HNECC PHN Domestic and Family Violence Pilot

Primary Care Pathways to Safety: the Readiness program

Prototype model emerging from the PHN's co-design process

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I treasure that I live and work on Aboriginal country – the oldest living culture in the world. I offer my sincere respect to Aboriginal Elders from the past 60,000 years, those Elders currently with us and those emerging in the future.

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Acknowledgments

This program is being implemented on the lands of the of the Kamilaroi, Anaiwan, Banbai, and Darkinjung peoples. We acknowledge their resilience and pay our respects to their elders past and present.

Thank you to all the participants in the codesign workshops for their generosity, wisdom and focus. The design ideas that emerged and the implementation problems solved through the workshops are the result of their hard work.

Introduction to the program

Background

Domestic and Family Violence (DFV) is a significant problem at national, state and local levels. For many years the prevention and amelioration of DFV was seen as principally residing within the functions and remit of the judicial system. It is now widely acknowledged that addressing DFV requires a multi-faceted approach. An approach that harnesses a range of preventive and protective factors, and multi-disciplinary collaboration across sectors.

The health sector has a critical role to play.

Imagine if there was a condition, that if diagnosed and referred to effective treatment, would result in the following outcomes:

- 18% less early pregnancy loss
- 19% less suicide & self-inflicted injuries
- 19% less depressive disorders
- 12% less anxiety disorders
- 4% less alcohol disorders (AIHW 2019)[1].

If we knew we could achieve these health outcomes, what would we be prepared to do?

Treatment for the physical and mental health impacts of violence is an obvious intersection between DFV and the health care system. However, for many individuals affected by DFV, contact with a primary health care professional can be their only link to a community-based service, with an average of seven to eight visits occurring prior to disclosure. Unfortunately, the evidence suggests that when a disclosure is made, the responses received can be inappropriate and poor in quality.

In addition, specialist service providers continue to report a disparity between the high prevalence of the DFV identified within the primary health care environment and the number of referrals received from the sector. The existing referral mechanisms are becoming increasingly convoluted and fragmented which can make appropriate referral challenging for overstretched GPs.

[1] https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-australia-2019/contents/summary

Under the banner - ***Primary Care Pathways to Safety: the Readiness Program*** - the Hunter New England Central Coast Primary Health Network (HNECC PHN) is leading a range of initiatives focused on getting help to people experiencing DFV faster. We aim to achieve this by working with GP practices and building bridges between the primary care and specialist DFV sectors.

DFV is complex and multi-faceted, so the program has a range of activities to achieve individual practice level change, as well as broader systemic change.

The role of GP practices

For many, if not most GPs, identifying patients who are experiencing violence can be very difficult.

Often the violence doesn't present itself in an obvious way and may not be identified by the patient as their reason for presenting. Even though the Royal Australian College of GPs (RACGP) estimates that full-time GPs are seeing up to five women per week who have experienced some form of intimate partner abuse in the past 12 months how do GPs identify who they are[2]?

And if you do identify those patients, how do you start an effective conversation?

And if the GP does initiate a discussion, what effective solutions can they offer?

There are many challenges to GPs recognising and responding to domestic and family violence. There are further challenges to ensure that referrals go to the right services and supports.

But there are solutions to all these challenges. Some GPs have developed practices where they can respond in an empathetic and timely fashion to get their patients to the services they need.

The *Primary Care Pathways to Safety* project will support the uptake of these successful practices with GPs in the Central Coast and New England regions. The evidence shows that by partnering the primary care sector with the DFV specialist sector, we can deliver practical solutions and drive improved health and social outcomes for people who are experiencing violence at home.

[2] Abuse and violence: Working with our patients in general practice, 4th edn. Melbourne: The Royal Australian College of GPs, 2014, p 10

The program is part of a broader pilot

The Commonwealth Government, through the Department of Health, is funding six *Improving Health Systems Response to Family and Domestic Violence Pilots*. This funding is designed to improve primary health care responses for people experiencing domestic and family violence (DFV) and further integrate primary health into the DFV service system. The Commonwealth pilot is funded until June 2022.

Hunter New England and Central Coast Primary Health Network (HNECC PHN) received funding to implement pilots in three sites: Armidale, Tamworth and the Central Coast. Tamworth, Armidale and the Central Coast were chosen because these localities have high incidents of DFV per population, with many services outreaching to smaller towns and communities in their vicinity (see the *Primary Care Pathways to Safety* Evidence Profile for details).

Components of the model

The HNECC PHN pilot draws on work undertaken by Brisbane South Primary Health Network (PHN). Brisbane South developed their *Recognise, Respond, Refer: An integrated health response to domestic and family violence (RRR)* model in 2017. HNECC PHN used the RRR model as a design prototype and adapted it to fit with the NSW environment.

The model is not a single specific service. Rather, it takes a systems approach with six components and influencing activities operating across primary care practice and at a PHN systems led level.

The initiative enables primary health, particularly GPs and their medical centres, to play a visible and deliberate role within the domestic and family violence ecosystem that supports an integrated systems response to DFV.

Those components/influencing activities are:

1. DFV Local Link (DFVLL) – a commissioned service that works to integrate local DFV responses, play a connector function between primary care, DFV services and influential systems

stakeholders, and shift system blocks that prevent primary care patients from accessing DFV help sooner.

A DFV 'local linker' is based in a DFV service in three communities - Armidale, Tamworth, Central Coast. The DFV local linker has specialist DFV expertise and sector knowledge. They drive and coordinate local links and referral pathways between GPs/other primary care providers and the DFV sector. They help identify ways to integrate primary health care into the local DFV sector, including acute health care services addressing DFV.

2. Workforce Capacity Building - providing training and support for primary health care including:
    - Evidence-based whole of practice training, delivered by the University of Melbourne's Safer Families Institute of Research Excellence, for GP practice staff to identify and respond to the signs of DFV;
    - Ongoing local education and professional development activities for GP practice staff participating in the pilot and other primary care providers; and
    - *Student Multi-Disciplinary Communities of Practice* and training partnerships with universities to equip the next the next generation of health and social care providers (medicine, nursing, social work, psychology and law) so they are better able to respond DFV.

3. Primary Care's Role - Strategies to support primary healthcare providers to play a practical role in helping victims of DFV get expert help faster:
    - For the Central Coast, this will include partnering with the Central Coast Local Health District to commission an Outreach Paediatric Speech Pathologist. They will provide assessment and intervention to children and professional support and training to GPs on the impacts that DFV has on children and their language development.

4. Local Integration – so that the project is tailored for local circumstances. Identifying and responding to local challenges, gaps and opportunities. Gaps and opportunities already identified include:
    - For the Central Coast, working in partnership with a local Central Coast Family Practice to establish an Outreach Primary Care Practice Nurse to provide outreach services to local refuges.

- For Armidale, supporting an Aboriginal-led Community Taskforce to address the lack of First Nation's men's behaviour change programs in the area. The community taskforce members include the local magistrate and representatives from police, local general practices and other community services.

5. System Influence – tapping into local expertise and using this to make broader system changes.

6. Continuous Improvement– integrating design and evaluation so that evidence is used to improv iterations of the model in an ongoing way rather than at the end.

Co-design approach

Overview

The *Primary Care Pathways to Safety* program is using a co-design process. This means that people involved in delivering or receiving the services have a say in the design of the program and how it is implemented. This includes people who have experienced DFV, GPs, practice nurses and other health staff

who see patients experiencing DFV, and people who work in organisations that provide specialist DFV services to individuals and families experiencing DFV.

Project design has a number of phases. We are investing in understanding the problems, from a user perspective, that need to be resolved for the program to work.

The first stages of co-design included:

- Interviews and consultation meetings with a wide range of stakeholders;
- Development of an Evidence Profile to inform the design process; and
- Four co-design workshops, involving a wide range of service providers.

The risks, opportunities and design themes identified by our co-design stakeholders are detailed below.

The process of co-design will continue, testing ideas with stakeholders and building in feedback loops so we can make upgrades to the design and implementation of the project as we go along.

Co-design outputs and findings - risks, opportunities and design themes for each element

Element 1: DFV Local Link (DFVLL)

The Local Link is critical to the success of the pilot and at the time of writing, has guaranteed funding for 12 months only (until June 2022). This constraint poses significant risks, particularly to sustainability beyond June 2022, that need to be mitigated in detailed design and implementation stages. A threshold decision was that ***the DFVLL role would not be client-facing*** and would focus on developing processes and systems that could be maintained if funding for the pilot was not extended.

Risks

- The current 12-month funding timeframe.
- Setting the bar too high – unmanaged optimistic desires to 'fix the problem' and unrealistic expectations of what can be achieved with existing resources.
- The project design becomes over complicated, and effort is spread too thinly across a large range of strategies and deliverables.

- Not focusing sufficiently on strategies that ensure sustainability of deliverables without a DFVLL in place.
- Managing stakeholder expectations to ensure the Local Link is not overwhelmed and over-worked.
- Recruiting staff to the DFVLL roles who have the capabilities required to understand and drive connections between the:
    - General practice medical and business model and work effectively with GP practice staff,
    - Community-based specialist service model underpinning most DFV services and the
    - Acute care health delivery model driving DFV health services in the Local Health District.
- Generating sufficient whole-of-system support and engagement with the DFVLL so that they are not problem-solving in isolation. System-level solutions to problems are required to deliver sustainability.

Opportunities

- There is significant support for the project across the local DFV sectors in each site, including enthusiasm for the DFVLL playing a role in developing links between services and educating the different sectors/services about each other.
- There is strong agreement that the focus of the DFVLL role should be on helping to change the environment and system, rather than having direct client contact.
- There is particular support from the LHD Violence, Abuse and Neglect (VAN) teams. This is support is echoed by the Ministry of Health Integrated Prevention and Response to Violence, Abuse and Neglect (IPARVAN) program. There are DFV prevention and response goals and outcomes shared by the primary care and acute care sectors that can be leveraged by this pilot. For example, the *Primary Care Pathways to Safety* program could provide a stepdown pathway for patients discharged from VAN services. Alternatively, VAN services offer GPs a path to refer patients to treatment for injuries from violence such as strangulation, or a source of specialist medical advice from the new VAN staff specialists being recruited across the State.

Design Themes

The DFVLL role should not be client facing and the risks associated with the current limited funding timeframe must underpin decisions about what the role will and won't do.

The primary role of the DFVLL is to facilitate changes to the system that help integrate primary care and specialist DFV services. The DFVLL may lead changes but will also have a supporting role for reforms that are better led by other protagonists. As part of this, the DFVLL identifies barriers to integration, and actively participates in the continuous improvement activities driving the implementation of the project overall.

Key deliverables identified in the co-design process include:

1. 10 GP practices in each site are recruited to the project and staff attend 'Readiness' training.
2. The DFVLL attends *Safer Families* GP Readiness train-the-trainer sessions.
3. The DFVLL co-delivers GP Readiness training to 10 local GP practices with GP training partner.
4. Local service mapping is accurate and up to date.
5. A DFV patient care plan template is developed for participating GPs.
6. A primary care risk assessment and referral pathway is developed – it is aligned with the NSW Safer Pathways approach as well as the *HealthPathways* platform familiar to GPs.
7. GP practices participating in the program have referral and patient information and resources to assist patients experiencing DFV and support disclosure. This includes resources that support patients to feel culturally safe if they are Aboriginal or Torres Strait Islander, identify as LGBTQI and/or are a member of another cultural group.
8. The DFVLL is a regular visitor to participating GP practices and has a supportive relationship with practice staff.
9. The DFVLL attends local DFV interagency and coordination meetings.
10. The DFVLL facilitates regular formal and informal professional development and networking opportunities for participating GP practice staff eg *Lunch & Learn* sessions.
11. The DFVLL participates in continuous improvement and pilot evaluation activities, including gathering data and other feedback, identifying barriers to achieving project outcomes and problem solving.

Key Indicators of Success

1. The DFVLL has an achievable 12-month workplan tailored to local circumstances.
2. Participating GP practices are trained in recognising and responding to DFV and feel connected to and confident in their local DFV services.

3. Clinical tools required to respond and refer are developed (DFV patient care plan template, local DFV *HealthPathways,* a GP referral pathway aligned with the Women's Domestic Violence Court Advocacy Program (WDVCAP) and NSW Safer Pathways, secured messaging systems between GPs and specialist DFV agencies).
4. First 12-month deliverables can be sustained without continued support from the DFVLL.

Element 2: Workforce Capacity Building

The workforce capacity building element has three components:

- Evidence-based training for ten GP practices in each of the three pilot sites;
- Ongoing DFV education and professional development events and resources for GP practice staff;
- The development of a *Student Multidisciplinary Communities of Practice* - a PHN/University of New England partnership to create opportunities for the next generation of health and social care practitioners training in the New England Region to receive culturally appropriate training and education on DFV.

HNECC PHN commissioned Professor Kelsey Hegarty and the University of Melbourne's *Safer Families* Centre of Research Excellence to deliver the project's evidence-based training component to ten GP practices in each of the project sites.

The training program, known as *GP Readiness training*, aims to support and build upon GPs', nurses' and other practice staff's:

- Active listening and responding skills to build trust with patients
- Access up-to-date evidence and resources in responding to family violence
- Skills to assess readiness for change and non-directive goal setting
- Promotions of changes in the practice to support dealing with family violence

The training is delivered by volunteering local GPs and an experienced DFV trainer who is also a GP, supported by the *Safer Families* train-the-trainer program.

At the end of the training all primary care staff should be able to:	All primary care clinical staff should be able to:

- Respectfully engage with patients experiencing DFV including culturally safe ways to engage
- Review current clinical protocols and resources and implement changes to enhance response
- Reflect on their own attitudes which might facilitate or inhibit effective engagement with families experiencing family violence
- Recognise families presenting with the symptoms and signs of family violence
- Risk assess for safety of women and children experiencing family violence
- Respond to disclosures using the WHO first line response of LIVES, including being able to assess readiness for patient to take action, make safety plans and enable support for survivors and their families
- Refer appropriately depending on the needs of patients
- Record and share information in a safe, effective manner

Participants are provided with tools including:

- Healthy relationships tool
- Power and control tool
- Survivor risk assessment tool
- Safety planning tool
- Readiness to change motivational interviewing tool
- Non-directive problem solving goal setting tool
- Whole of Practice Checklist

The program components have been tested through two world first randomised controlled trials in general practice. The WEAVE Study[3] (Women's Evaluation of Abuse and Violence Care in General Practice) found that the intervention reduced women's symptoms of depression and increased how often GPs asked about safety of women and children. The IRIS Study[4] (Identification and Referral for Safety) found that the

3 Tarzia, L., Bohren, M., Cameron, J., Garcia-Moreno, C., O'Doherty, L., Fiolet, R., Hooker, L., Wellington, M., Parker, R., Koziol-McLain, J., Feder, G., Hegarty, K. *Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis.* BMJ Open.

4 Feder, G., Davies, R. A., Dunne, D., Eldridge, S., Griffiths, C., ….Sharp, D. (2011). *Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: A cluster randomised controlled trial.* Lancet, 378, 1788-1795. https://doi.org/10.1016/S0140-6736(11)61179-3

intervention increased identification and referral of women experiencing domestic violence setting them on a pathway to safety and well-being.

Risks

- Lost income when attending training is a disincentive for GPs staff attendance.
- Short training courses are not sufficient to cover the complexities of DFV.
- Training on recognising DFV and responding to patients in the clinic could be undermined if learnings are not reinforced in day-to-day practice.
- Post-training GP practice staff's new skills recognising DFV and responding to patients in the clinic could be undermined if assessment/referral tools are not developed and local referral options are not in place.
- The content of the GP training and the strong evidence-base supporting its efficacy are not well known. Subsequently, some DFV stakeholders have questions and concerns about whether it will cover the right issues and share the same principles and values as the DFV sector.

Opportunities

- Early recruitment to DFVLL roles will allow DFVLL staff to participate in GP train-the-trainer sessions and promote the training when recruiting the 10 local GP practices for each pilot site.
- Local GP training events provide an opportunity for promotion of the project overall and broader networking.
- There is significant support from stakeholders for all proposed workforce capacity building strategies. This includes a desire to partner where possible, with DFV specialist services either delivering or co-participating in local professional development events.

Design Themes

Barriers to interested GP practice staff engaging with the project and attending training need to be identified and addressed. The PHN introduced a practice incentive payment for all GP practices taking part in the training, but there may be other barriers.

The DFVLLs should promote the *Safer Families* GP training to DFV stakeholders to allay concerns that it won't align with current principles and values of the DFV sector.

GP practice staff engaged in the *Safer Families* training need to be given realistic timeframes regarding the development of supportive clinical tools, including referral pathways. The development of these tools and referral pathways must be an implementation priority.

Ongoing GP training and professional development activities must be informed by feedback gathered by DFVLLs.

Actively promote all components of the Workforce Capacity Building element of the pilot. There is tremendous interest in each of the components and they demonstrate primary care/DFV integration in action.

Key Indicators of Success

1. The GP *Safer Families* training is delivered to staff from 10 GP practices in each pilot site.
2. Delivery of the *Safer Families* training is aligned to the development of clinical tools for GPs to assess and refer.
3. Stakeholders from local DFV services are aware of and supportive of the content of the *Safer Families* training packages and ongoing GP practice staff professional development events.
4. GP practice staff participate in ongoing DFV-related training and professional development opportunities.

Element 3: Primary Care Role

Research found that on average, victims of domestic and family violence (DFV) have seven to eight visits with their GP before disclosing. When patients do disclose, many GPs report that they are unsure of the best response or who to refer to.

This project is about getting help to victims of DFV faster by building bridges between primary care and the DFV sector. GPs on their own will never be the total solution to such a complex issue as DFV, but they can play an important role in an integrated local response.

We know that both victims and perpetrators of domestic and family violence have diverse and complex needs. They frequently require multiple interventions from a range of health, social care and justice

services. This project aims to support a critical player - the local GP practice - to be part of the multidisciplinary and collaborative response needed to address family and domestic violence.

Risks

- The DFV sector has many actors. A broad range of practitioners from different disciplines respond to DFV including police, housing/accommodation providers, social workers/case workers, health workers, court and legal support workers etc. This landscape can be difficult to navigate.
- General Practitioners need to know a little about a wide range of health issues. Needing to quickly understand the complexities of DFV dynamics and the DFV sector is a challenge that might deter some GPs.
- Some stakeholders in the DFV sector expressed concern about a power differential between GPs and DFV specialist services which might manifest as a lack respect for community-based services.

Opportunities

- Stakeholders are very supportive of taking a strategic approach to defining the role of the GP practice within pre-existing referral systems such as the NSW Safer Pathway approach. Similarly, stakeholders are enthusiastic about adapting risk assessment and decision-making support tools and processes, so they work effectively in the primary care environment.
- The DFVLL could personify the desired 'bridge' between primary care and the DFV sector, especially at the local level, linking GP practices and services through information sharing and relationship building activities.
- Local DFV specialists could mentor GP practice nurses of other staff on DFV issues.
- Existing GP practice software could be adapted for DFV.
- There is significant interest in exploring opportunities to better recognise and respond to children who have experienced DFV.

Design Themes

DFV specialist services and GP practices are very different entities with vastly different operating environments. Many DFV services are government or charity funded to deliver services such as crisis accommodation, and often demand outstrips their service capacity. GP practices are small businesses, covering a wide of health related issues. They have a high turnover of patients daily and in some areas, have limited capacity to take on new patients.

The role of GP practices and the GP themselves in responding to DFV needs to be tightly defined so that it does not replicate the role of other DFV practitioners or work across existing multidisciplinary systems or place expectations on GP staff that they can't possibly meet.

A range of staff with differing roles and clinical scope work in GP practices eg receptionists and practice managers; practice nurses and general practitioners. Staff engagement and professional support strategies will be more effective if underpinned by a nuanced understanding of the roles of GP staff.

GP practice software should be expanded to embed DFV clinical assessments/plans and referrals and allow for DFV data collection where possible. Secure messaging must be expanded to include specialist DFV services that GP practices will refer to.

DFVLLs need to work closely with the PHN, specialist community advocacy/support groups and pilot stakeholders to support the design, development and implementation of pilot tools, resources and strategies to ensure appropriate primary health responses to:

- Children impacted by DFV;
- Aboriginal and Torres Strait Islander people;
- People from culturally and linguistically divers (CALD) backgrounds;
- People who identify as lesbian, gay, bisexual, transgender, intersex and queer
- People with disabilities; and
- Perpetrators of DFV.

Recognising and responding to the impacts of DFV on children is an emerging area. Experiencing or witnessing domestic abuse can have an impact on the development of children and young people's speech, language and communication skills.

A 2021 Australian study[5] showed that children who experience DFV have poorer language skills than children who do not experience DFV. Poor child language skills are associated with adverse outcomes

5 Laura J. Conway, Fallon Cook, Petrea Cahir, Stephanie Brown, Sheena Reilly, Deirdre Gartland, Fiona Mensah, Rebecca Giallo, Children's language abilities at age 10 and exposure to intimate partner violence in early childhood: Results of an Australian prospective pregnancy cohort study, Child Abuse & Neglect, Volume 111, 2021

across the life span, including academic under-achievement and mental health problems. Early treatment may reduce the long-term health and social impacts.

Key Indicators of Success

1. The gateway role of the GP practice in recognising and responding to patients experiencing DFV is well defined and supported so that GP staff are not expected to do work beyond their primary care scope.
2. The DFV sector understands the opportunities and limits of the operating environment of GP practices.
3. Tools and procedures developed for GP practices are aligned with NSW DFV approaches and systems.
4. GP practices are welcoming and culturally safe places where patients feel supported to seek help.
5. Opportunities to build the capacity of primary care to recognise and respond to the impacts of DFV on children is explored.

Element 4: Local Integration

Tamworth, Armidale and the Central Coast were chosen because these localities have high incidents of DFV per population, with many services outreaching to smaller towns and communities in their vicinity. Each locality also has its own unique population demographics, community dynamics and service stressors.

GP practices are strongly rooted in their communities. To deliver quality primary healthcare, GPs and other practice staff have a good understanding of the range of other healthcare services their patients might need, and how to refer to them.

Ensuring the project is tailored to local circumstances in each locality is key to success.

Risks

- Without a nuanced understanding of the local service system, GP practice staff could have a frustrating experience trying to refer their patients experiencing DFV to local DFV services. For example, some DFV services are stretched and have waiting times, others may have policies that exclude certain demographics eg boys over 16 years of age etc
- Some localities have thin service systems or are devoid of specialist services that patients might need, such as behaviour change programs for men who use violence.

- Some people experiencing DFV will receive services from the Local Health District (LHD) acute healthcare system as well as the primary care system. Patient outcomes may be jeopardised if there is not a mechanism for these two healthcare systems to talk with each other.

Opportunities

- The DFVLL role could map local services, their operating principles and constraints and use this information for practical solutions such as updating local DFV *HealthPathways*, promoting DFV services to GP practices and facilitating broader system solutions to services gaps.
- The DFVLL gathers and distributes local DFV resources to participating GP practices.
- The DFVLL can develop mechanisms for local DFV service staff and GP practice staff to establish ongoing working relationships.
- Work with communities in the Armidale area to look at options for establishing a behaviour change program for Aboriginal men.
- Partner with a Central Coast Family Practice to establish an outreach practice nurse who can visit women/children in refuges and provide vital health checks and referrals.

Design Themes

Co-design identified local service mapping as a key function for the DFVLL, noting that in each locality, some level of service mapping had already been undertaken that would service as a base.

Each locality had interagency groups that met to assist in service coordination, and in some localities, these operated at a sophisticated level. The DFVLL was universally welcome to join these interagency groups.

GP practice staff will benefit from having an intimate understanding of local DFV services and developing working relationships with DFV service staff. This will assist in better referrals and potentially opportunities to troubleshoot complex cases.

Key Indicators of Success

1. GP practices know the local services their patients might need and how to refer to them.
2. Participating GP practice staff feel supported by the local specialist DFV sector.

Element 5: System Influence

Responding effectively to DFV requires a multisystemic joined-up approach. The *Safer Pathways* model is cognisant of this as well as the need to influence the environment at a systems level in order to deliver better services. The Systems Influence element of the model provides an opportunity to tap into local expertise and link it to broader system reforms and infrastructure.

Risks

- Not harnessing the expertise in local communities.
- Service delivery to people experiencing DFV remains siloed.
- Developing tools and processes for GP practice staff to use, in isolation of the broader system.
- People experiencing DFV falling through the cracks of the various sectors and disciplines that operate in the DFV space.

Opportunities

- Use the pilot project as a springboard to support the principle that DFV needs a multisectoral approach.
- Develop local systems that work for patients ***across services*** using a multi-disciplinary shared care or joined-up approach.
- Explore links between the PHN primary care *Safer Pathways* model and the LHD Violence, Abuse and Neglect (VAN) model.

Design Themes

The NSW Government's 2014 *It Stops Here* framework provides an overarching approach to referral pathways that helps services swiftly and efficiently wrap around the victim of DFV in a coordinated way. Service providers use the same tools to assess domestic and family violence risk of harm, and have mechanisms to share essential information between services, where this is critical for safety.

The PHN should facilitate the use the assessment tools and referral pathway developed under *It Stops Here* wherever practical to deliver consistency to people experiencing DFV.

Similarly, NSW Health has its *Integrated Prevention and Response to Violence, Abuse and Neglect (IPARVAN) Framework* for NSW Health services. The framework's intention is to guide an integrated public health approach that recognises that victims and their families often have complex needs requiring multiple interventions provided by a range of services.

PHN will initiate discussions with LHD VAN teams and the Ministry of Health IPARVAN unit and explore opportunities to develop patient-centred continuity of care pathways.

Key Indicators of Success

1. The Primary Care Pathways to Safety pilot's assessment tools and referral pathways are aligned with those developed under *It Stops Here* wherever practical.
2. The Primary Care Pathways to Safety pilot programs in each locality and LHD Violence, Abuse and Neglect team services are aligned where possible.
3. GP patients experiencing DFV experience continuity of services across the range of support services they are referred to.

Element 6: Continuous Improvement

Collecting evidence to inform and support the on-going iteration and delivery of pilot activities will occur across all elements of the model. These activities are informed by the PHN's *Plan, Do, Study, Act* (PDSA) principles and a *Participatory Action Research* (PAR) approach that involves a range of stakeholders gathering and interpreting evidence.

Risks

- The pilot currently has a short funding timeframe and an ambitious sustainability goal. It will not succeed without continuously testing solutions and making adaptations throughout the implementation phase.
- The pilot is part of an independent evaluation gathering data on outcomes of six different models across Australia, aimed at assisting primary care providers to recognise and responding to people experiencing DFV. The data collection mechanisms for this evaluation could be superfluous to or distract from the day-to-day implementation of the pilot if not integrated early.
- Data and other feedback gathering mechanisms could be onerous for GPs if not integrated into practice clinical software systems.
- Pilot data collection could be haphazard, inconsistent, incomplete or not linked to strategic outcomes across the three sites.

Opportunities

- Clinical software systems used in GP practices could be used to automatically collect some data.
- Data collected by the Commonwealth's independent evaluator may also be used for local continuous improvement purposes.
- Some NSW strategies and frameworks related to DFV have begun identifying outcomes and measures that could be used in this project.
- Capture data and reflections from a range of stakeholders, including people with lived experience.

Design Themes

The PHN needs to develop an overarching program logic for the pilot. The program logic should align with the Commonwealth evaluation plan and with related NSW DFV program logics where practical.

Build data collection systems into the clinical software systems used by GP practices wherever possible. Maximise the use of data collected by the Commonwealth's independent evaluator for continuous improvement.

The PHN should convene regular participatory action research forums for stakeholders to review continuous improvement data. This will ensure the rollout of the program is informed by evidence.

Key Indicators of Success

1. A shared program logic guides data collection and analysis across pilot sites.
2. Data collection systems are not onerous for GP practice staff or other stakeholders.
3. The independent evaluation is linked to the program's continuous improvement.
4. An approach to continuous improvement is developed, incorporating *Plan, Do, Study, Act* and *Participatory Action Research* approaches.

Implementation roadmap on a page

The initial implementation deliverables and indicators of success identified in the co-design workshops are outlined below in the form of a plan on a page.

This roadmap will be used to initiate implementation and will be updated as continuous improvement activities develop new design iterations and new initiatives emerge.

Primary Care Pathways to Safety: the Readiness Program

Draft Implementation Roadmap

Element	DFV Local Link	Workforce Capacity Building	Primary Care Role	Local Integration	System Influence	Continuous Improvement
Implementation deliverables	The DFVLL facilitates sustainable system changes across all project elements rather than having face-to-face client contact The DFVLL develops a12 month workplan tailored to local circumstances The DFVLL has a communication and engagement plan to develop relationships with between GP practices and DFV specialist services The DFVLL understands the scope of practice for each staff role in a GP practice	The DFVLL recruits 10 GP practices in each site to the project and practice staff attend Safer Families[1] GP Readiness training The DFVLL co-facilitates the *Safer Families GP Readiness* training with GP training partner The DFVLL facilitates regular formal & informal professional development & networking opportunities for participating GP practice staff: • Including four *Safer Families* led Communities of Practice A *Student Multidisciplinary Communities of Practice* is established by the PHN and University of New England	A DFV patient care plan template is developed for participating GPs and practice nurses. The care plan template can be used to refer cases to *NSW Safer Pathway* Local Coordination Points Primary care DFV referral pathways are refined and adapted as local services develop & change. They allow secure messaging and align with the *NSW Safer Pathway* approach GP practices participating in the program have information and resources to support disclosure & assist patients to select the DFV services they want GP practice staff & resources support patients to feel culturally safe if they are Aboriginal or Torres Strait Islander, identify as LGBTQI &/or are a member of another cultural group The primary care role to provide support for children experiencing DFV is explored	Barriers to GP practice staff engaging with the project & attending training are identified & addressed Local DFV service mapping is accurate and up to date DFV *Health Pathways* are developed based on local DFV services Connections between general practices, DFV specialist services and other support services locally and within the HNECC footprint are developed Connections are developed between the HNECC primary care response to DFV and local Violence, Abuse & Neglect (VAN) teams A partnership with a Central Coast Family Practice provides an outreach primary care practice nurse for women/children in refuges Specialist DFV services are supported to close the referral loop with primary care	The DFVLL attends local DFV interagency and coordination meetings The DFVLL promotes the *Safer Families GP Readiness* training to DFV stakeholders and familiarises them with the content The DFVLL and the PHN identify service system gaps and opportunities to address them An Aboriginal-led community taskforce is established in Armidale to address the lack of First Nations men's behaviour change programs The HNECC Primary Care Pathways to Safety program is integrated into state-wide planning	Plan, Do, Study, Act (PDSA) continuous improvement principles are built into all aspects of the model The DFVLL participates in continuous improvement activities, including gathering feedback, identifying barriers to achieving project outcomes and problem solving Ongoing GP training and professional development activities is informed by feedback gathered by DFVLLs The PHN convenes regular Action Planning meetings for key stakeholders The PHN informs the independent evaluation of the Commonwealth program and develops appropriate data collection mechanisms
Indicators of Success	Program deliverables are achieved within 12 months The DFVLL is confident facilitating the development of DFV supports for various staff within GP practices Key program deliverables can be sustained without continued support from the DFVLL	The *Safer Families GP Readiness* training is delivered to staff from 10 GP practices in each pilot site Delivery of the *Safer Families* training is aligned to the development of clinical tools for GPs to assess & refer Stakeholders from local DFV services are aware of and supportive of the content of the *Safer Families* training packages and ongoing GP practice staff professional development events GP practice staff participate in ongoing DFV-related training & professional development Patients in HNECC experiencing DFV are identified & supported by their GP	Tools and procedures developed for GPs are aligned with current NSW DFV approaches and systems Patients feel supported to disclose DFV to their GP and seek help Initiatives to expand services for children experiencing DFV are developed	Participating GP practices are connected to and confident in their local DFV services GP practices refer patients to DFV services Victims of DFV experience continuity of care across the primary care and acute care systems in HNECC	GPs refer to the NSW *Safe Pathway* Service system gaps within the HNECC footprint are identified and addressed The HNECC primary care response to DFV is integrated with and supported by the NSW DFV system	The rollout of the *Primary Care Pathways to Safety* program is informed by evidence *Primary Care Pathways to Safety* program tools and processes are prototyped and iterated over time based on feedback The independent evaluation measures success factors that relate to the *Primary Care Pathways to Safety* program

[1] *Safer Families* refers to the University of Melbourne's Safer Families Centre of Research Excellence, which developed the *GP Readiness* training.

Program logic

The HNECC PHN is working closely with the Sax Institute and Australia's National Research Organisation for Women's Safety (ANROWS) on the evaluation of its *Primary Care Pathways to Safety* program and the five other Commonwealth pilots.

The *Primary Care Pathways to Safety* program has its own program logic, aligned with the Sax/ANROWS program logic. Where possible, the program logic is also aligned with the *NSW DFV Outcomes Framework*, particularly in terms of overarching system improvements.

Objectives

- Increase the capacity of workers in primary care settings to better care for people living with family and domestic violence
- Improve the primary care system's capability and integration with the broader family and domestic violence service system.

Aims

- Enhance education and training opportunities for primary care workers to better care for victim survivors of DFV
- Improve collaboration across specialist support services, sectors, and workforces to ensure coordinating responses to those affected by DFV
- Improve health outcomes for people experiencing DFV.

A detailed program logic is provided below.

Activities	Outputs	Mechanism of Change	Outcomes
The DFVLL facilitates sustainable system changes across all project elements rather than having face-to-face client contact.	Program design accounts for short-term funding arrangements.	The bridges built between the primary care and the DFV specialist sectors will not be dependent on the DFVLL role remaining in place. Patients experiencing DFV can continue to receive quality responses from their GP without requiring the DFVLL.	Program deliverables are sustained beyond DFVLL funding timeframe.
The DFVLL develops a 12-month workplan tailored to local circumstances.	DFVLL workplan.	Having a clearly defined workplan will ensure goals and role expectations are achievable.	Program deliverables are achievable.
The DFVLL understands the scope of practice for each staff role in a GP practice.	DFV-related tasks match roles.	Understanding the operating environment of GP practice staff assists the DFVLL to develop strategies and tools that will function in the GP practice.	Program deliverables are achievable.
The DFVLL recruits 10 GP practices in each site to the project and practice staff attend *Safer Families*[1] *GP Readiness* training.	Staff from 10 GP practices in each site attend *Safer Families GP Readiness t*raining.	GPs and other practice staff will attend training with a strong evidence base, increasing the likelihood that change can be adopted across the entire practice and that new skills taught will be effective.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GPs recognising DFV • an increased number of GP referrals to local specialised DFV services.
The DFVLL facilitates regular formal & informal professional development & networking opportunities for participating GP practice staff: • Including four *Safer Families* led Communities of Practice.	Staff from 10 GP practices in each site participate in DFV-related professional development opportunities.	Exposure to ongoing professional development allows GP practice staff to build in their initial 'readiness' skills, building capabilities in other aspects of responding to DFV.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GPs recognising DFV • an increased number of GP referrals to local specialised DFV services.
A *Student Multidisciplinary Communities of Practice* is established by the PHN and University of New England.	Students learn how to respond to DFV within their disciplines.	Training the students in best practice responses to DFV means the emerging workforce is more likely to see	Future workforce of health and social care providers is equipped to respond to DFV.

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Activities	Outputs	Mechanism of Change	Outcomes
		responding to DFV as part of their profession and increase the likelihood of cross-agency/cross-sector collaboration.	
A DFV patient care plan template is developed for participating GPs and practice nurses. The care plan template can be used to refer cases to *NSW Safer Pathway* Local Coordination Points.	A tailored DFV template for documenting patient care.	GP practices will have a tool that assist them to take a structured approach to planning DFV-related patient care, consistent with how they approach other chronic/shared care health concerns. A patient's care plan, with patient permission, can be shared with other services. This reduces the number of times the person experiencing DFV has to tell their story and supports patient-centred continuity of care across the various services.	Primary care staff have: • improved readiness to address DFV • an increased number of GP referrals to local specialised DFV services GP practice staff can provide continuity of care to patients experiencing DFV.
Primary care DFV referral pathways are refined and adapted as local services develop & change. They allow secure messaging and align with the *NSW Safer Pathway* approach.	Tools and procedures developed for GPs use secure messaging systems to transfer patient information between services and are aligned with current NSW DFV approaches and systems.	Structured tools and referral pathways assist GPs to develop effective care plans efficiently. Through the introduction of secure messaging software to DFV Service Providers, GP's will have a safe, electronic and integrated mechanism to refer patients (using the DFV Care Plan) into the DFV service sector. Through this software the DFV service provider will have the ability to 'close the feedback loop', that is in line with current privacy legislation for General Practice. Aligning these tools with the existing *NSW Safer Pathway* approach means GPs can leverage local and statewide responses more readily and improves collaboration across services. This is particularly important when the victim-survivor is at high risk of harm as the NSW Safer Pathway has a dedicated response for this.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GPs recognising DFV • an increased number of GP referrals to local specialised DFV services. Specialists DFV services have: • Improved understanding of the role of primary care in supporting victim-survivors • An increase number of victim-survivors attending their services as a result of GP referrals • Increased number of 'closed referrals'. Victim-survivors have: • Increased access to DFV services/supports. GP practice staff can provide continuity of care to patients experiencing DFV.
GP practices participating in the program have information and resources to support disclosure & assist patients to select the DFV services they want.	Information and other resources about DFV tailored for each site.	More victim-survivors will disclose if they feel welcome, safe and supported by GP practices and their staff.	Primary care staff: • have improved readiness to address DFV • an increased number of GP referrals to local specialised DFV services. Specialists DFV services have: • Improved understanding of the role of primary care in supporting victim-survivors • An increase number of victim-survivors attending their services as a result of GP referrals • Increased number of 'closed referrals'. Victim-survivors have: • Increased awareness of support services available and how to navigate them • Increased comfort to discuss partner abuse with GP • Increased access to DFV services/supports.
GP practice staff & resources support patients to feel culturally safe if they are Aboriginal or Torres Strait Islander, identify as LGBTQI and/or are a member of another cultural group.	Information and other resources about DFV tailored for each site that values and welcomes diversity.	More victim-survivors will disclose if they feel welcome, safe and supported by GP practices and their staff.	Primary care staff: • have improved readiness to address DFV • an increased number of GP referrals to local specialised DFV services.

Activities	Outputs	Mechanism of Change	Outcomes
			Specialists DFV services have: • Improved understanding of the role of primary care in supporting victim-survivors • An increase number of victim-survivors attending their services as a result of GP referrals • Increased number of 'closed referrals'. Victim-survivors have: • Increased awareness of support services available and how to navigate them • Increased comfort to discuss partner abuse with GP • Increased access to DFV services/supports.
Central Coast only – the DFVLL engages with and refers to the PHN commissioned Outreach Paediatric Speech Pathologist to improve outcomes for children who experience DFV.	Participating GP practices in the Central Coast refer children experiencing DFV to the Outreach Paediatric Speech Pathologist.	Experiencing or witnessing domestic abuse can have an impact on the development of children and young people's speech, language and communication skills. A 2021 Australian showed that children who experience DFV have poorer language skills than children who do not experience DFV. Poor child language skills are associated with adverse outcomes across the life span, including academic under-achievement and mental health problems. Early treatment may reduce the long-term health and social impacts.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GPs recognising DFV • an increased number of GP referrals to local specialised DFV services. Victim-survivors have: • increased access to DFV service/supports.
Barriers to interested GP practice staff engaging with the project and attending training are identified and addressed.	Staff from 10 GP practices in each site attend Safer Families GP Readiness training.	Identifying and eliminating barriers will facilitate access to the training.	Primary care staff: • have improved readiness to address DFV.
Local DFV service mapping is accurate and up to date.	List of DFV services that GP practices can refer patients to.	Accurate and up to date service mapping will mean GP referrals are appropriate.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GP referrals to local specialised DFV services. Specialists DFV services have: • An increase number of victim-survivors attending their services as a result of GP referrals Victim-survivors have: • increased access to DFV service/supports.
DFV *HealthPathways* are developed based on local DFV services.	A DFV *HealthPathway* for each site.	*HealthPathways* is web-based information portal to help primary care clinicians plan patient care through primary, community and secondary health care. *HealthPathways* offers clinicians locally agreed information to make the right decisions together with patients, at the point of care.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GPs recognising DFV • an increased number of GP referrals to local specialised DFV services. Specialists DFV services have:

Activities	Outputs	Mechanism of Change	Outcomes
			• An increase number of victim-survivors attending their services as a result of GP referrals Victim-survivors have: • increased access to DFV service/supports.
Connections between general practices, DFV specialist services and other support services locally and within the HNECC footprint are developed.	Staff from general practices, DFV specialist services and other support services. know about each service.	By developing connections and relationships, practitioners in the different services required by victim-survivors can jointly problem-solve, provide better coordinated support and continuity of care to victim-survivors.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GP referrals to local specialised DFV services. Specialists DFV services have: • Improved understanding of the role of primary care in supporting victim-survivors • An increase number of victim-survivors attending their services as a result of GP referrals • Increased number of 'closed referrals'. Victim-survivors have: • Increased access to DFV services/supports.
Connections are developed between the HNECC primary care response to DFV and local Violence, Abuse & Neglect (VAN) teams.	Aligned policies and procedures.	By developing connections and aligning policies and procedures, shared patients who are victim-survivors will receive continuity of care.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GP referrals to local specialised DFV services. Specialists DFV services have: • Improved understanding of the role of primary care in supporting victim-survivors. Victim-survivors have: • Increased access to DFV services/supports.
A partnership with a Central Coast Family Practice provides an outreach primary care practice nurse for women/children in refuges. The Nurse will provide vital health checks and referral into the broader health care system.	Outreach primary care practice nurse see patients in refuges.	This activity is highly welcomed by the DFV service sector, as attending GP appointments can pose a security risk whilst women are seeking refuge. As a result, many women choose not to seek medical services, as the risk of the perpetrator finding them is too high.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GP referrals to local specialised DFV services. Victim-survivors have: • Increased awareness of support services available and how to navigate them • Increased comfort to discuss partner abuse with GP • Increased access to DFV services/supports.
Specialist DFV services are supported to close the referral loop with primary care.	Tools and procedures that support DFV services to communicate with GP practices about	GPs regularly refer their patients to specialists for care and receive feedback on specialist treatments and outcomes that can be retained on patient files. If this practice is adopted by DFV specialist services, the GP can monitor specialist outcomes with their patient at other appointments.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GP referrals to local specialised DFV services.

Activities	Outputs	Mechanism of Change	Outcomes
	referred patients' outcomes.		Specialists DFV services have: • An increase number of victim-survivors attending their services as a result of GP referrals • Increased number of 'closed referrals'. GP practice staff can provide continuity of care to patients experiencing DFV.
The DFVLL attends local DFV interagency and coordination meetings	DFVLL is well informed about the local DFV sector.	The DFVLL needs to be integrated into the local DFV sector to maintain up to date knowledge and share problem-solving	Specialist DFV services have: • improved understanding of the role of primary care in supporting victim-survivors.
The DFVLL promotes the *Safer Families GP Readiness* training to DFV stakeholders and familiarises them with the content.	Communication.	Local DFV specialists are not familiar with Safer Families and the institute's GP readiness training. They need to be assured that the theories and practices advocated by the training algin with best practice in the DFV sector.	Specialist DFV services have: • improved understanding of the role of primary care in supporting victim-survivors.
The DFVLL and the PHN identify service system gaps and opportunities to address them.	List of service system gaps and opportunities.	DFV is a complex social and health issue, and the service system is not homogenous across the state. Some communities have unique DFV concerns. Identifying local service system gaps and opportunities provides some scope to do local problem-solving.	Victim-survivors have: • Increased access to DFV services/supports.
An Aboriginal-led community taskforce is established in Armidale to address the lack of First Nations men's behaviour change programs	A service model for a First Nations men's behaviour change program	Armidale does not have community-based Men's Behaviour Change Program. This was highlighted by GPs as a significant barrier in being able to provide the RRR model. Many First Nations women are reluctant to disclose DFV when there is no intervention available for Aboriginal men apart from the justice system. The pilot will commission the design of an innovative First Nations Men's Behaviour Change Program. The community taskforce will provide program governance and has the membership of the local magistrate, police, GPs and other relevant community services.	Primary care staff: • have improved readiness to address DFV • improved understanding of the role of specialist DFV services in supporting victim survivors • an increased number of GP referrals to local specialised DFV services. Victim-survivors have: • Increased awareness of support services available and how to navigate them • Increased comfort to discuss partner abuse with GP • Increased access to DFV services/supports.
The HNECC *Primary Care Pathways to Safety* program is integrated into state-wide planning.	Key state-wide stakeholders know about the program.	DFV is a complex social and health issue with a wide range of agencies and service provides engaged responding. In NSW a coordinated approach is being taken and the HNECC Primary Care Pathways to Safety program has a roll to play in improving outcomes for victim-survivors in NSW.	Specialist DFV services have: • improved understanding of the role of primary care in supporting victim-survivors. Victim-survivors have: • Increased access to DFV services/supports.
Plan, Do, Study, Act (PDSA) continuous improvement principles are built into all aspects of the model.	Implementation documents and meetings refer to PDSA.	By having a focus on continuous improvement throughout implementation, swifter progress can be made on delivering outcomes.	Services are evidence-based and continuously improve by learning from best practice.