# *Primary Care Pathways to Safety*: the Readiness Program for general practice

Evidence Profile

## Introduction

The Commonwealth Department of Health is funding Hunter New England Central Coast Primary Health Network (HNECC) to trial a new approach to assist primary health care providers to recognise and respond to people experiencing domestic and family violence (DFV).

The program is currently funded until June 2022.

The project is using a co-design process. This means that people involved in delivering or receiving the services will have a say in the design of the project. This includes people who have experienced DFV, GPs, practice nurses and AMS 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 project to work. We are 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.  This document is one step in the co-design process.

This project 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.

# Problem Description

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?

The Australian Institute of Health and Welfare calculated that if no female aged 15 and over had experienced partner violence in 2015 this would have been the outcome. These are important health outcomes for women.

But for many, if not most GPs, identifying patients who are experiencing violence can be very difficult. How can you deliver the treatment if you can't identify the condition?

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 of 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

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

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

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.

# Some definitions

## What is domestic and family violence?

The AIHW definition of family and domestic violence describes family violence as violence between family members, such as between parents and children, siblings, and intimate partners.

Domestic violence is a type of family violence and refers specifically to violence which occurs between current or former intimate partners (sometimes referred to as intimate partner violence). Both family violence and domestic violence include behaviours such as:

- physical violence (hitting, choking, use of weapons)
- emotional abuse, also known as psychological abuse (intimidating, humiliating)
- coercive control (controlling access to finances, monitoring movements, isolating from friends and family).

Sexual violence covers sexual behaviours carried out against a person's will. This can occur in the context of family or domestic violence, or be perpetrated by other people known to the victim or by strangers.

Other forms of violence and harassment that can occur within the context of family and domestic violence include: stalking, technology-facilitated abuse and image-based abuse.

Elder abuse can also occur in the context of family violence, and occurs where there is an expectation of trust and/or where there is a power imbalance between the party responsible and the older person[3].

[3] https://www.aihw.gov.au/reports/australias-health/health-impacts-family-domestic-and-sexual-violence
Snapshot - Health impacts of family, domestic and sexual violence, 2020, Australian Institute of Health and Welfare

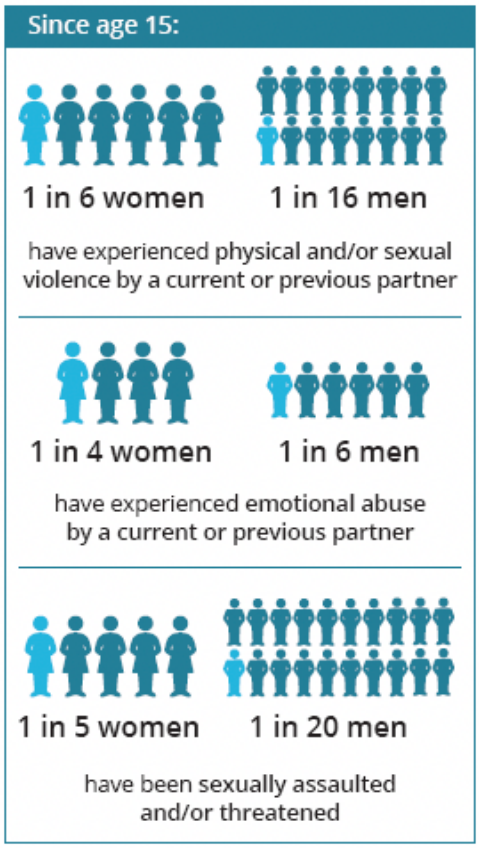
## Prevalence

Family, domestic and sexual violence is a major health and welfare issue. It occurs across all ages, and all socioeconomic and demographic groups, but predominantly affects women and children. Data from AIHW[4] shows:

One in 6 Australian women and 1 in 16 men have been subjected, since the age of 15, to physical and/or sexual violence by a current or previous cohabiting partner. Family, domestic and sexual violence happens repeatedly— more than half (54%) of the women who had experienced current partner violence, experienced more than one violent incident.

Almost 1 in 4 (23%) women and 1 in 6 (16%) men have experienced emotional abuse from a current or previous partner since the age of 15 .

Almost 1 in 5 women (18%) and 1 in 20 men (4.7%) have experienced sexual violence (sexual assault and/or threats) since the age of 15. Women were most likely to experience sexual violence from a previous cohabiting partner (4.5% of women) or a boyfriend/girlfriend or date (4.3% of women).




DFV is well recognised as a social justice concern. What is less recognised is its significant contribution to the nation's health burdens, in particular the poor mental health outcomes and substance use problems associated with experiencing DFV. In 2011, it contributed to more burden of disease (the impact of illness, disability and premature death) than any other risk factor for women aged 25–44. Mental health conditions were the largest contributor to the burden due to physical/sexual intimate partner violence, with anxiety disorders making up the greatest proportion (35%), followed by depressive disorders (32%).

Because of this evidence, the Australian Royal College of GPs is strongly supporting GPs to play a greater part in addressing DFV.

[4] https://www.aihw.gov.au/reports/australias-health/health-impacts-family-domestic-and-sexual-violence
Snapshot - Health impacts of family, domestic and sexual violence, 2020, Australian Institute of Health and Welfare

*GPs have a role to play in prevention, early identification, responding to disclosures of intimate partner abuse, and follow-up and support of patients and their children experiencing the health effects of violence and abuse*[5].

The RACGP manual for health practitioners, *Abuse and Violence: Working with our patients in general practice*, identifies depression as one of the strongest clinical predictors of intimate partner abuse[6].

*One in five currently depressed women attending Victorian general practices has experienced severe physical, emotional and sexual abuse by a partner or ex-partner in the past 12 months. Multiple physical symptoms are also a key indicator of abuse.*

Types of presentations are likely to include:

*… depression, anxiety, other psychological disorders, drug and alcohol abuse, sexual dysfunction, functional gastrointestinal disorders, headaches, chronic pain and multiple somatic symptoms … Sexual abuse has also been linked with chronic pelvic pain.*

Table 1: From RACGP Abuse and Violence: Working with our patients in general practice

| Potential presentations of intimate partner abuse | |
|---|---|
| Psychological | Physical |
| • Insomnia<br>• Depression<br>• Suicidal ideation<br>• Anxiety symptoms and panic disorder<br>• Somatiform disorder<br>• Post-traumatic stress disorder<br>• Eating disorders<br>• Drug and alcohol abuse | • Obvious injuries (especially to the head and neck)<br>• Bruises in various stages of healing<br>• Sexual assault<br>• Sexually transmitted infections<br>• Chronic pelvic pain<br>• Chronic abdominal pain<br>• Chronic headaches<br>• Chronic back pain<br>• Numbness and tingling from injuries<br>• Lethargy |

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

[6] Op cit

# Priority communities

Family, domestic and sexual violence occurs across all ages and demographics. However some groups are more vulnerable than others, because they are at greater risk or because the impacts and outcomes of violence can be more serious or long-lasting. It is important to recognise and respond to the experiences and needs of high risk or vulnerable communities including:

- Aboriginal and Torres Strait Islander communities
- People living in lower socio economic areas
- People living in remote areas
- People with disability
- Families from culturally and linguistically diverse communities
- People from LGBTQI+ communities
- Children and young people
- The elderly

In particular, for *Aboriginal and Torres Strait Islander peoples the trauma of colonisation and oppression is directly linked to the complexity and prevalence of family violence that exists today. The impact of colonisation on Aboriginal and Torres Strait Islander peoples' cultural practices, laws, customs and ways of life has been devastating, generating multiple layers of trauma spanning generations* [7].

While most Aboriginal and Torres Strait Islander families have strong and healthy relationships, Aboriginal and Torres Strait Islander peoples are significantly more likely to experience family violence than non-Indigenous people[8]. A recent report looking at improving family violence legal and support services for Aboriginal and Torres Strait Islander people noted:

- Estimates suggest that up to 90 percent of incidents of violence perpetrated against Aboriginal women go undisclosed (Department of Social Services, 2016; Willis, 2011).

- Aboriginal and Torres Strait Islander women living in regional and remote areas are understood to be at greater risk of experiencing family violence compared to women in metropolitan areas, and face additional challenges when dealing with their experiences of violence (Department of Social Services, 2016).

[7] Strong Families, Safe Kids: Family violence response and prevention for Aboriginal and Torres strait Islander children and families, Policy Paper, 2017, SNAICC, National Family Violence Prevention Legal Services and National Aboriginal & Torres Strait Islander Legal Services

[8] Op cit

The report also noted that the presence of Aboriginal controlled service providers is critically important. However, there can also be conflicts of interest that deter victims of violence from seeking help.

# Project description

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 - to be part of the multidisciplinary and collaborative response needed to address family and domestic violence.

Research has 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, to be piloted in Armidale, Tamworth and the Central Coast, 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.

The project has six components:

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

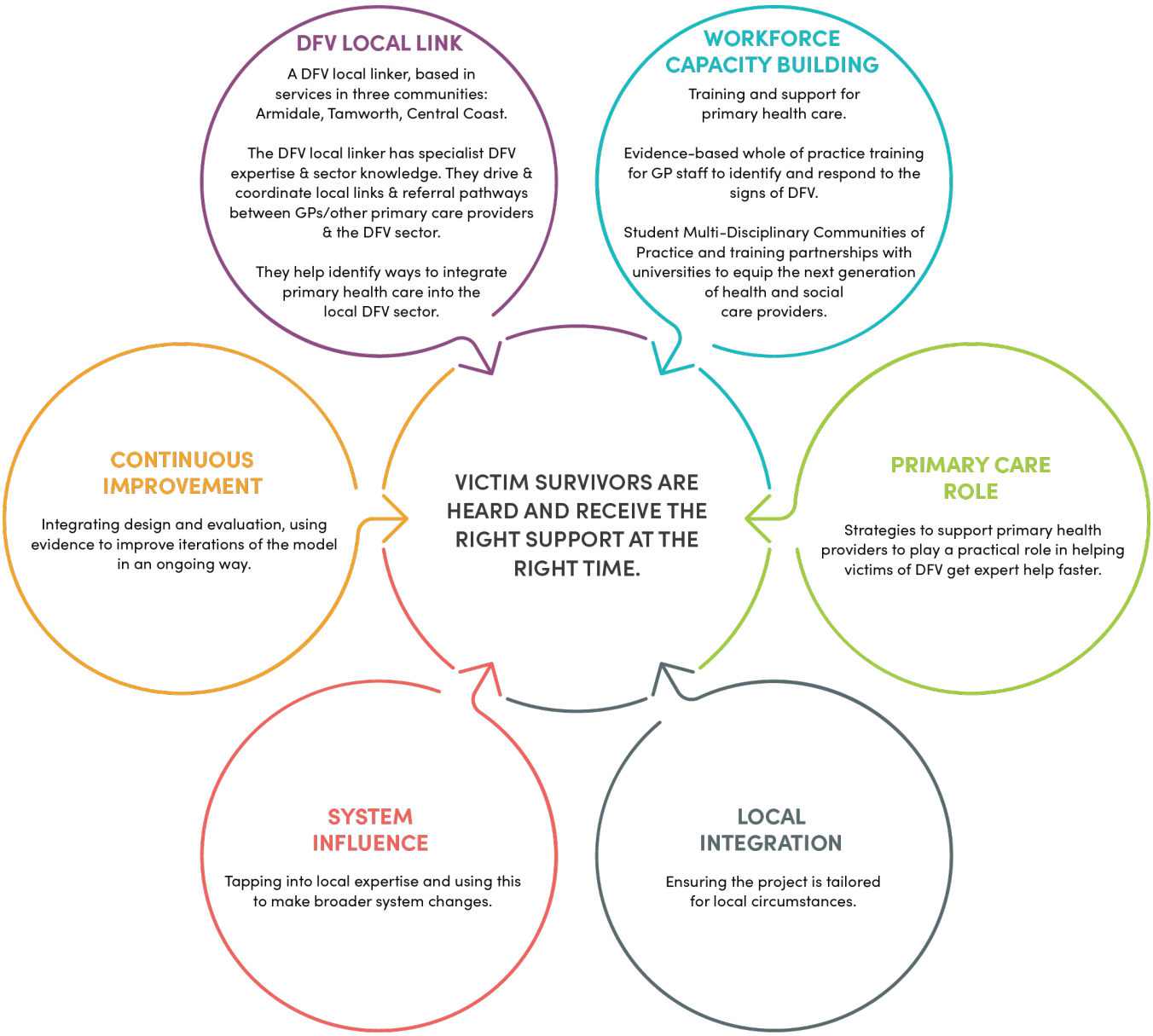
2. Workforce Capacity Building providing training and support for primary health care including:
    - Evidence-based whole of practice training for GP staff to identify and respond to the signs of DFV
    - *Student Multi-Disciplinary Communities of Practice* and training partnerships with universities to equip the next the next generation of health and social care providers.

3. Strategies to support primary health providers to play a practical role in helping victims of DFV get expert help faster.

4. Local integration, so that the project is tailored for local circumstances.

5. System influence, tapping into local expertise and using this to make broader system changes.

6. Continuous improvement by integrating design and evaluation, so that evidence is used to improve iterations of the model in an ongoing way rather than at the end.



# Why Tamworth, Armidale 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.

| LGA | Incidents of domestic assault (2019 rate per 100,000 population) | Rank in NSW LGAs (out of 120) | 2018 Estimated Resident Population |
|---|---|---|---|
| **Armidale hub and outreach** | | | |
| Armidale | 651 | 22 | 30,707 |
| Glenn Innes Severn | 605 | 27 | 8,908 |
| Inverell | 940 | 10 | 16,844 |
| Tenterfield | 781 | 12 | 6,206 |
| Uralla | 262 | 90 | 6,062 |
| Walcha | 414 | 60 | 3,132 |
| **Tamworth hub and outreach** | | | |
| Gunnedah | 541 | 37 | 12,661 |
| Gwydir | 452 | 53 | 5,349 |
| Liverpool Plains | 521 | 42 | 7,893 |
| Moree Plains | 1,301 | 3 | 13,350 |
| Narrabri | 678 | 19 | 13,231 |
| Tamworth | 671 | 20 | 62,156 |
| **Central Coast** | 474 | 50 | 342,047 |

# Evidence

GPs have a critical role to play with victim survivors and perpetrators, as they are often an initial and consistent point of contact for both victim survivors and perpetrators. In contrast to others in the ecosystem, they are more likely to receive disclosures and have opportunities to intervene.[9]

Evidence suggests that in order to support universal services such as general practice to play a role in family violence interventions - the guidelines, training and processes that underpin the response must be consistent, standardised and of high quality. Evidence also suggests that healthcare professionals do not currently intervene effectively in family violence due to barriers such as time constraints, frustrations with perceived 'non-compliant' patients, a lack of awareness of the conditions required to support people to disclose, ineffective or harmful (unintended) responses and a general lack of knowledge surrounding the complexities of DFV.[10]

The safety and wellbeing of adult and child survivors of domestic and family violence (DFV) is the first priority of any response. Risk must be identified, comprehensively assessed and appropriately responded to by holding the perpetrator responsible and accountable for their behaviour and actions.[11]

Responses to violence must recognise that people have different experiences and needs due to their gender, race, class, age, cultural background, sexuality, and/or disability and other individual factors. Victims should be supported no matter how they choose to respond to the violence including if they decide to leave a relationship or stay, if they want to pursue legal charges or not).[12]

A trauma-informed practice commits to and acts upon the core principles of safety, trustworthiness, choice, collaboration and empowerment. It values and respects all individuals, along with their choices, autonomy, culture and values, while building hope and optimism for a better future.[13]

It is necessary for GPs to identify and confront their own belief systems and values to understand how these impact upon their clinical decision making. Just as GPs develop clinical skills, they must

[9] Domestic and Family Violence Death Review and Advisory Board 2017-18 (2018), Brisbane QLD: Domestic and Family Violence Death Review and Advisory Board.

[10] Cameron, P. (2016) Expanding early interventions in family violence in Victoria. Melbourne: Domestic Violence Victoria.

[11] Toivonen, C., & Backhouse, C. (2018). National Risk Assessment Principles for domestic and family violence: Quick reference guide for practitioners. Retrieved from https:// d2rn9gno7zhxqg.cloudfront.net/wp-content/uploads/2018/07/19030414/ ANROWS_NRAP_Quick-Reference-Guide.1.pdf

[12] Domestic Violence Resource Centre Victoria (2013). Our Principles of Practice. Retrieved from https://www.dvrcv.org.au/about/welcome-dvrcv/our-principles-practice#intervention)

[13] Trauma-informed Practice: How important is this for domestic and family violence services? (2016). Trauma-Informed Practice in Domestic and Family Violence Services. Retrieved from https:// www.blueknot.org.au/Home/Front-Page-News/ID/46/Trauma-informed-Practice-in-Domestic- and-Family-Violence-Services

also develop their cultural competence and sensitivity. GPs must examine their own attitudes about abuse and violence in their own and other cultures.[14]

## University of Melbourne *Safer Families* evidenced-based training for GPs and general practice staff

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

The training program aims to support and build upon GPs', nurses' and other practice staff:

- 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

At the end of the training all primary care 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

All primary care clinical staff should be able to:

- 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

[14] Abuse and violence: Working with our patients in general practice (2014), 4th ed. Melbourne: The Royal Australian College of General Practitioners.

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[15] (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[16] (Identification and Referral for Safety) found that the intervention increased identification and referral of women experiencing domestic violence setting them on a pathway to safety and well-being.

[15] 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.

[16] 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

# Lived experience of domestic and family violence

We know that there is no one standard journey for a person experiencing domestic and family violence. Each person's experience of violence or other forms of abuse in their domestic setting is different. The domestic and family violence literature and recent stakeholder interviews identify some key themes that this project can potentially address and work with.

### Readiness to discuss or act

*Not all DFV is physical, a lot of abuse is in the form of coercive control, limiting the person's access to friends, social activities or finances or, or verbal/psychological abuse.*

*We need to understand that many people may not immediately characterise their partner's behaviour as abuse. It may take time for them to recognise it as such – particularly if the abuse is coercive and controlling but not physical.*

*Realising that you are in an abusive relationship can take time. For me everything seemed normal for a long time.*

*I have had patients who took two years or more before they were ready to begin discussing what was really happening.*

*I didn't think I could tell my story because he seems to be such a nice guy – I thought at the time, 'no one will believe me it sounds surreal'.*

### Hear my story

*If you ask and there is not a story told, do not assume that there is not a story to tell.*

*All you have to do is listen. Everyone has a story and you need to know about a person's life.*

*Be empathetic. Tell me that you believe me. Acknowledge how hard it must be to say that and give me a soft place to land rather than another hurdle.*

### Shame and fear

*I can't tell you how many times patients have said to me …. 'I shouldn't need my doctor's help with this; I should be able to deal with it myself'*

*What will happen if he knows that I've been to doctor? He knows that I'm not ill.*

*I should be strong enough to deal with this. All I want is a happy family - why can't I make that happen?*

*I need to get my house calm so he won't erupt but I can't control my kids.*

## Trauma and mental health

*Living with domestic and family violence is traumatising. It can lead to a range of health problems including substance misuse, addiction and mental illnesses.*

*Domestic violence and mental health issues go hand in hand.*

*After a routine hospital procedure I kept having panic attacks when they tried to discharge me. No-one linked it to domestic violence.*

*Often it is the kid's behaviour or regression in development that is the first sign that there is violence in the home.*

# The GP experience

GPs will see many patients in a day and need to be adept at diagnosing and treating a wide range of health and mental health concerns. They rely on streamlined referral pathways to medical specialists for complex health conditions, and with mental health practitioners for psychological concerns. Our stakeholder interviews identified key themes to be considered to support GPs to effectively recognise, respond and refer.

### GPs service delivery conditions

*Many GPs view their practice as both a public health and community service. Many are long term community members who are deeply embedded in their communities. This provides both opportunities and challenges for GPs who want to provide an effective response for their patients who are living with violence.*

*The public funding model for GPs compels practices to operate as small businesses. This places limitations on how services are delivered including time limitations on consultations. Not every community will have sufficient GPs and the cost of services can be a barrier to people accessing a GP.*

*GPs operate in a range of practice models: single provider; larger practices with multiple GPs; nurses and allied health staff; and corporatised models that may offer extended hours and a range of additional onsite services such as pathology and radiology.*

*Most GPs are so under the pump, if we ask them to take on a complex issue like this they will say 'I'm already snowed under'.*

### GPs like to help and solve problems

*Many GPs, myself included, see themselves as problem solvers. They diagnose the health problem and then provide a prescription or a referral to commence treatment for their patient. They are not used to dealing with problems that don't have a clear prescription or referral pathway.*

*If a GP has the experience of trying to make a referral for DFV and failing – it discourages them from trying again.*

*We don't want GPs in the situation where they ask a question and then don't know what to do. If there is a clear referral process it will make a difference. We can say "we're not asking you to manage this – you can refer".*

*GPs are used to receiving feedback from specialist and other health services about the treatment that their patient has received. It will be important to provide a feedback loop to GPs when they refer to DFV services.*

### GPs are only part of the solution

*Domestic and family violence is a social epidemic with health consequences.*

*You can't solve this problem with a pill but there are important things that GPs can do.*

*GPs are an important cog in a much larger wheel. They have a role to play but they are not on their own.*

*The buck doesn't have to stop with the GP. They are just the conduit.*

### Building GP skills

*We can build GP confidence if we give them a script to start the conversation, and a set of steps to guide referral.*

*If they know that they can refer to single referral point, that assures the GP that they don't have to solve all the problems. They can provide a sound referral and concentrate on what they do best, delivering general medicine.*

*Need to say to GPs – this is simple, this is all you have to do. A lot of GPs have an inkling that something is going on with their patients but don't know what to do.*

*If we offer GPs a solution – the skill to be comfortable to ask and then refer – it makes things easier for them.*

# Emerging design themes

Over the next few weeks we will be progressively developing a design for the *Recognise, Respond and Refer: Making domestic family violence visible in general practice* program. Even after an initial design is finalised for implementation, we will continue to reflect on the model and refine it. We will be drawing on observations and lessons that we learn as we implement the model.

The following are some of the emerging themes and questions that we will explore as we develop the initial model for implementation.

### Ensuring that the model improves the experience of patients/consumers

We know that each person's experience of violence or other forms of abuse in their domestic setting is different. Each person will be at different stages of understanding and readiness to act according to their lived experience and current circumstances. The pilot program should support GPs and GP practices to empower patients. It should enable practice that meets patients where they are on their journey. It should be trauma-informed and facilitate responses that do not retraumatise patients who have experienced domestic and family violence.

- How should we incorporate trauma Informed care approaches in the pilot?
- How do we equip practices to recognise the range of experiences of people who experience domestic and family violence?
- How can the program respond to the spectrum of aspirations, goals and readiness to act?

### Developing a model that is adaptable and appealing to different general practice contexts

How can we develop a consistent model that is sufficiently flexible to account for different General Practice contexts:

- Urban, rural and remote
- Single providers
- Large multi-team practices
- Corporate practices

There are multiple demands on General Practices to engage with other service system providers.

- How can we promote this initiative to get the attention of GPs and the practices they work in?
- How do we get through the front door and engage GPs, practice managers and practice nurses?
- How do we describe and package the initiative so it is simple and easy for GPs and their practices to adopt?

- How do we deliver the service so that we 'close the loop' and give GPs feedback about the outcome of a referral?

### Developing a model and implementation plan that maximises system improvement.

Guaranteed funding for this pilot program is short term - ending in June 2022. Many services that support people experiencing domestic and family violence report that they are at or beyond capacity. These facts raise significant questions in relation to the design and implementation strategy of the pilot program.

- How should we establish the activities of the pilot to optimise sustainable improvements in our service systems?
- How should the pilot program respond if people are referred to services that cannot provide the required service?
- Are there particular general practices, program elements or communities that should be prioritised by the program?

### Working with Aboriginal communities

There is evidence that domestic and family violence is underreported in some Aboriginal communities.

- How could the project support greater disclosure and engagement with services in Aboriginal communities?
- What could the *Recognise Respond and Refer* project do to ensure that it delivers culturally competent and safe services?
- How could the project partner and co-deliver services with local Aboriginal health services?

### Access to GP Services

Many communities are unable to attract or retain sufficient General Practitioners for the local population. This can lead to some practices closing their books and being unable to take on further new patients.

Sometimes the solution to GP numbers is to engage higher numbers of locum GPs and/or to create registrar rotations for doctors seeking to become GPs. While this can lead to increased GP services for a community, the GP population can experience high levels of turnover. Short term GPs will not be familiar with local communities and available assets and services. More critically, high turnover of GPs inhibits the establishment of trusting therapeutic relationships.

Many GP practices do not bulk bill. Co-payments can be a barrier to access to services.

Recognising and responding to the experiences and needs of high risk or vulnerable communities

Domestic and family violence can lead to homelessness, social isolation and disadvantage in range of economic and social settings. In those circumstances, the requirement to make a co-payment can be a barrier to accessing services such as GPs or other human or health services.

- How can the program be designed to deliver equity of access – particularly for the most vulnerable and needy?
- How can the program be designed and delivered to recognise and respond to the experiences and needs of high risk or vulnerable communities?
- How could the program be designed and delivered in those communities where there is limited access to GP services?

## Next steps

This evidence profile will be used to support co-design activities held in Tamworth in March 2021 and the Central Coast in April/May 2021. Participants include General Practitioners, family support services, women's services, PHN staff, LHD staff and community health providers.

Following these activities we will continue to consult with our partners and stakeholders. We will explore the emerging design ideas and start solving any critical issues we identify. We will host more co-design activities to further refine the design for the *Primary Care Pathways to Safety* pilot program with our partners.