becoming a telephone/telehealth service.

Feedback from some clients of the service was that they found receiving counselling via telephone or video link a liberating experience and much preferred it to a face-to-face in session because it made them more comfortable and allowed them to share more details of their situation.

Recommendations:

The Commonwealth and state and territory governments must continue to fund and resource support for victims of family and domestic abuse during the COVID-19 pandemic, and beyond. New models of care such as telehealth/counselling hotlines must be investigated to provide further reach to those in need.

j) The views and experiences of frontline services, advocacy groups and others throughout this unprecedented time.

Frontline services play a critical role in responding to family, domestic and sexual violence in Australia. As mentioned earlier, a hospital may be the only service in the family violence system that a victim or person at risk is accessing, or chooses to access (usually as a result of their health needs). Hospitals can, and should, play a role in not only identifying family, domestic and sexual violence but importantly also assessing risk and providing interventions and support to prevent violence from escalating and improve a victim's ongoing safety post-discharge.

During the COVID-19 pandemic, and as raised in response to (i), we are currently seeing much higher numbers of patients experiencing family and domestic violence. As such, St Vincent's recommends ongoing support to victims of family and domestic abuse, but also stresses the importance of providing support for the health workforce during this time, and into the future. This includes appropriate and timely responses to vicarious trauma which may be experienced by frontline health workers. The safety and wellbeing of workers who address family and domestic violence and abuse can be subject to added risks to their own personal safety and wellbeing. The provision of workplace safety, support, legal consultation, and counselling can all be requirements for staff working in what is a high risk environment and context.

Recommendations:

- In response to the potential for vicarious trauma, provide frontline workers with open and regular space to provide feedback on their experiences and protect their health and wellbeing. All health services within the family and domestic violence sector should embed support mechanisms for their staff.
- That guidance be developed for mainstream services on best practice in responding to disclosures or suspicions of abuse perpetrated by a client.

3 SUMMARY OF RECOMMENDATIONS

Terms of Reference	Recommendations
c) The level and impact of coordination, accountability for, and access to services and policy responses across the Commonwealth, state and territory governments, local governments, non government and community organisations, and business.	Governments should consider mechanisms for strengthening frontline coordination between health services, police and specialist family violence services. St Vincent's Health Australia suggests that safety action meetings provide a useful model for further consideration in other states and territories, where appropriate.
	That the role of hospitals in responding to family violence (beyond identification) including providing risk assessment, safety planning and first line responses is recognised and supported in government policy and practice guides.
	Trial the establishment of regular pop-up Centrelink clinics in public hospitals

	with large cohorts of vulnerable patients, to enable patients and hospital social workers to see a Centrelink officer in person (eg: the Salvation Army's Oasis Community Centrelink clinic).
	Trial a direct phone line for hospital social workers to senior Centrelink officers making representations on behalf of high-risk and vulnerable patients with specialised Centrelink advisors/subject experts (eg: family violence, homelessness, health, aged care) to liaise with.
	Centrelink to provide regular training and education sessions for hospital social workers on its range of payments, eligibility requirements, and their application processes.
	Establish a pilot program in conjunction with state health departments that aims to expedite Centrelink payment applications for inpatients to avoid discharge delays.
d) The way that health, housing, access to services, including legal services, and women's economic independence impact on the ability of women to escape domestic violence.	Explore opportunities to, where appropriate, develop safe houses / refuges in close vicinity to public hospitals responding to family and domestic violence, allowing easy and responsive access to crisis and temporary accommodation that have dedicated family violence, housing and legal workers.
	Develop a one-stop-shop approach for a comprehensive response to family, domestic and sexual violence. For example, this could include embedding a legal service into health services for comprehensive assistance when a person presents or is available for consultation when the person attends for counselling in person or via telehealth. Housing security could also be part of this innovation.
f) The adequacy of the qualitative and quantitative evidence base around the prevalence of domestic and family violence and how to overcome limitations in the collection of nationally consistent and timely qualitative and quantitative data including, but not limited to, court, police, hospitalisation and housing.	Introduce universal family and domestic violence screening across all Emergency Departments, where it can be done safely and with appropriately trained staff.
	Introduce 'safe rooms' in Emergency Departments where people can be assessed in a safe place and while other services (such as police or accommodation) can be arranged.

	Support education and training for appropriate hospital staff to improve their competence and confidence in responding to family violence, and trained in using screening tools and questions.
	Data should be collected to reflect all victims of domestic and family violence, rather than the counting of singular domestic violence incidents.
h) The experiences of all women, including Aboriginal and Torres Strait Islander women, rural women, culturally and linguistically diverse women, LGBTQI women, women with a disability, and women on temporary visas.	The provision of suitable, safe and accessible accommodation options for women and children, including those on temporary visas, who are leaving abusive homes.
	Regardless of visa type or status, every person experiencing domestic and family violence should access: o social security including Centrelink, and Medicare (enabling suitable access to healthcare and flexible financial support packages to attend to immediate needs); and o the Family Violence provisions under the Migration Regulations.
	When developing policy reform, governments should engage with, and reflect the lived experiences of, victims of family and domestic violence.
	Governments support further work with Aboriginal and Torres Strait Islander and CALD communities to develop guidance for health services in how to appropriately support people to access support services.
	Governments support a review of resourcing, training and cultural competency within support services to meet the needs of Aboriginal and CALD people experiencing family violence.
	That the best practice elder abuse framework at St Vincent's Hospital Melbourne be adopted more broadly in hospitals for responding to family violence.
	Each state and territory should consider appointing an Ageing and Disability

	Commissioner.
	Dedicated outreach family and domestic abuse and violence services should be provided for LGBTIQ communities, along with training for health and other support workers in identifying same-sex domestic violence and abuse.
i) The impact of natural disasters and other significant events such as COVID-19, including health requirements such as staying at home, on the prevalence of domestic violence and provision of support services.	The Commonwealth and state and territory governments must continue to fund and resource support for victims of family and domestic abuse during the COVID-19 pandemic, and beyond. New models of care such as telehealth/counselling hotlines must be investigated to provide further reach to those in need.
j) The views and experiences of frontline services, advocacy groups and others throughout this unprecedented time.	In response to the potential for vicarious trauma, provide frontline workers with open and regular space to provide feedback on their experiences and protect their health and wellbeing. All health services within the family and domestic violence sector should embed support mechanisms for their staff.
	That guidance be developed for mainstream services on best practice in responding to disclosures or suspicions of abuse perpetrated by a client.

4 CONCLUSION

St Vincent's Health Australia has directly seen the impact of family and domestic abuse and violence in our communities. We understand that this touches the lives of so many, and it affects people across the lifespan. We take this opportunity to stress the importance of a trauma-informed care approach in response to family and domestic abuse and violence, and that experiences of trauma requires a thoughtful and skilled response to ensure optimal outcomes for patients. Equally, it is critical to support, and build the capacity of, the healthcare workforce who provide care and support to victims of family and domestic abuse and violence in Australia.

Our central message is that hospitals play a key role in responding to family and domestic abuse and violence, and that interactions with the health system are a significant window of opportunity for intervention with victims that should be maximised. This not only refers to screening, but importantly, the provision of timely and appropriate support services as and when they are needed by victims.

APPENDIX ONE

Cassie, is a 21 year-old female who presented to the SVHM Emergency Department (ED) after headaches and loss of consciousness after a violent assault from her ex-partner. She was diagnosed with a fractured cheek bone and referred to ALERT for assessment and management of her health and psychosocial issues. At first Cassie was reluctant to engage in conversations of her assault but with support and a consistent approach to her care from the ED medical team / nurses and ALERT, Cassie felt comfortable to engage in some safety planning and confidence in speaking to the police.

Cassie's preference was to return to her accommodation but ALERT continued to provide support for Cassie into the community.

As Cassie already had services involved including youth specific case management, a psychologist, and housing support agencies, ALERT focused on coordinating the services in response to Cassie's care in addition to helping her navigate the health system.

She had several further ED presentations over several months in relation to her assaults but ALERT continued to engage her in the ED and into the community. Given time she was able to express her readiness to accept support services including interim crisis housing, GP, Safesteps, and RAMP (Risk Assessment and Management Panels) direction due to the severity of her assaults and risk of death.

ALERT involvement assisted Cassie with:

- ensuring adequate safety planning and referrals to Victoria Police, Safe Steps, and Risk Assessment Management Planning input (RAMP) due to the severity of her assaults and risk of death;
- securing safe interim housing until alleged perpetrator was secured and IVO in place;
- ensuring an ongoing safety plan in her home via Safe Steps' safety watch;
- Support to find a local GP for follow up care;
- Targeted Neuropsychologist support for her mental health needs;
- Support to access Optometry and Audiology in addressing her health needs after her fractured cheek bone;
- Access to St Vincent's Good Samaritan Fund to provide financial support, house cleaning, and furniture to support maintaining her current rental property; and
- Continued and target support from her existing youth case management services.

Cassie now remains at her current accommodation with ongoing support of housing and youth services and a psychologist. She has recovered from her fracture and Police have taken out a full Intervention order in regards to the ex-partner with no bail conditions.

APPENDIX TWO

Alexi was 83 years old when Hugo, his partner of 50 years died, leaving Alexi on his own for the first time in many years. Alexi didn't have much family left, and his neighbour Gary, who was in his 30s, started coming around to visit him. At the beginning, Alexi was grateful. Gary could use the internet, and helped him to pay his bills online. Gary would organise the shopping, and do some cleaning in the house from time to time. Alexi started to rely on him.

As time went on though, Gary became controlling. When Alexi came out of hospital after some minor surgery, Gary had rearranged the furniture without asking Alexi. Gary would collect Alexi's mail, and open it without permission; he would make demands for items in Alexi's house and feeling he had no choice, Alexi would give them to him. Alexi wanted to make a new will as everything in his current one was left to Hugo. Alexi felt pressured, as Gary had started to make comments about what he wanted Alexi to leave him - as well as telling him he should be appointed power of attorney so he could manage Alexi's finances. Alexi wished Gary would leave him alone - he had no intention of leaving anything to Gary, or appointing him as attorney.

Through his St Vincent's Hospital Melbourne social worker, Alexi was put in touch with a Health Justice Partnership (HJP) lawyer who was based at the hospital. The HJP lawyer was able to give some advice on Powers of Attorney, and link Alexi in with pro bono lawyers who could draft a new will for him, without Gary's interference. Alexi's will is now complete and stored in private. He sees Gary less often, but when he does come around, Alexi is no longer worried by Gary's comments as he feels confident in his understanding of his rights.