"Patient centred,
doctor centred,
but also practice centred"

General Practitioner

FINAL REPORT OCTOBER 2022

Primary Care Pathways to Safety

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Safer Families

Primary Care Pathways to Safety

Final Report: October 2022

Acknowledgements

We acknowledge the Traditional Custodians of the lands on which the work was undertaken.
We pay our respects to Elders and community members past, present, and emerging.

We acknowledge the North Western Melbourne PHN (NWMPHN) staff for leading this complex work, and the hardworking family violence specialist workers and general practitioners who facilitated the Program. In particular we thank the primary care staff from the 26 practices who participated in the Program.

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EXECUTIVE SUMMARY

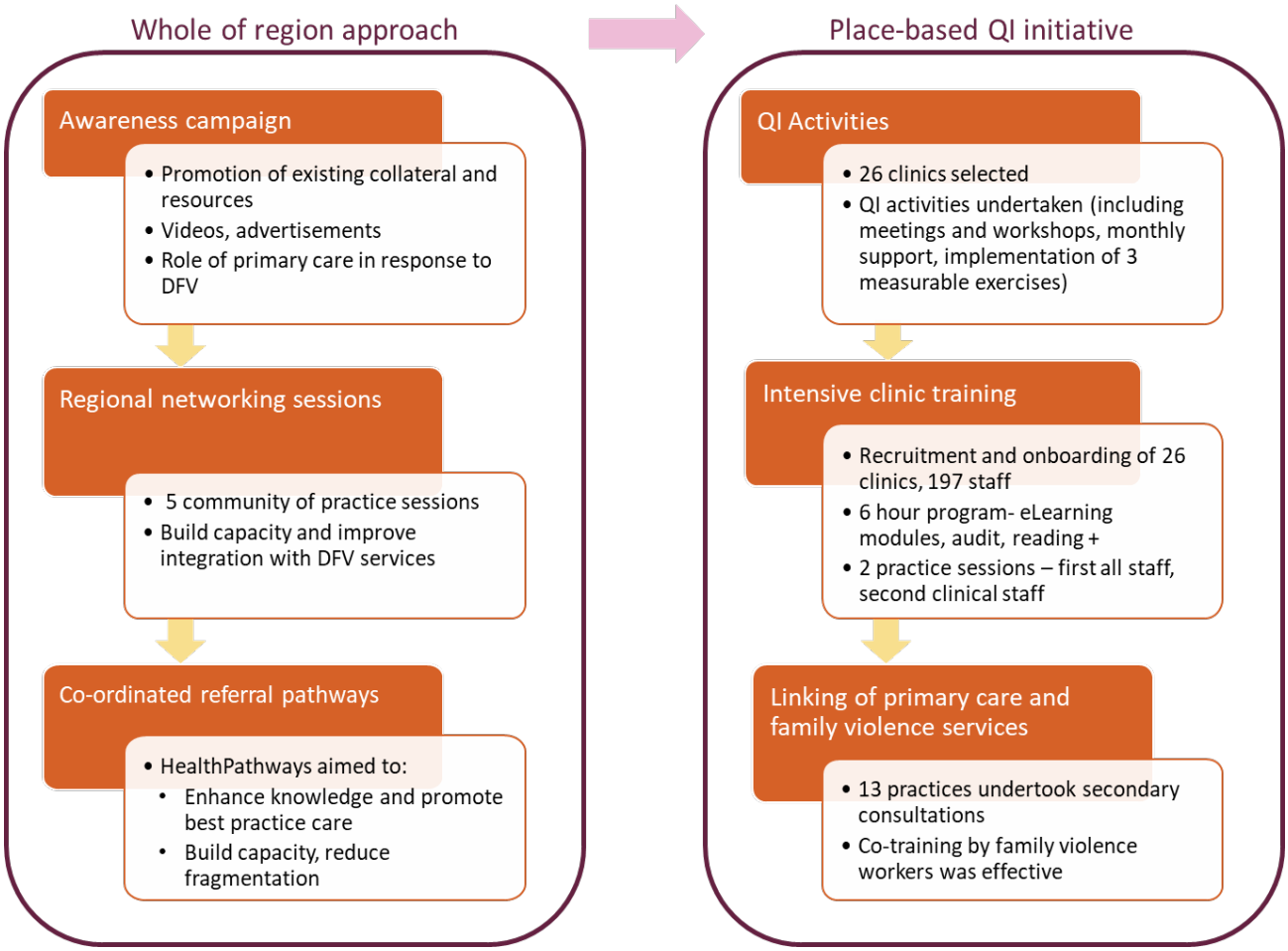
This final report is for the evaluation of the Primary Care Pathway to Safety Family Violence program (the Program). The Program enabled primary care practitioners in a regional area to deliver evidence-based care and support for domestic and family violence (DFV). The Program built on a previous North Western Melbourne Primary Health Network (NWMPHN) and University of Melbourne (UOM) pilot with 12 practices which focused on clinician skills to address DFV. This Program (September 2020 to June 2022) expanded to a whole of region and whole of practice approach to improve the quality of care provided to victim/survivors and children exposed to DFV. It included tailored training to primary care staff, an intensive quality improvement component, and family violence specialist support for referral information and secondary consultations. The Program (see figure below) involved:

A whole of region approach including:

- Communication and awareness campaign
- Regional interdisciplinary education and networking sessions (Communities of Practice)
- Development and promotion of co-ordinated referral pathways – Melbourne HealthPathways

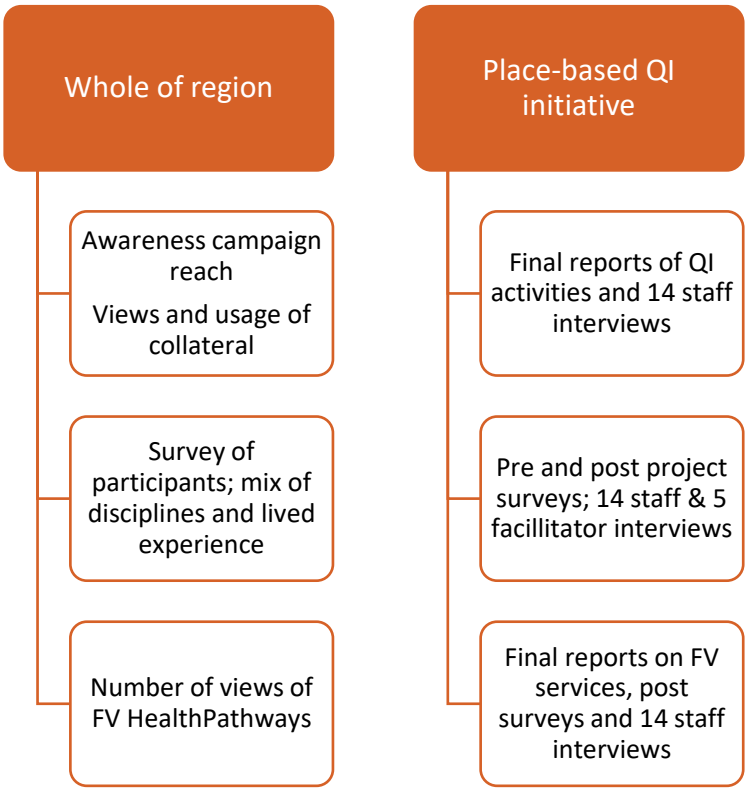
And a place-based intensive Quality Improvement (QI) Component including:

- Implementation of QI activities to build internal capacity to respond to FV within a practice
- Intensive whole of practice training, delivered by general practitioner (GP) and FV support worker
- Linking of primary care and family violence services through secondary consults



Evaluation Methods

The evaluation used a mixed methods approach, including surveys, final reports, and interviews.



As part of the Whole of Region approach, the following was achieved:

Communication and awareness campaign

- 'Starting the Conversation about Family Violence' video reached 5,826 views
- Social media reach for Family Violence content achieved 17,557.
- E-newsletter reach = 6,617 subscribers.
- Creation of a dedicated webpage with resources for clinicians, including information about the Family Violence Information Sharing Scheme and Child information Sharing Scheme, interviews with GPs, nurses and practice managers on quality improvement and building internal capacity within practice in the area of family violence
- Promotion of education events and webinars by NWMPHN and other services

Education and Networking sessions

- Five multidisciplinary family violence communities of practice were established and five sessions were run in the North, Centre and West of Melbourne with 86 attendants, connecting with a mix of professions from primary care, hospitals, mental health services, AOD, Aboriginal health, crisis services, community health, legal services, LGBTQIA+ services, specialised family violence services and lived experience speakers;
- 61% reported that they intend to make a change to their practice as a result of attending the session

Coordinated referral pathways

- 16 Family Violence related HealthPathways were developed, updated and promoted.
- Family Violence HealthPathways page views increased on average by 38% per quarter.

As part of the Place based Quality Improvement initiative, the following was achieved:

- Program successfully recruited 26 general practices with a spread across the North (12) and West (14) of Melbourne.
- Intensive whole of practice training was delivered including two interactive training sessions delivered by GP facilitator and a FV support worker, a clinical audit tool, practice readiness checklist, online e-learning modules, resources including HealthPathways. A total of 197 staff (81% female) participated; 41% GPs, 28% nurses alongside 23% administrative staff and 10% allied health.
- Practices implemented at least three improvements each with the aim to increase their internal capacity to respond to FV. As a result, 531 patients were asked about FV on average per month with 52 disclosures within 3 months after training (reported by 20 practices).
- Primary care and FV services were linked through training and secondary consultations were undertaken, although limited by lack of FV workers to visit practices due to COVID pandemic: 13 practices (50%) contacted FV workers for secondary consultations and additional support.

Outcomes from the evaluation of the place-based initiative included:

Training delivery (n=61/197 post primary care clinical and non-clinical staff)

Vast majority of participants rated as 'Good' to 'Excellent': overall quality of the training and learning gained (98.4%); learning gained in Session 1 (96.7%) and in Session 2 (100.0%); appropriateness and length of training program, and amount of material covered (96.7%); and opportunity to ask questions and interact (100%).

All learning needs of the participants overall were rated as 'Completely met' (82%) or 'Partially met' (18%). Further 85.2% rated the training as 'Entirely' or 14.8% 'Partially relevant' to the needs of their practice.

Survey of clinical staff participants (n=121/151 pre and 84/151 post)

- 54.5% of participants had less than two hours prior family violence training
- Mean age was 43 years and had worked an average of 11 years in general practice

Change in knowledge, skills, and attitudes:

- Vast majority (76.3%) of participants after the training were 'Comfortable or Very comfortable' about asking about family violence than before (61.2%); 5% were very uncomfortable after training
- Post training more participants asked about family violence across a range of clinical presentations
- On the GP Readiness Scale, Self-efficacy domain improved after training, Motivational and Emotional readiness domains improved only slightly

Referral and secondary consultations

- Confidence (Very/Extremely) to use HealthPathways rose from 11.2% before training to 48.1% after training. Those 'Not at all/No so confident' fell from 45.7% before training to 5.1% after training
- Confidence in deciding when to refer patients was enhanced after training (increased from 45.5% to 86.4% after training)

Qualitative- interviews (n=14 staff – 7 GPs, 3 nurses, 4 practice managers, and 5 facilitators)

Staff participants' views

The four main themes derived from the interviews around staff participants views on the training were: benefits of the innovative approach to meeting a knowledge and skill gap; valuable doing it as a team with

the whole of practice approach; confidence building to start the conversations; and training components and design were engaging. Specific to this group:

- Structured planning and goal setting embedded in the QI process allowed sustainable positive changes, although staff generally found it quite time-consuming. The QI process led to modifications in individual participants' practices and systemic changes.
- Program was seen as comprehensive, relevant, informative, and practical. Some of the content of the training led to new ways of thinking for several participants. Potentially inaccurate notions held about victim/survivors regarding why women stayed in abusive relationships, likely symptom-related presentations of DFV to clinics and assumptions about types of women affected were changed.
- Structure of the training program was engaging, including pre-activities, handbook, role plays. Suggestions made for improvements included restructure of handbook to condense material and inclusion of more case studies.
- Additional suggestions included enhancing role of clinical champions and extending the support and follow up period with FV support worker post training.

Facilitators' views

The five themes derived from the facilitators' interviews were: professionally rewarding; intersectoral approach created connections; valuable to clinicians and the whole practice; program implementation, and additional training needs. Specific to this group:

- Facilitators viewed it as an opportunity to advance their own learning in the DFV area, professionally develop and give back to practitioners and staff in primary care services.
- Some facilitators also wanted feedback to guide improvement in their work.

Staff and facilitators' views

- The value of the whole of practice team approach received very strong endorsement across participants.

> *'I think the other facet of it that I think is really, really good, is that it's multidisciplinary. So, it wasn't just clinicians, that we were – particularly in the first session because we were able to engage our clerical staff in that as well. Because like I said, we like to think we're a team. We all function inter-dependently of each other, not separately. So that was really good to do that together with everyone including clerical staff.' P3, GP*

- Engagement of both a GP and a FV support worker as co-facilitators, combining expert knowledge and the option to consult with or follow up with FV specialist services were valuable. The initial connections created between GPs/clinics and FV support workers/specialist services were likely to foster long-term professional relationships.

> *'Also being very clear that there was help down the end of the phoneline, that ringing up the [name of FV specialist service], those marvellous women can - are a real asset, and I wasn't very strongly across which organization I'd ring, so that was ...I think that's the thing.' P1, GP*

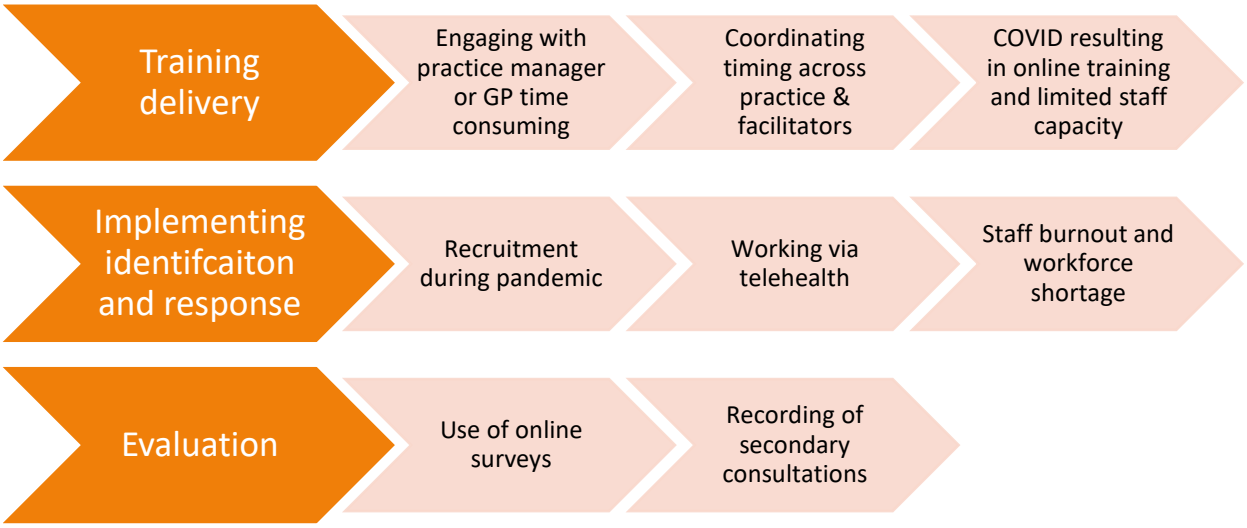
- Preferred a face-to-face mode of delivery for the training rather than an online mode to engage participants more fully.
- Additional topics suggested included – dealing with perpetrators, child abuse and elder abuse cases, people in the LGBTIQ community, and people from diverse cultural backgrounds.

From the final reports of the QI activities the following patient data was gleaned:

- 13 practices used secondary consult support with 2 cases escalated by services and police were called (unexpected)
- 531 people were asked about FV per month and 52 disclosures were made within 3 months after training

The survey results showed that the proportion of participants who were 'Very confident' to 'Extremely confident' rose on each QI item. The highest result was achieved in "My understanding of QI in General Practice" where confidence doubled from 24.8% to 51.2%.

Challenges in delivering the Program were at several levels and included:



Enablers included:

Whole of practice approach

The whole of practice meetings was a great chance for participants to get onboard and kept the issues at front of mind to implement during consultations. Each staff member had a unique perspective, which helped in creating a well-rounded approach and ensuring the team was on board to work towards a goal.

> *In one practice, the reception helped with marking out appointment types e.g. mental health reviews. Practice managers assisted with making the prepopulated notes. Nursing team assisted with promotional material and keeping a tally of the appointment types. The doctor was then able to use the skills taught in practice with the patient.*

Training delivery was effective

This included feedback that the training had good facilitation of workshop, beneficial role playing concerning how to approach patients, actual case studies, opportunities for getting feedback from the FV worker and lived experience feedback, discussion among practitioners, communication and sharing stories and effective educators and support from PHN and FV support workers.

Clinic Leads

> *identified key passionate stakeholders who drove the implementation, i.e., a nurse, a refugee health nurse, receptionist etc*

Team building

> *We have been able to come together as a team to listen to the workshops to help us learn how to identify and support victims and perpetrators to get the help they need. P7, Practice manager*

Feedback from patients and resources

Several clinics described more patients disclosed than they anticipated and that they had positive feedback from patients when they asked about domestic and family violence. Resources in waiting areas, treatment rooms and GP desks helped spark conversations which led to disclosures.

> One patient advised (after seeing posters): 'I am fortunate that I am safe, but if I wasn't, I'm happy to know I can come here and seek help'

Conclusion

Primary care settings have been identified by the World Health Organization as suitable for early intervention for domestic and family violence. Although a large proportion of women experiencing abuse seek help at some point from general practice, they do not always receive appropriate responses. The Primary Care Pathway to Safety Program was designed to provide direct tailored support to primary care providers, build internal capacity within practices to respond to FV presentations, improve collaboration and build greater cohesion and coordination across the range of local health and family violence services. A whole of region communication campaign raised awareness about the role of general practice in the response to family violence and promoted relevant resources. The place-based initiative comprised QI activities that led to increased patient identification via effective and sustainable changes in the area of family violence response. Intensive in-practice education increased knowledge and confidence, promoted the whole-of-team approach and linked primary care with family violence services.

The evaluation used mixed methods including online data from awareness campaign, surveys before and after networking sessions and training, final reports from clinics and interviews with staff and facilitators. Like the Program as a whole, the Evaluation was strengthened by the willingness and diversity of practices who participated, and support from the NWMPHN. However, there were limitations, including the response rate to the surveys which may have affected results as staff who were particularly engaged with the program might have been more likely to respond. Furthermore, the surveys for clinical staff were conducted three months after training was completed, and while this provided them with the opportunity to reflect on how

the training had affected their practice, it may have affected their recall of the training sessions. In addition, the number of interviews that could be conducted in the timeframe were limited which in turn potentially limited breadth the data collected.

The integrated approach adopted by combining a successful awareness campaign, multidisciplinary communities of practice, and development of coordinated referral pathways were important to ensure that a basic structure was in place to help embed the knowledge and skills acquired from the QI initiative and the education program. The intensive training employed engagement of GPs and FV specialist workers as facilitators. This enabled the Program to harness the expertise of GPs, on one hand, with knowledge of the practicalities of attending to DFV patients in a primary care setting, as well as FV specialist workers with broader experiences and knowledge in the dynamics of FV and available resources.

The whole of practice approach of training all staff in practices was key in generating interest among staff. These directly fed into follow on QI initiatives that health practitioners adopted to ensure sustainability of trauma-informed practices in identifying and responding to DFV. The appreciation of each primary health worker's role and potential team contribution to efforts was a significant motivator for clinical and non-clinical staff alike. However, the interlinking of FV specialist workers and GPs for secondary consultations was limited by the Covid-19 pandemic and associated restrictions.

The Program's success was largely attributable to its unique approach, strong co-ordination from the NWMPHN along with the Pathways to Safety Education Officer, and a recognition of the multifaceted and collaborative efforts required to tackle the complex issue of DFV.

'As I reflect on this program, I think it's probably one of the most comprehensive and well-presented programs that I've ever attended, … because it's extremely well organised. The integration of the theory with practice, the inclusion of a clinical audit, the checklist for the practice and the actual workshops, … it's a beautifully integrated program, and I think is quite unique.' P11, GP

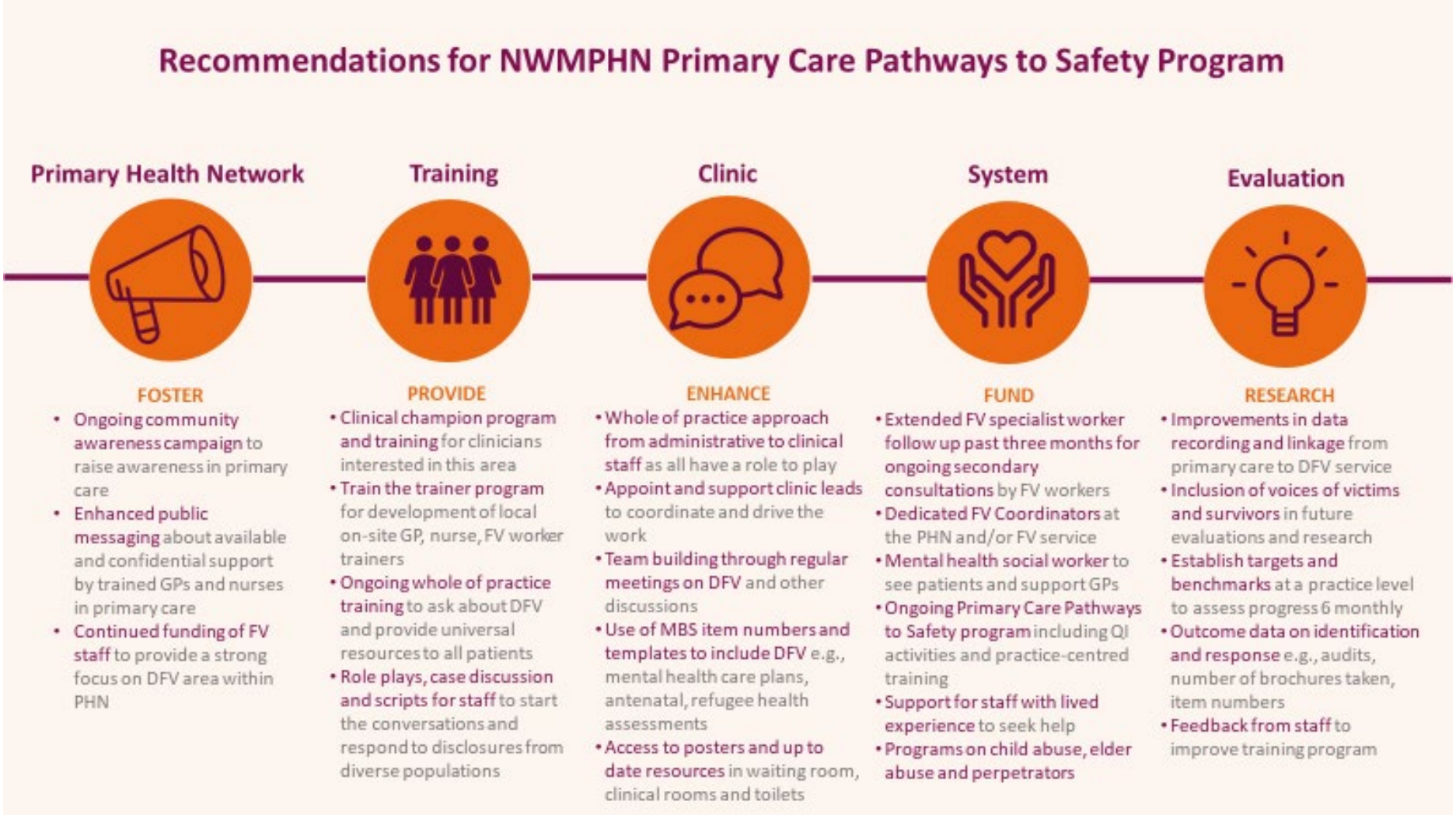
'I was excited to have access to so many experts, resources and information that the program offered. It is brilliant to be able to contact [name of FV support worker] and her team at [name of FV service]. It really feels like a wonderful clinical/professional connection has been made and that our clinic will make the most of her support.' P5, GP

'A beautiful program. We were able to get a lot of support, resources and a lot of advice as well. Even doing this program went hand in hand to be able to make changes, implement changes, start the process, documentation, information, education. just to get the ball rolling. It just went hand-in-hand.' P9, Nurse/Practice Manager

'I had more tools in my backpack in terms of things like being able to say, you know it's never okay for someone to feel threatened or harmed by their partner. Having those kind of – feeling the confidence that that was the right thing to say, like you always feel like oh, I don't want to say the wrong thing, so then we don't say anything.' P4, GP

Recommendations

Recommendations were made after a synthesis of all the data at the PHN, Training, Clinic and System levels and for future evaluations.



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INTRODUCTION AND BACKGROUND

Family violence damages the social and economic fabric of communities, as well as the mental and physical health of individual women, men, adolescents, and children [1, 2]. Women are more likely to be victims of intimate partner violence than men and are more likely to be injured or killed. Intimate partner violence results in an estimated annual cost of $13.6 billion in Australia [5] or roughly 1.1 per cent of GDP. Aboriginal women and children in Australia are victim to the highest rates of violence [6]. Women who live with a disability, women who live in remote areas, and women from culturally and linguistically diverse backgrounds are also likely to experience higher rates of violence than other women or have major access issues to services [7].

Health services have lagged other agencies in responding appropriately to this issue, although the World Health Organization highlights primary care as suitable settings for early intervention in family violence. Primary care health professionals are often the only clinicians seeing both women experiencing abuse and the perpetrator. Abused women use health services more frequently because of increased rates of emotional health issues [9] [10] and physical health issues [11]. For example, estimates are that up to five abused women per week per doctor attend unsuspecting general practitioners (GPs) [12]. At least 80 per cent of women experiencing abuse seek help at some point from health services, usually general practice.

Further, primary care workers have an important role in early intervention as women suffering the effects of family violence typically make 7-8 visits to health professionals before disclosure [14]. Importantly, women want to be asked directly about abuse by supportive health professionals [13]. However, if women do disclose family violence to their health professional, there is evidence of some inappropriate, poor-quality responses [15]. As GPs are family doctors, they also see the male perpetrator in the family and the children, although very little training is available to manage the perpetrator's role in the family. The World Health Organization (WHO) and Council of Australian Governments have prioritised preventing and reducing the extensive damage from family violence especially on children and identified the crucial role of an effective primary care system [3, 4].

System Model to address family violence response in primary care

North Western Melbourne Primary Health Network (NWMPHN) has partnered with the Safer Families Centre at the University of Melbourne to expand on the model previously tested on 12 practices (see Figure 1) for capacity and capability building to address the lack of awareness, knowledge, skill and confidence in primary care to identify, respond and refer people experiencing, domestic and family violence. Evidence of best practice informing this Model includes systematic reviews of health care interventions [16] and of qualitative studies [17], international primary care guidelines and evaluation of primary care-based family violence studies [18, 19] [20-28].

The Model is chiefly built on two primary care trials – WEAVE in Australia and IRIS in the United Kingdom (see Appendix 1). The Program components within the Model have been tested through two world first randomised controlled trials in general practice. The WEAVE study (Women's Evaluation of Abuse and Violence Care in General Practice) led by the University of Melbourne sought to build a better picture of how GPs and other practice staff can provide care for women who live with fear of a partner or ex-partner. The study found that trained GPs enquired more about safety of the women and their children, and that depression outcomes were better for women invited to attend the counselling. IRIS trial (Identification and Referral to Improve Safety) in the UK tested the effect of integrating a domestic violence advocate into primary care through training and referrals to that advocate. The study found training primary care practitioners and integrating specialist advocates into primary care increased identification of women experiencing domestic violence and referrals to the family violence specialist service.

PATHWAYS TO SAFETY PROGRAM MODEL

The Safer Families Centre developed a 'Sustainable Primary Care Violence Model' (Figure 1) that overcomes the key challenges impacting the capacity within primary care to address domestic and family violence.

The key elements of the Program Model are:

Figure 1: Sustainable Primary Care Family Violence Model

Hegarty, 2018

- **Clear leadership and governance arrangements**
- **Linked primary care and family violence providers** by practice support from a clinical lead and a family violence worker undertaking secondary consultations.
- **Coordinated referrals** by engaging a network of primary care and specialised organisations (family violence, sexual assault, child protection) in a geographical catchment to deliver a joined-up response. Clear referral protocols and pathways coordinated by the family violence worker will ensure all members of the family are guided to seek help.
- **Improved workforce capability** through whole-of-practice based support, resourcing, and primary care training (by the clinical lead and family violence worker) to improve knowledge, skills, and confidence of both clinical and non-clinical staff to identify and respond to family violence.
- **Feedback, evaluation, and improvement systems** ensuring that constant improvements are shaped by timely feedback and local evidence.

The key outcomes of the Program Model anticipate the following:

- **First line response:** Patients (victims and perpetrators) need to be responded to at the point of initial disclosure. Families can be guided to appropriate ongoing care, including if appropriate mental health and AOD (Alcohol and Other Drugs) services.
- **Pathways to safety**: Health professionals need advice and access to resources and referrals in their local areas. Where GPs identify problems or at the point of disclosure there is a need for priority access to supports and services for high-risk patients.
- **Safety assessment response:** Families need to have their safety assessed at the time of disclosure. Families can be guided to appropriate ongoing care, which might include the health practitioner seeing the patient for ongoing support if lower risk.

OVERVIEW OF THE PROGRAM

The Program (see Figure 2) enabled primary care practitioners in a regional area to deliver evidence-based care and support for domestic and family violence (DFV). The Program aimed to strengthen and improve the quality of care provided to victims and children exposed to DFV.

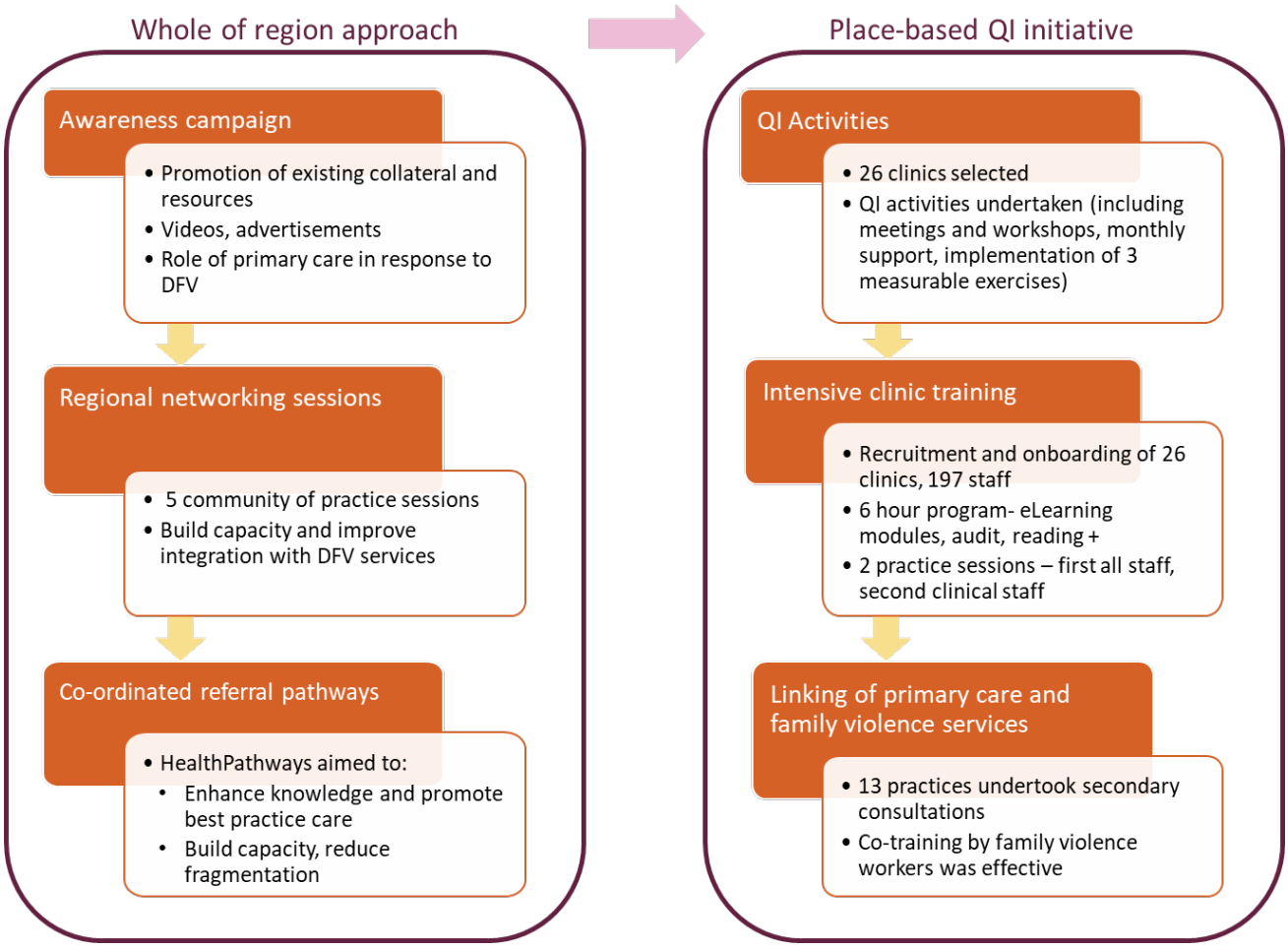
It involved a whole of region approach including:

- Communication and awareness campaign
- Regional interdisciplinary education and networking sessions (Communities of Practice)
- Development and promotion of co-ordinated referral pathways (Melbourne HealthPathways)

And a place-based intensive Quality Improvement (QI) initiative including:

- Implementation of QI activities to build internal capacity to respond to FV within a practice
- Intensive whole of practice training delivered by general practitioner (GP) and FV support worker
- Linking of primary care and family violence services through secondary consults.

Figure 2: Overview of the Program



The whole of region capacity building and system integration activities included:

- A targeted social marketing campaign to address the lack of awareness of the prevalence of family and domestic violence in the community and within general practice.
- A series of annual sub-regional learning networks (Communities of Practice), bringing together professionals from general practice, mental health and drug and alcohol services, hospitals, and the family violence sector to foster interdisciplinary and cross-sector learning and pathway development.
- Ongoing development and maintenance of freely available care pathways, tools, and resources via the Melbourne HealthPathways platform, identifying family and domestic violence navigators and services to enable timely supports, referral and access to health and family and domestic violence supports.

Place-based capacity building and system integration activities included:

- Five quality improvement (QI) waves where 26 practices were supported by NWMPHN to participate in a place-based initiative, using data driven improvement strategies to address practice-level population priorities for people at risk of, or experiencing family and domestic violence. This included implementation of sustainable change in the area of family violence with a whole of practice focus to enable increased capacity to identify, respond and refer. This included QI wokrshops before and after training to provide opportunities for shared peer-learning, problem solving and discussion about cases.
- Intensive whole of practice in-service training that is trauma informed and culturally responsive was delivered by a GP facilitator and FV support worker.
- Establishment of local family and domestic violence pathways and access to specialist secondary consult and mentoring support from the local FV support worker. This FV worker provides secondary consultation for health providers to provide practical support, and develop risk and safety assessments and management as needed.
- Practical application of improvements through systematic implementation of the training handbook, audit tool and practice checklist via plan, do, study, act (PDSA) cycles, ensuring changes are made at the individual staff, practice team and service level.

EVALUATION METHODS

The evaluation involved the following data methods (see Figure 3):

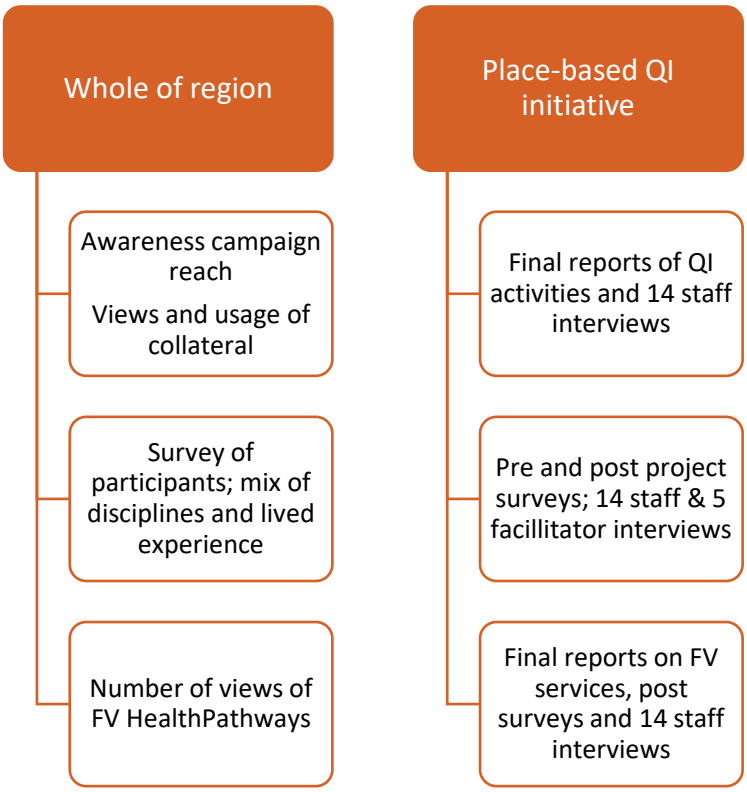
Whole of region level

- Communication and awareness campaign – number of views
- Regional networking sessions – attendance and feedback from surveys
- Referral pathways – HealthPathways number of views

Place-based level

- Quality improvement activities – Final Reports and interviews
- Intensive whole of practice training – one pre survey and two post surveys, and interviews
- Linking of primary care and family violence services through secondary consults – final reports, post-surveys, and interviews

Figure 3: Overview of Evaluation Methods



Below we outline details concerning the final reports, surveys and interview methods used at the place based level.

Practice 'Final Reports' on QI activities

Practices were provided with a 'Final Report' form to complete.

They were asked to address the quadruple aim (Improved patient experience, Care Team wellbeing, Population health, Reducing costs) through considering:

- **Patient story:** did individual patients or families benefit from your QI project? (e.g. better care: safe, quality care; timely and equitable access; patient and family needs met.)
- **Population health:** the benefits for population/benefitted changes achieved in population?
- **Team:** The ways in which the teamwork culture benefitted from the QI project, the overall team experience, increased clinician and staff satisfaction; leadership?

- **Cost:** How has this project improved efficiency in any area of your practice, which could reduce costs (in practice or healthcare system)?

The individual practices were asked to reflect on the sustainability going forward and whether it was feasible to continue the improvements that they had implemented.

- **Sustainability:** What actions will you implement to ensure your quality improvement activities are sustainable?

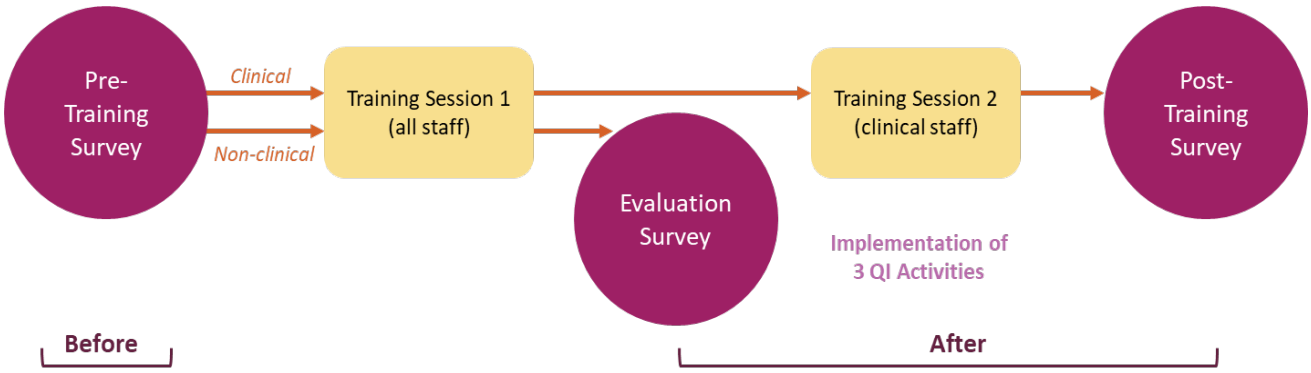
They were also asked to self-reflect on:

- What has your practice learned about your topic area?
- What has your practice learned about quality improvement in general?
- Reasons for success?
- Overall challenges or barriers?
- Unexpected outcomes related to family violence activities in your practice (positive or negative)?

Methodology for Surveys

As part of the evaluation, online 'Before' and 'After' surveys were conducted using Qualtrics Survey Software – see Figure 4. All participants (non-clinical and clinical) were asked to complete a 'Pre-Training Survey' prior to commencing the first training session – 'Before' responses. 'After' responses were conducted differently for non-clinical and clinical staff. Non-clinical staff were asked to complete an 'Evaluation Survey' after Session 1. The second training was attended by clinical staff who were asked to complete a 'Post-Training Survey' three months after undertaking Session 2 – this allowed time for participants to reflect on their practice since the training.

Figure 4: Overview of 'Before' and 'After' surveys



The 'Pre-Training Survey', 'Evaluation Survey' and 'Post-Training Survey' covered the following areas: demographic information (which allowed for tracking of individual 'Before and 'After' responses), Quality Improvement, views on the program, practice, Readiness Scale, and HealthPathways. The 'Pre-training Survey' also included open ended questions concerning reason for participation, learning wishes, challenges in participating, and any further comments. 'After' surveys ('Evaluation' and 'Post-Training' surveys) also included questions on quality of the program, learning objectives, resources, and open-ended questions concerning experience of the program and provided room for further comments.

Responses from the surveys were exported from Qualtrics and cleaned. Data analysis of closed ended questions was conducted using IBMSPSS (Version 26) statistical software package – descriptive statistics were used with graphs created in Microsoft Excel. Data was summarised using percentages for categorical data and means and range for continuous data. Open text responses were uploaded into MS Word for content analysis.

Interview Methods

Training participants

Semi- structured interviews were conducted with 14 participants (seven GPs, three nurses, three practice managers, and one nurse/practice manager) who volunteered to provide feedback on their experiences of the Program. Interviews were conducted via Zoom videoconferencing, and each took an average of about 30 minutes to complete. All participants were asked for their permission to record the interviews. They were also assured that their contributions would be deidentified. Participants' responses were transcribed and exported to Nvivo for analysis. Thematic analysis was conducted through an iterative process of examining the data to find recurring patterns, create codes and make meaning of the data.

GP facilitators and FV support worker

As part of the Pathways to Safety Program, a train-the trainer course was completed by three FV support workers and five GP facilitators. The FV support workers also contributed to further development and refinement of the training package.

Purposeful sampling was used to recruit GP facilitators and FV support workers (who had participated in the training of clinic staff for the training package) for semi-structured interviews. Potential participants were sent an email requesting volunteers to take part in an interview concerning their experiences of the Pathways to Safety program. Five of those approached took part – one FV support worker and four GP facilitators. Interviews were conducted via Zoom video conferencing at pre-arranged times. All participants provided verbal consent for the interviews which lasted about 15 to 20 minutes. Participants also consented to the recording of interviews, which were later anonymised and transcribed. Transcripts were subsequently thematically analysed.

This section has outlined the methods used in the evaluation. The next section will begin the first findings section. The findings are divided into two main areas the 'Whole of Region' and the 'Place based initiatives. Each of these has three components which intermix findings from the different methods.

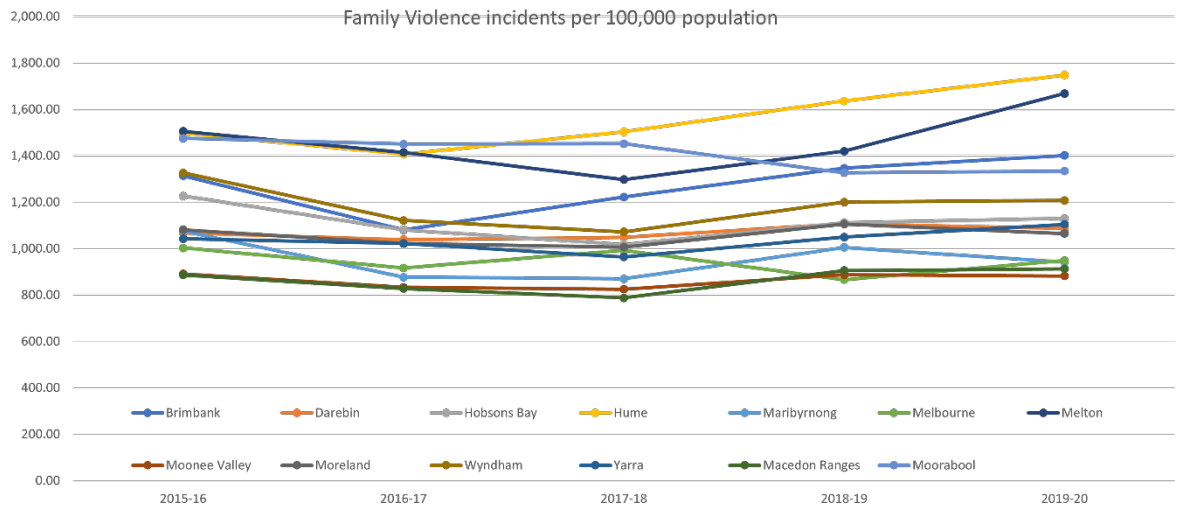
WHOLE OF REGION APPROACH

Communication and awareness campaign

The campaign included, where appropriate and possible, input from participating practices, services, and stories from people with lived experience. The results of this campaign contributed to increased awareness:

- amongst primary care providers about the need for and their role in supporting people experiencing domestic and family violence
- of the prevalence of family violence in the community (see Figure 5) and in individual practices.

Figure 5: Prevalence of family violence in the community



A 'whole-of-region' campaign was defined as targeting all primary health care professionals in NWMPHN region. These included:

- the whole of practice team: general practitioners, nurses, practice managers and receptions staff, allied health professionals
- allied health services and maternal and child health providers.

The secondary audiences for this campaign were:

- community health and family violence organisations/providers
- the broader health sector (hospitals, mental health, Alcohol and other Drug services).

The strategy was to increase current levels of reach, engagement and activity through the promotion of new and existing assets, including NWMPHN channels and sector media. News stories and case studies (see Appendix 2 concerning 'Case Studies' as an example) were developed as the centrepiece of this campaign. These aimed to stimulate conversations and raise awareness about the issue of family violence and the role of general practitioners and practices.

The delivery of news and editorial from a trusted source, such as NWMPHN or recognised family violence organisations, were used rather than a graphical campaign (such as 'Making family violence visible' – used for the engagement of practices in the QI activity). Resources, such as videos and photographs, were created to support news stories and promotion. The campaign included:

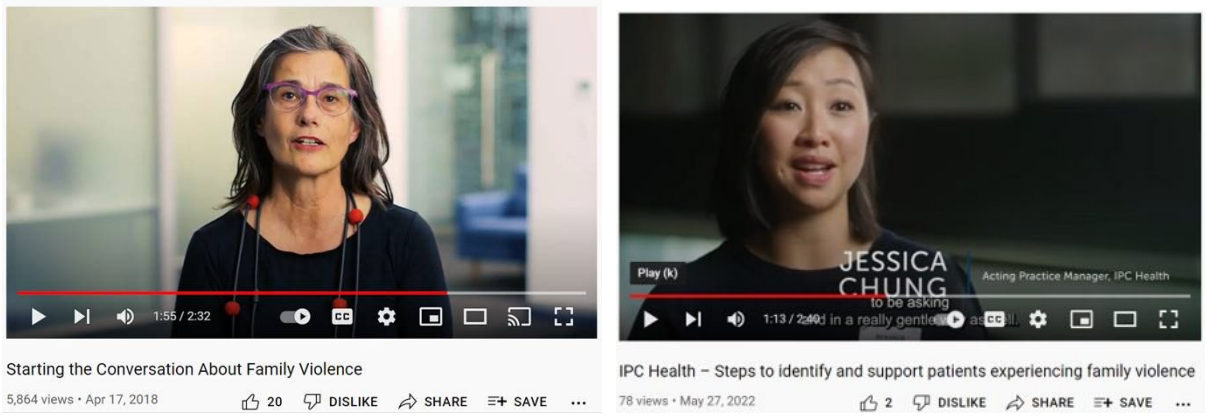
- Promotion of Primary Care Pathways to Safety activities such as events, webinars, Expression of Interests – these also included promotion to videos, information, tools and resources.

- Other family violence related announcements and media were promoted through NWMPHN channels, and where appropriate through sector and local media, to support the campaign and raise awareness.

Data for website and social media views and engagement was tracked and, where possible, compared to pre-campaign data.

The campaign contributed to increased uptake of family violence information, including via resources such as:

- Family Violence HealthPathways Melbourne (local referral pathways) views increased by 38%
- NWMPHN Family Violence webpage views reached an average of 607 views per quarter
- Video 'Starting the Conversation about Family Violence' video reached 538 views per quarter (see below)
- Education – recorded webinars and training options (see image below)



NWMPHN created dedicated web pages with resources for clinicians – Family Violence Support for Clinicians. Further they promoted existing family violence collateral such as the "Starting the conversation about family violence" video and Family Violence HealthPathways. In particular NWMPHN promoted The Family Violence Information Sharing Scheme (FVISS) and Child information Sharing Scheme (CISS) that aim to make it easier for professionals to share information for family violence risk assessment or risk management in relation to both children and adults. See NWMPHN website page for Information Sharing Scheme.

Specific outcomes (detailed in Table 1) included the following:

- Articles related to family violence, and stories from participating practices with social media reach for Family Violence content by 30 June 2022 = 17,557 and E-newsletter reach = 6,617 subscribers.
- The article on Communities of Practice 2022 was in top 5 most clickable articles of the financial 21/22 year.
- The most watched/read articles were interviews with practices: Interview with Dr Kirsty Tamis (328 views), PN Nicole Cross (266 views) and IPC Health Deer Park (124 views in one month).
- One of the practices launched their own awareness campaign via social media.
- International recognition of NWMPHN materials: the NYS Office for the Prevention of Domestic Violence (OPDV), the USA's only executive level state agency dedicated to the issue of domestic violence (DV) was granted a permission to use NWMPHN materials in their training on gender-based violence in the LGBTQ community.

Table 1: Summary of whole of region communication campaign

Articles and Page Views	Date	Number of views							
		Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022	Apr – Jun 2022	Total	Average per quarter
Children and Families / Family Violence page	2018	**434**	316	396	302	396	372	2,216	**369**
Family Violence Support For Clinicians page	May-22	n/a	n/a	n/a	n/a	n/a	**67**	67	**67**
Family Violence Quality Improvement page	May-22	173	**220**	125	160	216	134	1,028	**171**
Working together we can tackle family violence	28-Jun-22	n/a	n/a	n/a	n/a	n/a	**40**	40	**40**
Primary Care Pathways to Safety video	16-May-22	n/a	n/a	n/a	n/a	n/a	**109**	109	**109**
Family Violence Community of Practice 2022 initiative	25-May-22	n/a	n/a	n/a	n/a	n/a	**52**	52	**52**
How can General Practice respond to family violence – interview with IPC Health Deer Park	16-May-22	n/a	n/a	n/a	n/a	n/a	**124**	124	**124**
New QI activity templates to support general practice response to family violence	29-Mar-22	n/a	n/a	n/a	n/a	17	**159**	176	**88**
There is something wrong and I can help: Learning to recognise and respond to patients who use intimate partner violence	29-Mar-22	n/a	n/a	n/a	n/a	21	**325**	346	**173**
Better ways to help patients experiencing family violence - interview with Practice Nurse Nicole Cross	9-Nov-21	n/a	n/a	n/a	**173**	68	25	266	**89**
A brighter future: re-imagining domestic violence prevention and support	2-Aug-21	n/a	n/a	**40**	10	12	20	82	**21**
Making family violence 'visible'	15-Jul-21	n/a	n/a	**32**	9	6	4	51	**13**
Looking after your general practice team while caring for people experiencing family violence	18-Jun-21	n/a	18	10	12	**27**	17	84	**17**
Responding to Child and Family Violence Information Sharing Schemes requests: a guide for general practice	11-May-21	n/a	**47**	6	8	10	11	82	**16**
Health professionals join forces against family violence	26-Apr-21	n/a	87	36	26	60	**100**	309	**62**
Is your practice prepared to respond to the Information Sharing Schemes requests starting from 19 April 2021?	10-Apr-21	n/a	**29**	6	2	2	3	42	**8**
Responding to the shadow pandemic of family violence: interview with Dr Kirsty Tamis	22-Jan-21	**215**	37	12	17	22	25	328	**55**
NWMPHN to respond to the prevalence of family violence-related presentations in primary care *	18-Jan-21	**35**	5	14	5	5	6	70	**9**
Family violence: looking after your general practice team 20 November 2020	20-Nov-20	4	3	9	6	22	**24**	68	**11**
Starting the Conversation About Family Violence video **	17-Apr-18	349	625	**836**	495	371	550	3,226	**538**

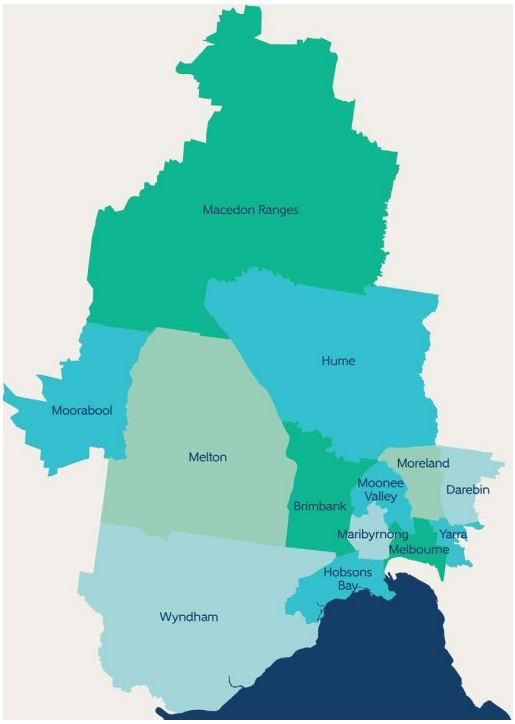
* In Oct – Dec 2020 there were 29 views; ** From 2018 (9-month period) to Dec 2020 there were 2,600 views: 2018 (9 months) = 972, 2019 (12 months) = 645, 2020 (12 months) = 983

Regional interdisciplinary education and networking sessions

The purpose of establishing **Family Violence Communities of Practice** was to bring together professionals from different sectors to build the capacity of primary health care providers to improve their first line and safety assessment responses and pathways to safety. A secondary objective was to achieve better integration of primary care services with the broader community and social care services sector.

In creating Family Violence Communities of Practice, the NWMPHN held five sub regional learning network sessions (Sessions 1-5) over the duration of the Project. Details of these are listed below along with a map showing the NWMPHN catchment area (see Figure 6).

Figure 6: Map showing location of NWMPHN catchment area



Multidisciplinary Family Violence Communities of Practice Sessions:

- 20th April 2021: Hobsons Bay, Maribyrnong, Melton, Moorabool and Wyndham (WEST)
- 28th April 2021: Melbourne, Moreland, Yarra and Moonee Valley (CENTRAL)
- 29th April 2021: Brimbank, Darebin, Hume and Macedon Ranges (NORTH)
- 17th May 2022: Hobsons Bay, Maribyrnong, Melton, Moorabool and Wyndham. Brimbank (WEST)
- 24th May 2022: Melbourne, Moreland, Yarra and Moonee Valley, Darebin, Hume and Macedon Ranges (CENTRAL & NORTH)

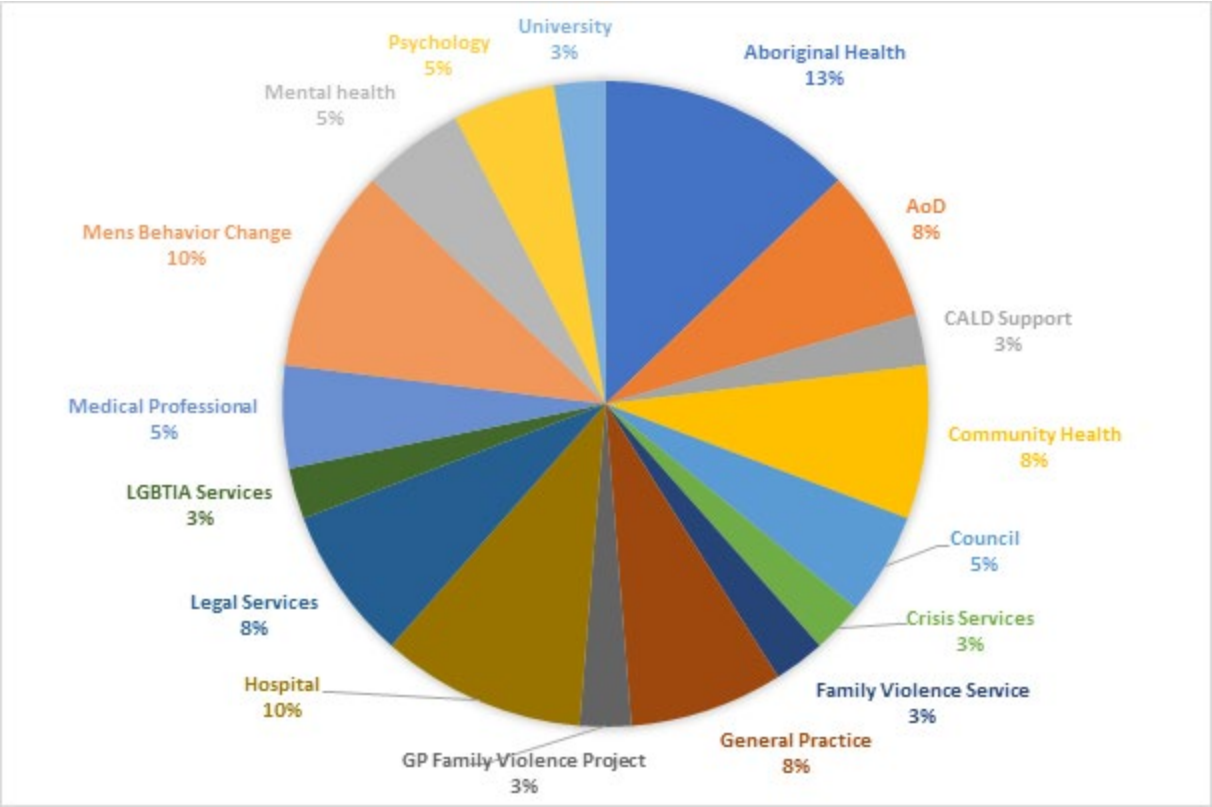
Sessions 1-3: Information Sharing Schemes

The first series of events, Sessions 1-3, were focused on the new Victorian Information Sharing Schemes and their implementation. The three sessions were attended by 47 health professionals from a variety of disciplines and 15 presenters/facilitators from range of health and sector organisations, as well as people with lived experience. Attendees included individuals from the primary health, community health, mental health, alcohol and other drugs, and Aboriginal and Torres Strait Islander health sectors – see Figure 7.

The three sessions were led by Dr Jennifer Neil, GP, Senior Lecturer at Monash University, along with three facilitators from Victoria Legal Aid and representatives from a panel of experts. Note that the expert panel included people from hospitals, women and children's support services, men's behavior change programs, legal services, local government and three lived experienced experts – two lived experience expert attended each session. See Appendix 4 for further details about the expert panel.

Each session consisted of an education component (led by Victoria Legal Aid) covering the new Information Sharing Schemes, and a case discussion in break out rooms. Guided by the facilitators and expert panel members, the attendees discussed their roles and system barriers and enablers. In the break-out rooms they examined a multi-faceted case study and considered the interlinked roles of multi-disciplinary services and networks.

Figure 7: Attendance at Sessions 1-3 (n=47)



Feedback on Sessions 1-3

Participants were asked to provide feedback (via a survey sent to participants after the session) and the results showed that amongst respondents:

- 100% would recommend a session like this for a colleague
- 80% very satisfied and 20% somewhat satisfied
- 62% reported that they intend to make a change to their practice as result of attending the session.

Some participants elaborated further as demonstrated through the selection of quotes below.

'I thought it was fantastic! Very engaging and I think we were able to have some nuanced conversations which was great.' (Attendee)

'I would just like to say that as a survivor I found the seminar both informative and encouraging…it was so nice to see a range of professionals from a cross-section of services interested in making positive changes to what is a very broken system…it gave me hope that finally something is happening.' (Lived experience attendee)

'Being included as a survivor of DV in the community of practice sessions where i was listened too, validated and understood in a trauma informed setting was a sheer pleasure' (Lived experience attendee)

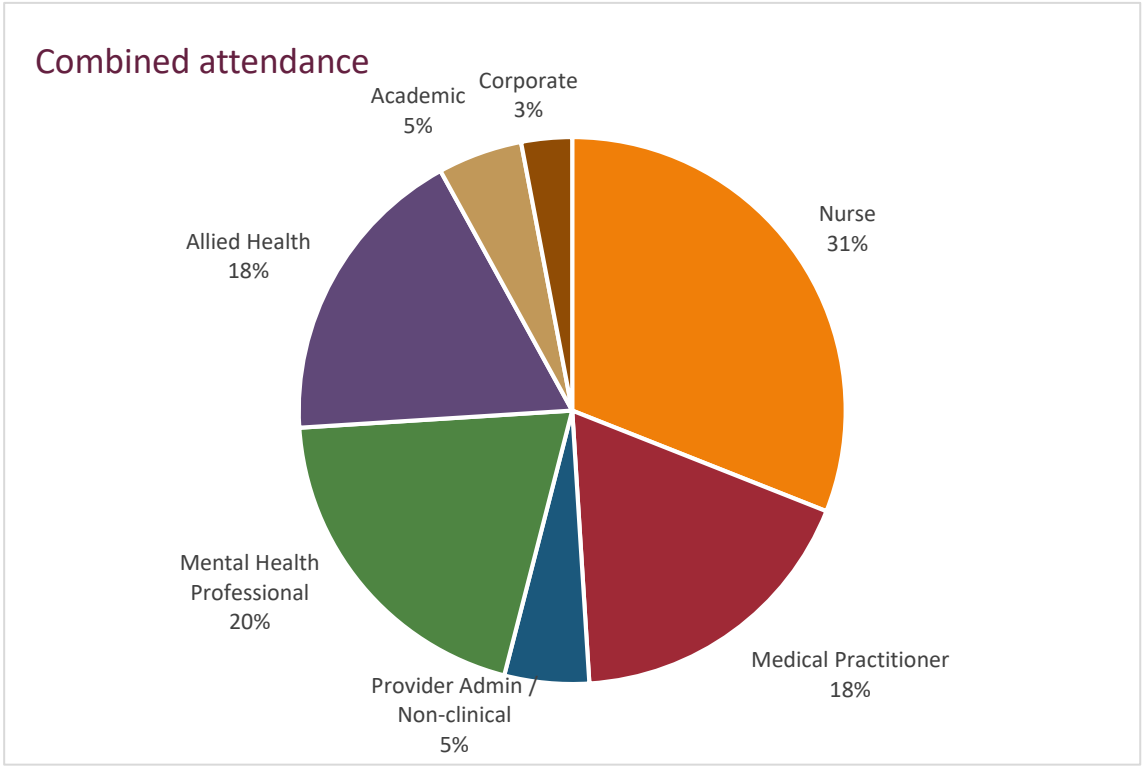
The feedback on the value of having lived experience speakers at the session was overwhelmingly positive.

- Offered a firsthand account of the barriers faced by people who have experienced family violence
- Presented a point of view on a complex multi-dimensional issue and a realistic perspective of what it is like to live with FV and the reality of being in the system.

Sessions 4-5: There is something wrong and I can help: Learning to recognise and respond to patients who use intimate partner violence

The second series of multi-disciplinary sessions (Sessions 4-5) were held in 2022 and 39 health professionals from a variety of disciplines attended (see Figure 8). It drew together professionals from general practice, mental health organisations, alcohol and other drug experts, hospitals, local councils, community health and counselling services. The sessions were led by Matt Addison from Safer Families Centre, Michelle Perry from Magistrates Court Victoria and Hai Nguyen from Melton Western Health. In addition, there were representatives from a panel of experts comprising six people from hospitals, women and children's support services, men's behavior change programs, legal services and local government. See Appendix 4 for further details concerning the expert panel.

Figure 8: Details of attendance at Sessions 4-5 (n=39)



Guided by the facilitators and expert panel members, the attendees discussed how to identify and respond to patients who use intimate partner violence. Participants also went into break-out rooms that were facilitated by a member of the expert panel. They examined a multi-faceted case study and considered the interlinked roles of multi-disciplinary services and networks. A recording of the session was available online after the event which was watched by 52 participants within a month of publishing.

Feedback on sessions 4-5

The 39 participants were asked to provide feedback via a survey and the results showed that amongst respondents:

- 100% would recommend a session like this for a colleague.
- 61% reported that they intend to make a change to their practice as result of attending the session
- 50% were 'very satisfied' with the event and 44% were 'somewhat satisfied'.

Individual feedback from participants included:

'I was encouraged about the breadth of the perspective of the presenter,'

'It was good to hear his views that did not just repeat commonly heard rhetoric about family violence.'

'Excellent acknowledgement that frameworks are often limited to cisgender, heterosexual relationships.'

Most useful aspect of the session:

- Group discussions and learning from other participants
- Presence of lived experience survivors as part of the discussion
- Legal information and group discussion regarding the case study
- Case studies and the facilitators sitting in the breakout rooms with the small groups

Feedback on all sessions – Sessions 1-5

From sessions 1-5 participants responded to the following:

System barriers to quality care for people at risk of or experiencing family violence:

- Lack of experience, knowledge and confidence, and not knowing who to refer to, in particular not knowing the support available to perpetrators to get help
- Lack of time and privacy
- Gender inequality and societal acceptance of perpetrator's violent/controlling behaviour
- When children are involved, the perpetration of FV is a parenting choice and needs to be addressed from this framework, ensuring the safety of children and children's mothers is priority.

How might this QI activity contribute to a systems-based patient safety outcome:

- Learnt about additional options for onward referrals
- Working with perpetrators and what to recognise and ideas of how to engage and support male perpetrators to receive support
- Information sharing and reporting practices
- Supporting the general community in identifying FV
- Importance of collaboration between sectors and disciplines.

All health services sharing the same language and assessment and safety planning frameworks will assist to keep our patients safer, promote their health and reduce morbidity & mortality... ultimately helps us do what we're here to do!

Development, update and promotion of co-ordinated referral pathways

A key element for supporting the practices was the HealthPathways that was developed and launched in April 2019. The development and use of care pathways was included to strengthen the understanding of the system in which health professionals work. Care pathways work to:

- Enhance clinical knowledge and promote best practice care, and reduce number of patients referred to specialist care who could be managed in primary/community care
- Build collaboration and reduce fragmentation across the health service network and improve health outcomes.

They:

- **Provide evidence-based information regarding conditions and symptoms –** drawn from latest research and clinical guidelines, care pathways provide details on agreed best practice management with links to relevant clinical practice guidelines, key publications and consensus-based resources
- **Present localised service and referral information to support appropriate patient referrals –** accurate information on local referral options for community services and programs, including how to refer
- **Build collaboration across the sector to identify opportunity for service redesign and partnership opportunities –** development of care pathways is clinician led and collaborative, providing a structure and process for local health professionals and specialist clinicians to collectively articulate agreed criteria for assessment and referral requirement.

Melbourne HealthPathways

Access to Melbourne HealthPathways is shown in Figure 9.

Figure 9: Accessing the Melbourne HealthPathways

https://melbourne.communityhealthpathways.org/

NWMPHN developed, improved, and promoted the following 16 local HealthPathways to be accessed by clinicians at the point of care.

1. Screening for Family Violence has been added under the assessment section into Antenatal and Postnatal checks, published Dec 2021:
   - Antenatal Care - First Consult
   - Antenatal - Second and Third Trimester Care
   - Maternal Postnatal Check

2. Existing Family Violence Pathways were updated and improved to include new services, published in July 2022:
   - Disclosure of Family Violence
   - Family Violence Referral and Community Support
   - People who use Family Violence

3. New Adult and Child Abuse HealthPathways published in July 2022:
   - Adult Recent Sexual Assault
   - Previously Undisclosed Sexual Assault
   - Sexual Assault Counselling and Support
   - Allocate Injury Type
   - Child Abuse and Neglect
   - Child or Young Person Sexual Abuse – Caregiver Concern
   - Child or Young Person Sexual Abuse – Health Professional Concern
   - Disclosure by Child or Young Person of Sexual Abuse
   - Physical Assault and Injury Recording
   - Strangulation (Choking)

Outcomes

Promotion of reach of HealthPathways via Bulletin: 3000 people in the North, West and East Melbourne. Figure 10 shows the number of page views observed during the operation of the Program.

Figure 10: Page views of HealthPathways: family violence

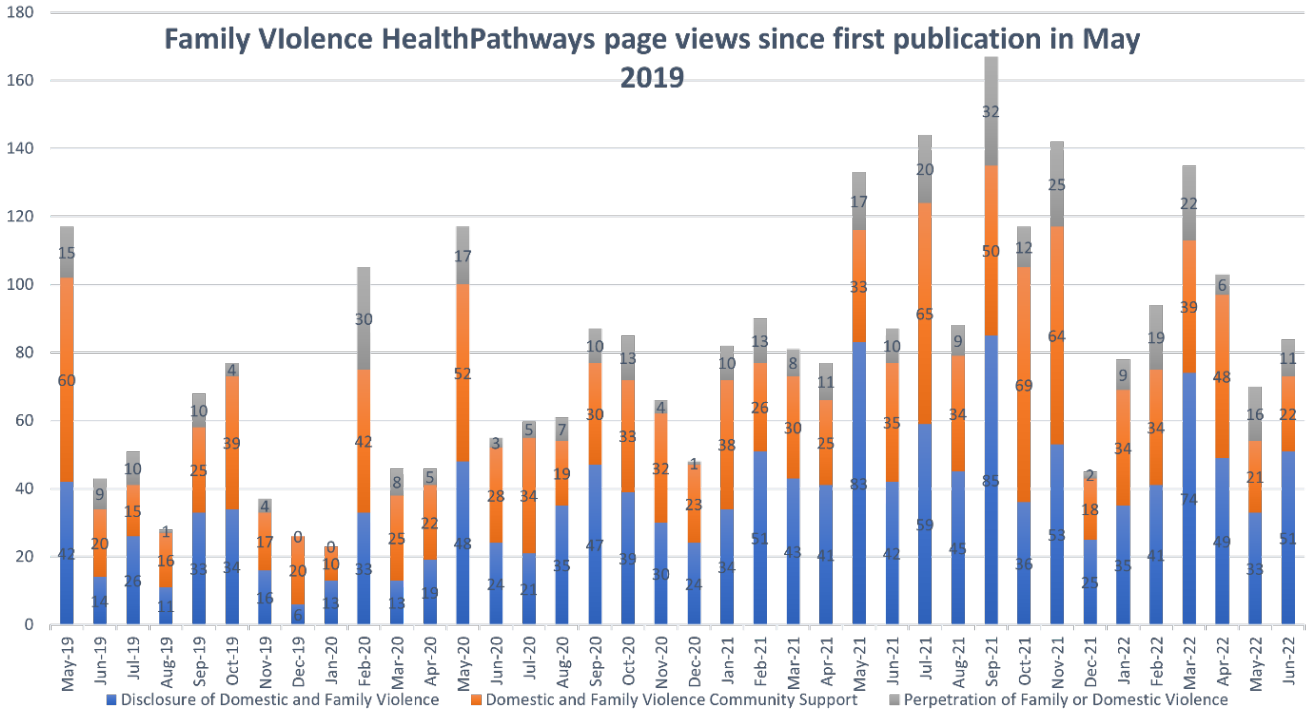


Table 2 shows that there was an average increase of 38% per quarter on number of page views observed during the operation of the program.

Table 2: Page views

Referral Pathway	2020/2021				2021/2022				Average	Difference	Increase
	Q1 *Baseline*	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q2 20/21 to Q4 21/22	*Average – Baseline*	Average/ Baseline
Disclosure of Domestic and Family Violence	103	93	128	166	189	114	150	133	139	36	**35%**
Domestic and Family Violence Community Support	83	88	94	93	149	151	107	91	110	27	**33%**
Perpetration of Family or Domestic Violence	22	18	31	38	61	39	50	33	39	17	**75%**
Total	*208*	*199*	*253*	*297*	*399*	*304*	*307*	*257*	*288*	*80*	***38%***

This section has overviewed the whole of region approach used in the Program. The next section outlines the place-based QI initiative.

PLACE BASED QUALITY IMPROVEMENT INITIATIVE

The context of practices recruited to this initiative will be described first, followed by the following activities involved in the initiative:

- A range of quality improvement (QI) activities undertaken by each practice
- Intensive whole of practice training
- Linking of primary care and family violence services through secondary consults

Context of Practices

Recruitment

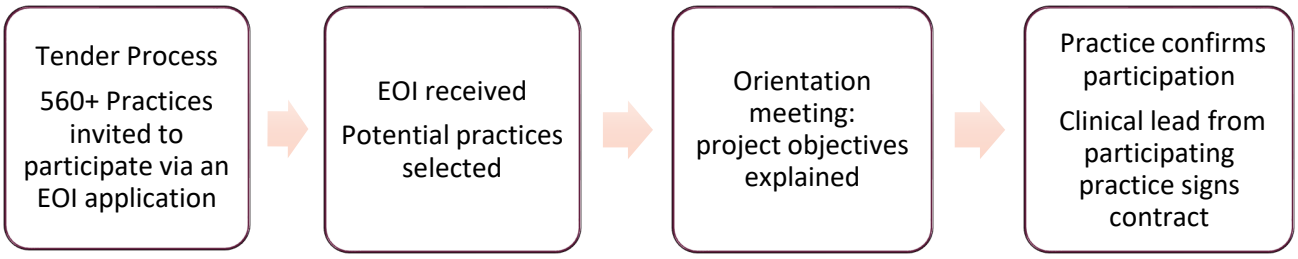
The recruitment approach employed by the NWMPHN involved a number of strategies to obtain maximum uptake during a period when the COVID pandemic was taking place (see Figure 11). Recruitment commenced in September 2020 and ended in February 2022. At the outset over 560 practices were invited to tender for a place on the project, with practices needing to be accredited and meet specific selection criteria determined by the NWMPHN.

An Expression of Interest (EOI), circulated by NWMPHN via the Project Tender page specified the minimum practice inclusion criteria, project goals and aims. The rational for this approach was that the EOI allowed for quick and timely reach to all practices in the specified project activity areas and within the funding timeframe. Funding was offered to practices ($3,000.00 per practice) to compensate them for their time being involved in the activities. To support the recruitment, the NWMPHN published the project on the current tender page on their website and via the GP newsletters and E-Blasts from September 2020 to January 2022. Please see Appendix 3 for the EOI.

The applications were reviewed against the selection criteria and the successful practices were accepted into the project. The practices then had an orientation meeting to go through the details and set expectations. A short agreement was signed between NWMPHN and each practice.

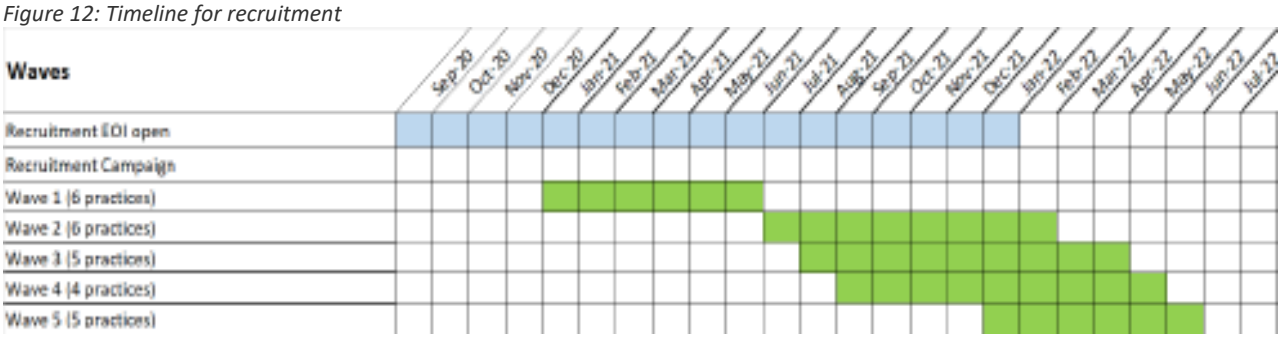
The Flowchart below (Figure 11) summarises the recruitment strategy adopted.

Figure 11: Recruitment strategy



Recruitment of the 26 practices occurred in five waves or time periods which are outlined in Figure 12. There was very strong interest in the first wave and recruitment was rapid. With Victoria enduring stages of restrictions and a state of disaster due to the COVID-19 pandemic the project was technically open, but practices priorities changed with the focus being on patient monitoring programs and the vaccination programs. As a consequence of the difficulties recruiting in the pandemic, the NWMPHN recognised the importance of including as many practices as possible to reflect the demographics of the catchment area. Therefore, one of the selection criteria became optional, and non -accredited practices were able to apply for the intensive quality improvement for the first time.

Figure 12: Timeline for recruitment



A total of 14 practices were recruited in the West and 12 practices were recruited in North catchment region. Table 3 shows practices by Local Government Area.

Table 3: Practices recruited by local government area

Local Government Area	Number of practices
Brimbank	7
Melbourne	5
Moreland	4
Wyndham	3
Hume	2
Darebin	2
Melton	1
Macedon	1
Maribyrnong	1

Demographics

There are over 564 practices supported by the NWMPHN in the region and the 26 practices recruited to the training exemplify the diversity within the catchment area. The NWMPHN area has the highest rate of immigrants residing, with numerous distinct communities within each practice. Over 39.5% of the people living in the project catchment area were born overseas and Vietnamese is the most common language spoken after English. There are also significant Aboriginal populations in the region.

Table 4 outlines the types of practices involved in the training and shows of the 26 recruited practices, three were solo operators and the rest were multiple GP Practices. Billing varied with 12 bulk billing all patients, and the rest mixed billing. All but three of the practices were accredited. The range of practices consisted of services that provided resources and supported refugee and asylum seekers, individuals experiencing homelessness, vulnerable and marginalised clients and linguistically diverse communities in the catchment area.

Table 4: Types of practices

PRACTICE	LGA	TYPE OF PRACTCIE	ACCREDITAION STATUS	BILLINIG METHOD
1	Melbourne	Multi-GP Practice (2-5)	Yes	bulk billing only
2	Brimbank	Multi-GP Practice (11+)	Yes	Mixed billing
3	Wyndham	Multi-GP Practice (11+)	Yes	bulk billing only
4	Darebin	Multi-GP Practice (2-5)	YES	bulk billing only
5	Moreland	Multi-GP Practice (6-10)	Yes	Mixed billing
6	Brimbank	Solo Operator	Yes	Mixed billing
7	Melbourne	Multi-GP Practice (2-5)	Yes	Mixed billing
8	Brimbank	Multi-GP Practice (11+)	Yes	bulk billing only
9	Brimbank	Solo Operator	Yes	bulk billing only
10	Brimbank	Multi-GP Practice (2-5)	Yes	Mixed billing
11	Hume	Solo Operator	Yes	bulk billing only
12	Brimbank	Multi-GP Practice (2-5)	Yes	Mixed billing
13	Hume	Multi-GP Practice (2-5	Yes	bulk billing only
14	Moreland	Multi-GP Practice (2-5)	Yes	Mixed billing
15	Moreland	Multi-GP Practice (2-5)	Yes	bulk billing only
16	Darebin	Multi-GP Practice (6-10)	Yes	Mixed billing
17	Maribyrnong	Multi-GP Practice (6-10)	Yes	Mixed billing
18	Melbourne	Multi-GP Practice (11+)	Yes	Mixed billing
19	Brimbank	Multi-GP Practice (2-5)	No	bulk billing only
20	Wyndham	Multi-GP Practice (6-10)	No	bulk billing only
21	Macedon	Multi-GP Practice (2-5)	Yes	Mixed billing
22	Melbourne	Multi-GP Practice (6-10)	Yes	Mixed billing
23	Morland	Multi-GP Practice (2-5)	No	bulk billing only
24	Melton	Multi-GP Practice (2-5)	Yes	bulk billing only
25	Wyndham	Multi-GP Practice (11+)	Yes	Mixed billing
26	Melbourne	Multi-GP Practice (2-5)	Yes	Mixed billing

This first section has outlined the context of the practices involved in the place based intensive QI activity and intensive training. The next section will outline the QI activities process and outcomes.

Quality Improvement Activities

This section overviews the QI process, the role of the clinical leads and the outcomes from this process.

The QI Activities included the following components.

1. **Orientation Meeting** with the NWMPHN. This individual practice session gave an overview of the project, contract requirements, upcoming training and covered what's expected from participants. The session required participation from 1 or more representatives from one practice.

2. **A short contract** was signed by NWMPHN and each of 26 practices. The contract specified the length of the project (5-8 months) and deliverables. Deliverables included: 1. completion of pre-project surveys and attendance at the Orientation and Kick Off Workshop ($1,000); 2. Attendance of two education sessions and implementation of three improvements related to family violence response ($1,000); 3. Completion of post-project survey and Final Report ($1,000).

3. **Kick Off Quality Improvement Workshop**. This group workshop was organised at the beginning of each wave. It was required to have at least 2 representatives from each practice at the Kick Off Quality Improvement Workshop. The participants were introduced into the Quality Improvement methodology. It was also an opportunity to brainstorm about potential improvement activities related to family violence they could implement in their projects. The workshops were facilitated by Clinical Lead Dr Ralph Audehm (expertise in sustainable change in general practice, Irina Basanko (project timeframe) and Kitty Novy (outcomes from the previous pilot). The Learning Outcomes from the Kick Off Workshops included:

    i. Discuss the role of general practices in family violence prevention

    ii. Apply a whole practice approach to quality improvement

    iii. Test, evaluate and summarise ideas for improvement at general practice.

4. **Implementation.** A meeting after the intensive training (see next section) was scheduled to come up with the Project Plan and decide what *three measurable QI activities/exercises* (family violence improvements) could be implemented. The Project Lead provided practices with ideas for family violence improvements for further discussion with the practice team. The Practices could pick any measurable activity they felt was achievable. The Project Lead provided PDSA templates to record the results of activities. In addition, the practices were provided with the Final Report template (due at the end of the project).

    Although a champion within the practice led the project, the whole of practice approach was implemented, and additional participating staff were assigned to individual activities, which encouraged the whole of practice approach.

5. **Monthly Check In meetings** were held for three months with the NWMPHN to track progress and assist with implementation of at least three activities.

6. **Originally a Wrap Up workshop** was planned for the participating practices in each wave, however due to time commitments and the COVID pandemic the NWMPHN conducted individual Wrap Up sessions with each practice.

7. **One group Wrap Up session** was held for all 26 practices in August 2022. This workshop was an opportunity for practice team members to come together to network, reflect, clarify and reinforce learning and to strengthen relationships within the sector. A reflection session was followed by case study discussions to foster further interdisciplinary learning and sharing of ideas. This session was co-facilitated by A/Prof. Dr Ralph Audehm, Irina Basanko (NWMPHN) and Family Violence Workers (local and across the state). By the end of this session the participants were able to:

    - Summarise family violence related activities implemented by 26 participating practices

    - Identify challenges and enablers for implementing your family violence training into practice

    - Deliver activities to support sustainable change at your practice and strengthen relationships within the sector

Clinical Leads

Initially the Clinical Leads or Principal GPs engaged with Irina Basanko, Project Lead, Primary Care Pathways to Safety NWMPHN, to discuss the clinics participation in the project. When the Clinical Lead was not available the Practice Manager, or a senior nurse, would take on that role and be the link. Throughout the project the Clinical Leads would have frequent contact with the PHNs until the final report was submitted. The meetings would be arranged on a monthly basis for the duration of the project. The Clinical Lead role also involved in supporting the staff for the duration of the project and passing on any additional educational material that could be useful. They also assisted in navigating services if staff needed guidance or advice on how to respond to a challenging presentation at the clinic.

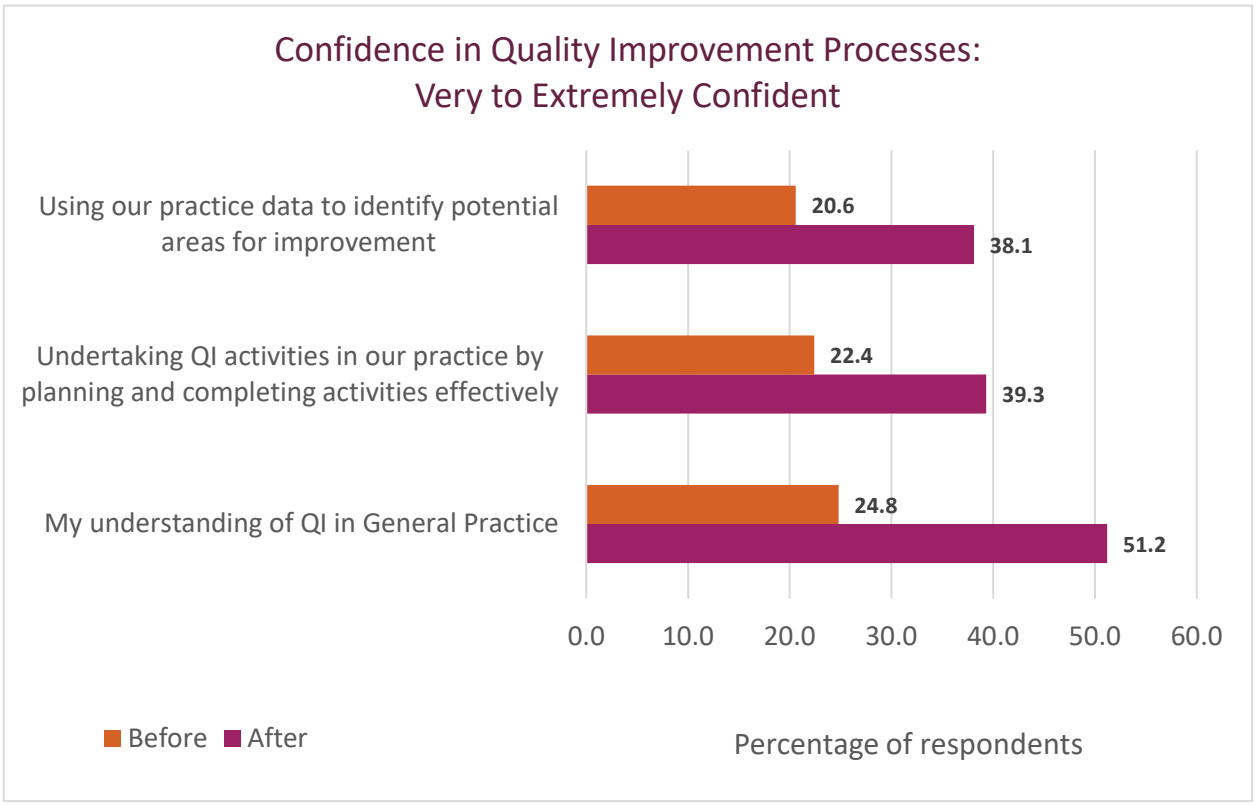
Outcomes

Quality Improvement processes

Survey

All survey participants who were clinical staff rated their confidence in three Quality Improvement (QI) Processes before and after the training: ‘Understanding of QI in General Practice’, ‘Undertaking QI activities by planning and completing activities effectively’, ‘Using practice data to identify potential areas for improvement’. The results, which are presented in Figure 13, show the proportion of participants who were ‘Very confident’ to ‘Extremely confident’ rose on each QI item. The highest result was achieved in ‘My understanding of QI in General Practice’ where confidence doubled from 24.8% to 51.2%.

Figure 13: Confidence in Quality Improvement Processes



Interviews

From the interviews with 14 participants one theme emerged relating to the QI component.

Theme: Quality Improvement Process beneficial but time-consuming

There were some mixed reports about the quality improvement process, but the participants' experiences were overwhelmingly positive. Participants felt the structured planning and goal setting embedded in the quality improvement process allowed sustainable positive changes.

> *'A beautiful program. We were able to get a lot of support, resources and a lot of advice as well. Even doing this program went hand in hand to be able to make changes, implement changes, start the process, documentation, information, education. just to get the ball rolling. It just went hand-in-hand.' P9, Nurse/Practice Manager*

> *'It helped us set a small set of goals to change and improve the way the clinic works as a whole with focus on a subset of patients (antenatal/postpartum) but also bring greater awareness as a whole to the clinic (with posters). Our clinical team feel more confident approaching this topic and having monthly meetings to discuss/debrief has been invaluable.' P5, GP*

The challenge with the quality improvement processes were mostly linked to how much demands it made on participants' time, despite their appreciation of its benefits for their practice.

> *'We tried to collect the data to see how many patients were screened, but we had a lot of trouble trying to access it through the quality improvement process. That was very time-consuming, I have to say. Now we've done – made a few amendments, to be able to source the data, to extract the*

data a lot easier, because, as a result of how difficult and time-consuming it was to get the data. I have to say, it was quite time-consuming and very challenging to get, to actually extract the data.' P6, Nurse

'Yeah, look I think doing the audit definitely has, and it'd been a while since I've done anything like that just because of COVID, and looking at okay, you know who came in to see my yesterday and did I ask them these questions. So yeah, I think it's always a helpful process to do that. I think the challenge is always going to be where does that fit into a day where you've got …twenty-five patients and seven people extra wanting to see you. So, I think that that has a QI [responded] is probably the biggest challenge in general practice, I think.' P4, GP

QI activity templates

Based on the Intensive Family Violence Quality Improvement Project 2021–22, two new QI activity templates (see Appendix 5) were developed:

- **Identifying people at risk of or experiencing family violence**
- **Increase the confidence of your practice team to identify and respond to family violence**

The final report template made it quick and easy to drive and record sustainable improvements in the 26 practices.

Final Reports

Key feedback from participating practices from their final reports included:

- they feel they are now able to offer an additional service to their community and reported increased confidence in support to people experiencing DFV, especially for people seeking asylum and refugees experiencing domestic violence
- identified continuous quality improvement activities through network meetings
- in-clinic posters support patients to make disclosures about family violence & that patients felt safe to seek help
- secondary co-consult service reported as being helpful particularly in extreme cases
- training supported practices to understand the impacts of a whole practice approach
- positive experience of a well-organized project and sustainability of the project & ensuring there are opportunities for new & future doctors.

QI activities implemented

The following Family Violence Quality Improvement Activities undertaken were recorded in the final reports (see Appendix 6) for summary of QI activities implemented at practices):

Resources

- Adding posters, cards with resources, My Safety Plan' brochure in waiting rooms, including Multilingual Resources (Arabic, Hindi, Burmese, English, Punjabi, Vietnamese, and Dinka)
- Posters and handout resources in nurse room, GP desk, Female/male toilets is applicable
- Family violence on TV Tonic, Practice Website; blogs and Instagram and Facebook

- Email signature banner about safer families
- Patients given pamphlets and asked if they knew about available resources/services

Clinical

Included domestic and family violence questions in the following assessments

- Mental Health Plans (6-192 patients asked per month) - 17 practices implemented this activity
- Antenatal/Postnatal appointments (2-36 asked per month - 7/9 practices implemented this activity 7/9 practices implemented this activity)
- Health Assessments, including refugee health assessments, annual executive health assessment; Social History assessment
- Chronic Care Plans / Aboriginal Assessments; GPMP, HA: ATSI, 75+, 45-49 HA (1-20 asked per month)
- Cervical screening (1-10 asked per month) if there are 'red flags'

Medical Director – added links to safety plan and assessments, accessible by GPs and nurses or post-natal autofill in Best Practice

Nurse led model where GPs would refer to a practice nurse to address FV.

Staff support

- Regular clinical and team meetings to present cases and reflect monthly or bi-monthly
- Mental Health Social Worker to work with patients and support GPs
- Updated address book
- Shared drive with resources
- Emergency Plan in case of escalated threat
- FV Internal Policy
- Mandatory FV training for new staff.

Interviews

In the interviews a theme was developed that reflected **the holistic place-based QI activities and intensive training.**

From training to implementation changes

Several participants had initiated changes to their own patient care practices and there were also systemic changes implemented across clinics to promote awareness among staff and patients and to support staff efforts in identification and response to DFV.

> *'Well, I'm not sure from a patient perspective how I would answer that but certainly, we did things to heighten awareness to our patients so that they knew that we were participating and that there was safety around any conversation that they might want to have. We used our Instagram to promote it, we used posters in bathrooms around the practice as well. I think it was all just really more about promoting awareness for patients that we were active participants in this and that this*

was a safe place for disclosure if they needed it. …I think one of the other things actually I wanted to say about the impact of the training on our practice which I just remembered is that I think it also sent a really positive message to the staff here that as a clinic we think it's really valuable to be involved in studies that are appropriate for our clinic and that we're not about just standing still and doing just what we have to do to get through one day to the next.' P2, Practice Manager

'Then, as a practice, I think we are doing things clinic-wide. So, we have done things like put up posters in places around our actual reception rooms. We've also updated some of our patient handouts. So, the one in particular that we were really proud of doing was we usually have like a pregnancy handout. So, women who have become pregnant, we give them a handout of all of the things that they should be thinking about when they're pregnant, so things like their vitamins and so on and so forth. But we didn't have anything in there before asking questions about how safe you feel or discussing that and normalising that as part of this handout. That's now part of our handout. …The other thing is we're doing sort of regular meetings now looking at – not only cases that may have come up for discussion, so again providing each other with support on how to manage that. But it's also a way for us to go okay, how is the posters going? Are they useful? Are patients being alerted with those posters, and should we be doing something else. So, we've got a QI meeting regularly to try and see how else we can progress the program.' P3, GP

Beyond the individual practitioner, the training seemed to have signalled to all the clinic staff that it was alright to discuss DFV cases for the purpose of sharing ideas or improving practice.

'Yes. There was something else. A lot of our six-week neonatal checks we do with mums, a lot of the time we get that period alone with the mum, so that we can disclose them. Then, a gap we identified was, on some of those visits, the husbands or the partners do attend, so, we really didn't want to – we just wanted to try and find a way around where we could screen for everyone, even if they had their partners attend. We came up with an alternative solution. If the husbands were there, or the partners were there, sorry, and the doctor was with the wife in the room, after she checked the baby, she would say to the husband, if you want to take the baby down to the nurses' room, just to get them ready for their vaccines? So that way, she'd at least have a few moments alone with the wife, just to do that screening. That way, the wives that were accompanied by the husbands weren't slipping through the cracks, and we were just writing, couldn't screen, because partner was present. That way, they still got screened anyway. So, it was just a good way. It took a little bit of thinking. We had to put our heads together and think about how we could safely do this without causing any alarm bells for the women, but I think it is a good – I think it's been a good strategy that we've implemented.' P6, Nurse

'What happened was that our family violence lead, the information that we gathered from here, even the cue cards and everything, he has been able to gather and upload it on iHub. A lot of changes have been made from us doing this, which has improved [name of clinic] as a whole. …I would just like to thank you for this opportunity, to be able to do this, to be able to not blue my dream, but to be able to - it was a goal in life that I had for a very, very, very long time. I had always been thinking, I would like to do my bit in which I am, to help other women out there. I have been able to not only do that, but I've been able to help implement some sustainable changes, that's going to be here with [name of clinic] for a long time.' P9, Nurse/Practice Manager

The next section provides details on the whole of practice intensive training process and outcomes.

Whole of practice intensive training

The whole of practice training sessions were designed and offered to all the participating staff, including GPs, nurses, practice mangers, receptionists, on-site allied health and administrative staff. The aim of the training program was to help staff understand how to recognise FV, respond and provide access to practical resources tailored to their area. This would enable patients to feel supported and safe. The training program provided an opportunity for the practice to discuss issues around strengthening the response to family violence in an individualised way with the GP facilitator and the FV support worker. It also allowed for a whole of practice discussion on the role of the practice in responding to those experiencing family violence, and how the practice might facilitate a more effective response. The use of role play provided participating GPs and nurses in the second session to try out different ways of providing care and experimenting with different communication styles and techniques. The training program also provided opportunities to discuss changes to the clinical protocols and procedures and access to domestic and family violence resources.

The training program was developed by Professor Kelsey Hegarty with assistance from Dr Libby Hindmarsh. Further improvement involved the participation of an educational team Dr Ralph Audehm, Dr Jennifer Neil, Jac Dwyer, Megan Perry and Christina Hotka who are all experts in family violence and facilitating training in the family violence space. Cultural aspects were written by Professor Angela Taft.

Structure of the program

The structure of the training program was designed so that it could be delivered successfully via ZOOM where staff could be either in the clinic or outside of the clinic setting. The components of training program were designed to be completed over a three-month period as outlined in Table 5. For a list of training resources see Appendix 7.

Table 5: Educational program structure

Week	Phase	Component	Time (approx.)
Week 1-2	Reflect	Complete survey and practice checklist	15 minutes
Week 3-4	Prepare	Pre-reading & elearning module on 'Identifying and Responding to Domestic and Family Violence' Watch short video "Start the Conversation "	Up to 1 hour
Week 4-5	Interact	Whole of Practice Training Session 1	90 minutes
Week 5	Learn	Complete practice audit and Reading	Up to 1 hour
Week 6	Interact	Clinical Practice Training Session 2	90 minutes
Week 7	Review	Undertake HealthPathways 'Domestic Violence' and Reading	45 minutes
Week 8	Evaluate	Complete training evaluation form & post-training survey	15 minutes
Week 9-12	Sustain	Follow-up with the FV support worker	60-90 minutes

Practice training sessions

As COVID-19 took hold in 2020, strong relationships with practices and the practice managers became very important – frequent consultations were required to confirm the training sessions due to recurrent rescheduling in response to COVID-19 changes and vaccination requirements. A total of 52 sessions were delivered either in the morning, lunch hour, late afternoon or evening depending on the practice's preference. The first training was delivered in February 2021 and the final in April 2022 (see Table 6 for further details).

Table 6: Outline of training at participating practices

Practice	Session 1	Session 2
1	25/02/2021	18/03/2021
2	2/03/2021	23/03/2021
3	25/03/2021	15/04/2021
4	22/04/2021	6/05/2021
5	18/05/2021	13/08/2021
6	2/03/2021	23/03/2021
7	11/08/2021	24/08/2021
8	23/08/2021	6/09/2021
9	20/08/2021	3/09/2021
10	1/09/2021	15/09/2021
11	19/08/2021	2/09/2021
12	1/09/2021	15/09/2021
13	23/09/2021	14/10/2021
14	9/09/2021	30/09/2021
15	17/09/2021	1/10/2021
16	25/11/2021	9/12/2021
17	10/08/2021	24/08/2021
18	19/10/2021	15/10/2021
19	23/11/2021	7/12/2021
20	17/10/2021	24/11/2021
21	18/11/2021	2/12/2021
22	1/03/2022	8/03/2022
23	9/03/2022	23/03/2022
24	24/03/2022	14/04/2022
25	17/03/2022	28/04/2022
26	29/03/2022	19/04/2022

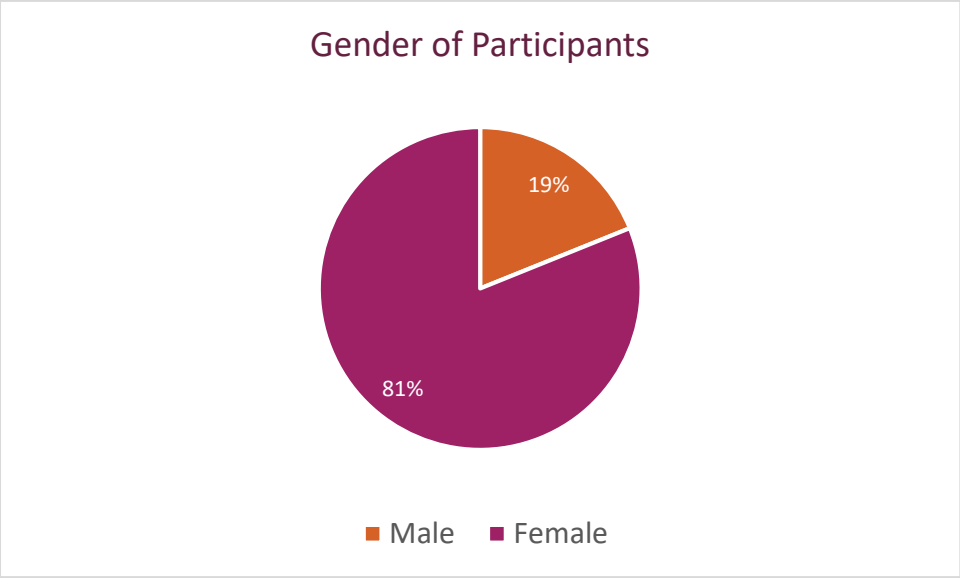
Although 254 people registered to participate, the consequences of the COVID pandemic resulted in a significant drop in attendance on the day. The number of participants attending the individual training sessions was wide ranging; the smallest group was two clinical staff, and the largest group trained was twenty-five staff.

The next section outlines the characteristics of training participants.

Characteristics of training participants

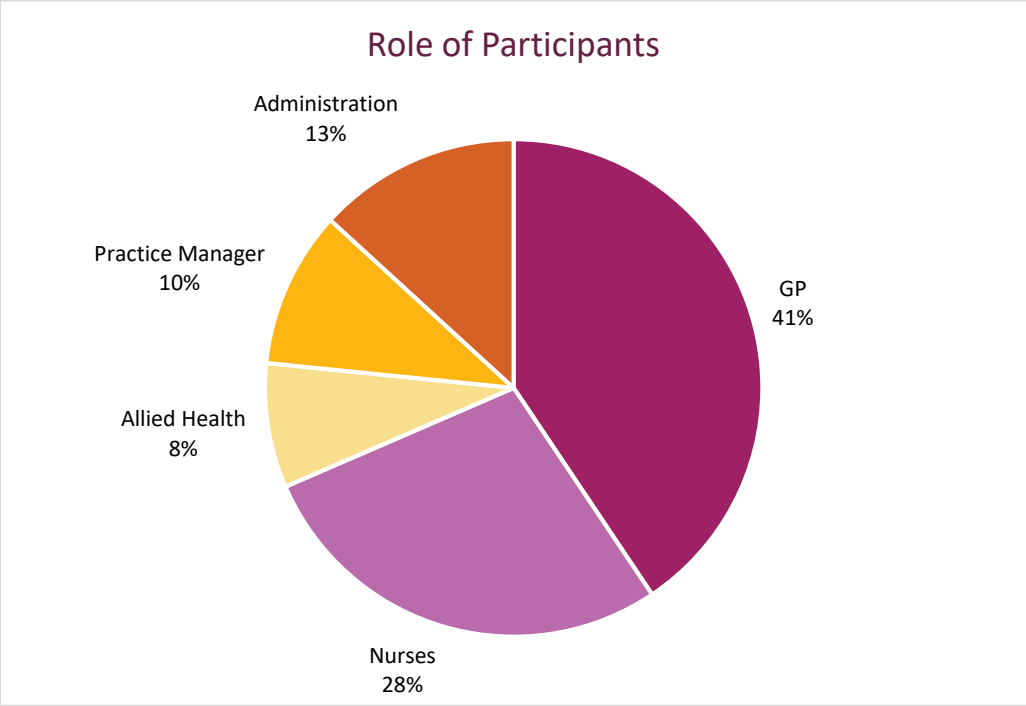
All staff registered for training were sent pre reading materials, and a total of 197 staff participated. The majority were female (81%); 9% were male and 1 participant identified as other (see Figure 14).

Figure 14: Gender of participants: Wave 1-5



Most attendees were GPs or nurses (69% combined) – this was followed by administration staff, practice managers and allied health professionals (see Figure 15).

Figure 15: Role of participants: Wave 1-5



A breakdown of participating staff by practice is shown in Table 7.

Table 7: Characteristics of participating staff by practice

Practice	Registered	Attended	Role						Gender	
			GP	Nurse	Allied Health	PM	Admin	Other	Male	Female
1	12	7	2	2	1	1	1	0	2	5
2	10	7	2	2	0	1	1	0	2	5
3	15	9	5	1	0	1	2	0	2	7
4	25	21	4	5	7	1	4	0	2	19
5	15	15	9	2	0	1	3	0	3	12
6	2	2	1	1	0	0	0	0	1	1
7	6	6	2	1	1	1	1	0	2	4
8	33	25	6	12	5	1	1	0	3	22
9	7	7	1	1	2	1	2	0	1	6
10	2	3	1	1	0	1	0	0	1	2
11	4	3	1	1	0	1	0	0	1	2
12	2	2	0	1	0	1	0	0	0	2
13	4	4	1	2	0	1	0	0	1	3
14	16	10	5	3	0	1	2	0	0	10
15	3	3	1	1	0	1	0	0	1	2
16	8	8	4	2	0	1	1	0	1	6
17	13	6	4	1	0	0	1	0	0	6
18	7	6	3	1	0	1	1	0	0	6
19	10	6	1	2	0	1	2	0	1	5
20	10	5	3	1	0	1	0	0	0	5
21	6	2	1	1	0	0	0	0	1	1
22	11	10	7	2	0	1	0	0	3	7
23	9	8	2	3	0	1	1	1	1	7
24	7	6	3	1	0	1	1	0	1	5
25	10	11	7	2	0	1	1	0	4	7
26	7	5	3	1	0	1	0	0	3	2

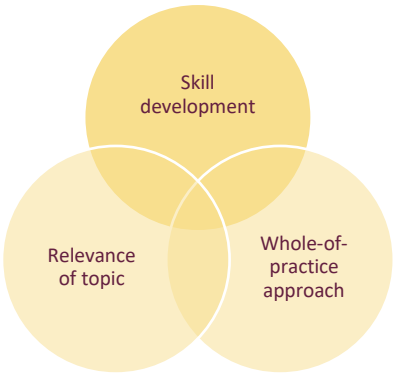
Motivations for participation in training

'I would like to improve my knowledge and skills to effectively respond to family violence in the clinic setting. Responding effectively to family violence in a medical setting requires non-judgemental, supportive attitudes, a knowledge of the physical and emotional sequelae of the violence, an understanding of appropriate and inappropriate responses, and on having good networks with local family violence services.' (GP)

There were open ended questions in the surveys that provided pre training reflections, and interviews with training participants, which were thematically analysed and grouped in major themes as outlined below. The staff articulated several themes around what they hoped to gain from the Program pre-training, and from the interviews why they were motivated to participate.

Pre-Survey

Main reason for participation



Prior to commencing the training survey participants were asked about the main reason they had chosen to take part in the program. Responses largely fell into three broad but overlapping themes: skill development, relevance of the topic, and the whole-of-practice approach.

Whether it was gaining knowledge and learning new skills, or building on their existing knowledge and skills, respondents spoke about skill development as an important reason for participating in the Program. Many went on to link this with providing better care – this was the case for both non-clinical and clinical staff. Where specific content was mentioned, it usually concerned the identification and management of family violence, while some respondents also had a desire to know more about the resources available for people affected by family violence.

'It would be great to learn and very helpful since we deal with initial phone calls and opening the door. It would be great to know how to deal with issues.' Administration

'General practice gives me the opportunity to get to know patients of the practice well and allow them to hopefully feel safe to disclose when they're experiencing violence. Being more aware and open to starting a discussion, looking for signs and providing a safe environment to allow the patient to feel they can disclose is such an important part of our role.' Nurse

'I think that family violence is very prevalent yet undetected, and so I want to learn more about being able to identify family violence as well as learn about different outlets where I can further assist my patients who are experiencing family violence.' GP

There was also a mention of building confidence by undertaking the training.

'So that my staff can have a better understanding of how to approach the subject with clients and how to better ask questions. What the referral pathways are and to build confidence in themselves and their patients.' Practice Manager

'Improve my confidence in dealing with family violence victims in a safe and sensitive manner.' GP

The decision to participate was generally decided at a practice level, and thus a whole-of-practice approach to training as a motivation also emerged. Other respondents spoke positively about undertaking training as a group/at a practice level, and the desire to provide a whole-of-practice awareness and approach concerning the identification of and response to family violence.

'We as a whole Clinic have decided to participate in this program to better understand the women that deal with domestic violence.' Practice Manager

'Recognising the depth of the problem in Australia, we wanted a whole-of-practice approach which brings along the GP, nurse and administration staff' GP

Highlighting the relevance of FV as an issue to the community in which their practices operated, amongst the patients who attended the practice, or at an individual patient practitioner level were all motivators for participation.

'Given the location of the practice, there is quite a lot of family violence and its something as a clinic that we need support on and confidence in dealing with.' Nurse

'High prevalence in my patient population. Desire to provide better care to patient. Improve patient outcome. Enable other members of the practice to participate effectively and constructively in dealing with family violence.' GP

There were a few references to an increase of family violence in the context of the COVID pandemic.

'Family violence has increased in the current pandemic and it is an area that I am not confident in - so i would like to increase my knowledge and also help support those individuals and families that are effected by family violence.' Nurse

Interviews

In the interviews with 14 staff participants, similar themes to above were found with the main theme being:

Theme: Motivation from identified need in the clinic

There was a combination of reasons why participants got involved in the training. For most, the idea was initially introduced by their practice manager or some other colleague who helped to arrange for the clinic's staff to receive training. Despite being initiated by others, most participants were motivated by a personal interest in the training. Some recognized the need to upskill and gain more confidence by reflecting on their previous interactions/experiences with their patients. Others had a keen interest in DFV issues and thought it was an opportunity to learn more. Reflecting on the demography of patients they generally attended, some participants identified the training as one which held value for their practice and patients.

'Well, I think there's probably two layers to the answer to that question. The first one is, in all honestly, it was instigated by one of my colleagues. So, it was [name] who I think told us about the program and said look this looks really interesting, is this something that you guys want to do? They

usually want a cohort of us to do it. That got me thinking, and that's sort of the second layer, and in my head, it was like well actually, yes, I would like to do this, because I felt – I didn't feel very confident in that area of my practice.' P3, GP

'It was part of the team education, so I thought that was important. Also, look, I think in my experience of 20 years of being a GP, I feel like family violence is probably one of the last - even though I feel that I try and ask about it, I find that it's the thing that I come up with the least. I grew up in a situation with family violence, myself. So as far as my parents, and it was pretty hairy in the '70s. So, it's something that I'm aware of myself, and I've lived through as a nine-year-old, 10-year-old kid, and so it's not something - it's something I'm very aware of, and I also am aware that I could, with that experience, try and block it or deny it, which I don't think I do. I just think that it's one of those things that people find really difficult to talk about, and so trying to work out which questions to use to help unlock.' P13, GP

This section has outlined the motivations for attending the training program. The next section will outline how the learning needs of training participants were met.

Evaluation of the training delivery

The focus in this section is around participants views about the training program and the extent to which it met the program aims and personal objectives.

Quality of the training program

A total of 61 participants completed the evaluation sheet – 32 were non-clinical staff and 29 were clinical staff. Amongst respondents:

- 98.4% rated the overall quality of the training as 'Good' to 'Excellent'
- 96.7% rated the learning gained in Session 1 (overview and discussion) and 100.0% rated the leaning gained in Session 2 (role play and simulation) as 'Good' to 'Excellent' (clinical staff only).
- 98.0% rated the leaning gained in follow-up as 'Good' to 'Excellent'
- 96.7% rated the appropriateness and length of training program, and amount of material covered, as 'Good' to 'Excellent'
- 100.0% rated the opportunity to ask questions and to interact as 'Good' to 'Excellent'

Learning objectives met

Three specific learning objectives were considered – 'Improved communication skills', 'Increased understanding of patients' point of view', 'Ability to reflect on own attitudes to DFV'. For all, participants indicated learning needs were 'Partially' or 'Completely met' (see Table 8); the vast majority indicated their learning needs were 'Completely met'. When asked to rate the degree to which their *overall* learning needs were met, 18.0% of participants responded with 'Partially' while the remaining 82.0% indicated 'Completely met' (see Table 8).

Table 8: Meeting learning needs

Learning objective	Not at all met %	Partially met %	Completely met %
Improved communication skills – active listening and responding skills	0.0	14.8	85.2
Increased understanding of the point of view of abused patients	0.0	21.3	78.7
Ability to reflect on my own attitudes to DFV	0.0	10.0	90.0
Overall, the degree to which your learning needs were met	0.0	18.0	82.0

Total n = 61; denominators vary

Resources

Participants were asked how useful the resources provided to them were including: Handbook, eLearning module on DV, RACGP White Book, referral resources, HealthPathways.

Amongst non-clinical staff (see Table 9):

- the 'RACGP White Book' and 'Referral resources' were least frequently used – not used by 53.3% and 35.5% of respondents respectively
- very few respondents felt the resources were 'Not at all useful' and 48.4% found the 'eLearning module on DV' 'Very useful'.

Table 9: Usefulness of resources: Non-clinical staff

Resources	Very useful %	Quite useful %	Not at all useful %	Did not use it %
Handbook	29.0	58.1	0.0	12.9
eLearning module on DV	48.4	32.3	3.2	16.1
RACGP White Book	20.0	26.7	0.0	53.3
Referral resources	29.0	35.5	0.0	35.5
HealthPathways	32.3	38.7	3.2	25.8

Total n = 32; denominators vary

Amongst *clinical* staff (see Table 10):

- 41.4% 'Did not use' the 'RACGP White Book'
- 'eLearning module on DV' and 'Referral resources' were the most frequently used and 44.8% indicated the 'eLearning module on DV' was 'Very useful'.

Table 10: Usefulness of resources: Clinical staff

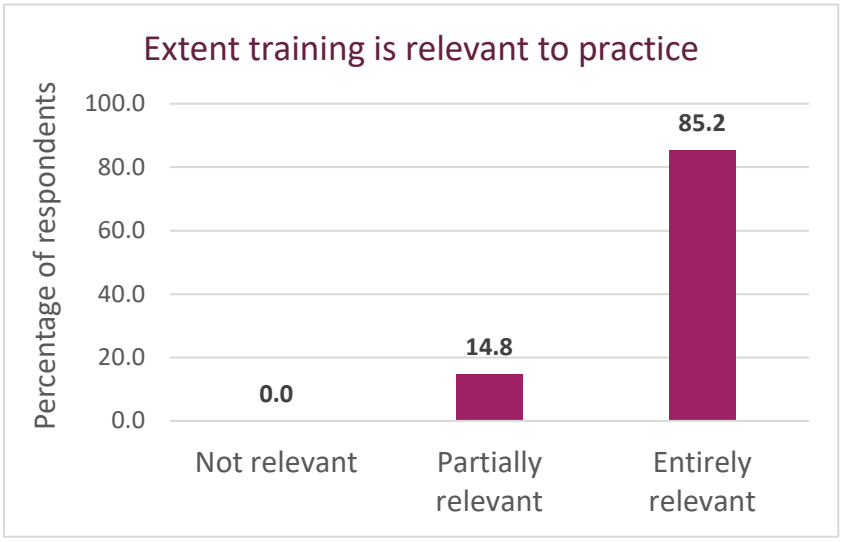
Resources	Very useful %	Quite useful %	Not at all useful %	Did not use it %
Handbook	27.6	41.4	3.4	27.6
eLearning module on DV	44.8	44.8	0.0	10.3
RACGP White Book	24.1	34.5	0.0	41.4
Referral resources	37.9	51.7	0.0	10.3
HealthPathways	24.1	51.7	0.0	24.1

Total n = 29

Training Programs relevance

Overall, 85.2% of participants rated training as 'Entirely relevant' to the needs of their practice.

Figure 16: Overall view of the training relevance



Outcomes of the intensive training program

Survey Results

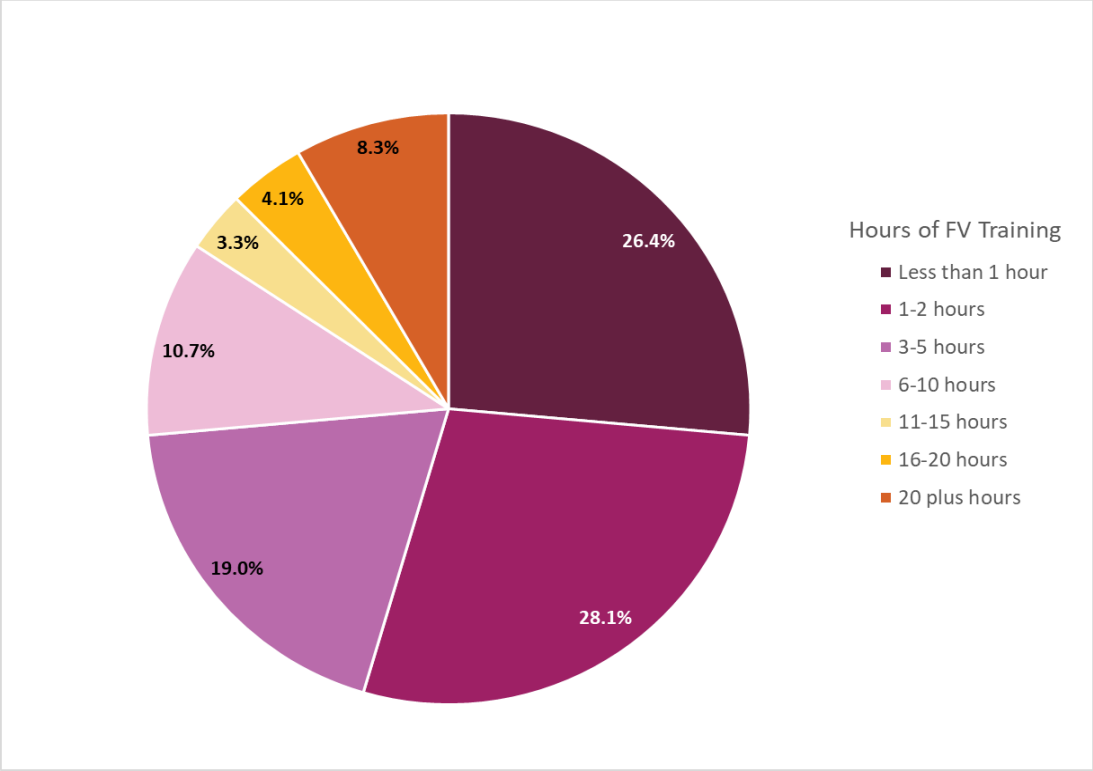
Characteristics of participants

A total of 121 clinical staff returned a pre-training survey before participating in the training – GPs (n = 66), nurses (n = 44), allied health (n = 11). There were 84 post-training surveys returned with 60 clinical staff responding to both the pre *and* post surveys. Amongst the 121 pre-training survey respondents the average age was 42.9 years with a range between 21 years and 74 years. Three quarters (76.9%) were females and one fifth males (20.7%); 'Other'; 'Prefer not to disclose' or did not respond comprised the remaining 2.4%. Amongst the GPs and nurses, the average time participants had spent working in general practice in Australia was 11.3 years with a range of two months to 51 years. Twenty-nine had worked overseas – the average time engaged in this work was 4.8 years with a range of six months to 10 years.

Previous education and training concerning managing family violence

Previous education or skills training for managing family violence was minimal. Around one quarter had spent less than one hour in such activities during their career, and over half had spent only two hours or less during their career. The pie chart in Figure 17 (below) shows a breakdown of participants based on the amount of family violence education/training they had undertaken during their career.

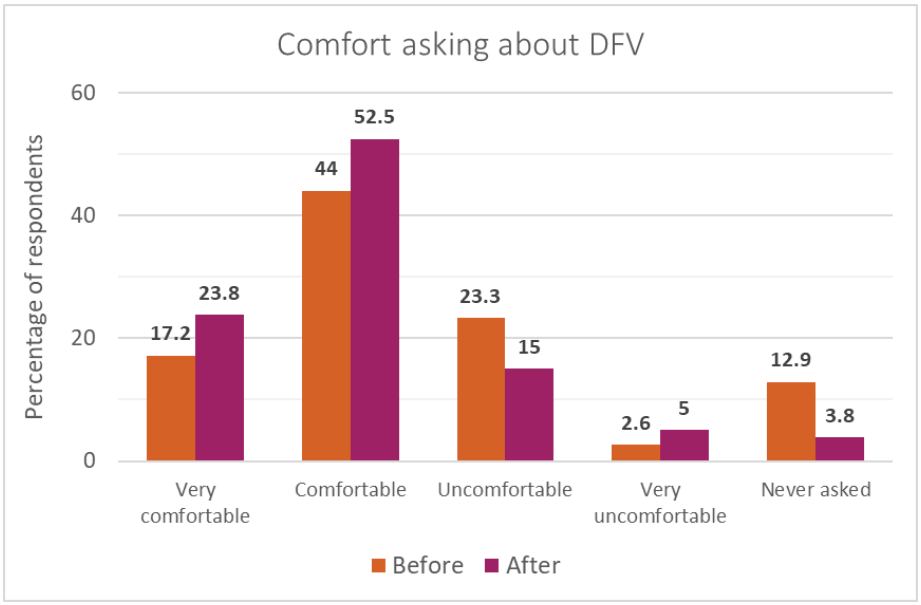
Figure 17: Hours of education concerning management of family violence for clinical respondents



Inquiry about domestic and family violence before and after training

Clinical participants comfort asking patients about DFV before and after completing the training is shown in Figure 18. After training, three quarters (76.3%) of participants were 'Very comfortable' or 'Comfortable' asking about 'DFV' compared with 61.2% before training. 'Never asked' fell to 2.8% after training from 12.9% before training. However, 20.0% were still 'Uncomfortable' or 'Very uncomfortable' asking after training.

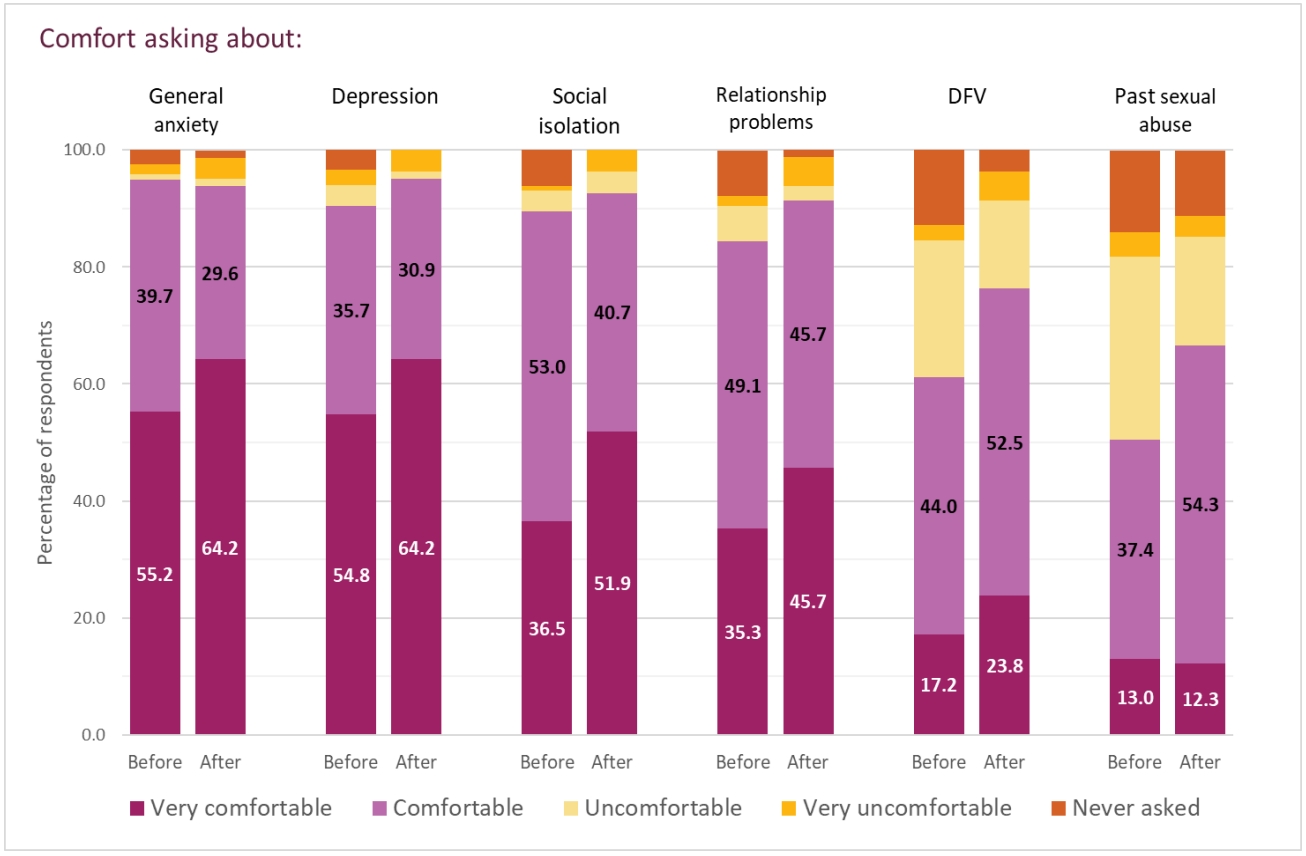
Figure 18: Level of comfort asking about domestic and family violence



Before: n = 121, After: n = 84

In addition to DFV, participants comfort asking about 'General anxiety', 'Depression', 'Social isolation', 'Relationship problems' and 'Past sexual abuse' were investigated – see Figure 19. This shows that following training respondents showed marked improvements in asking about DFV compared with the other areas.

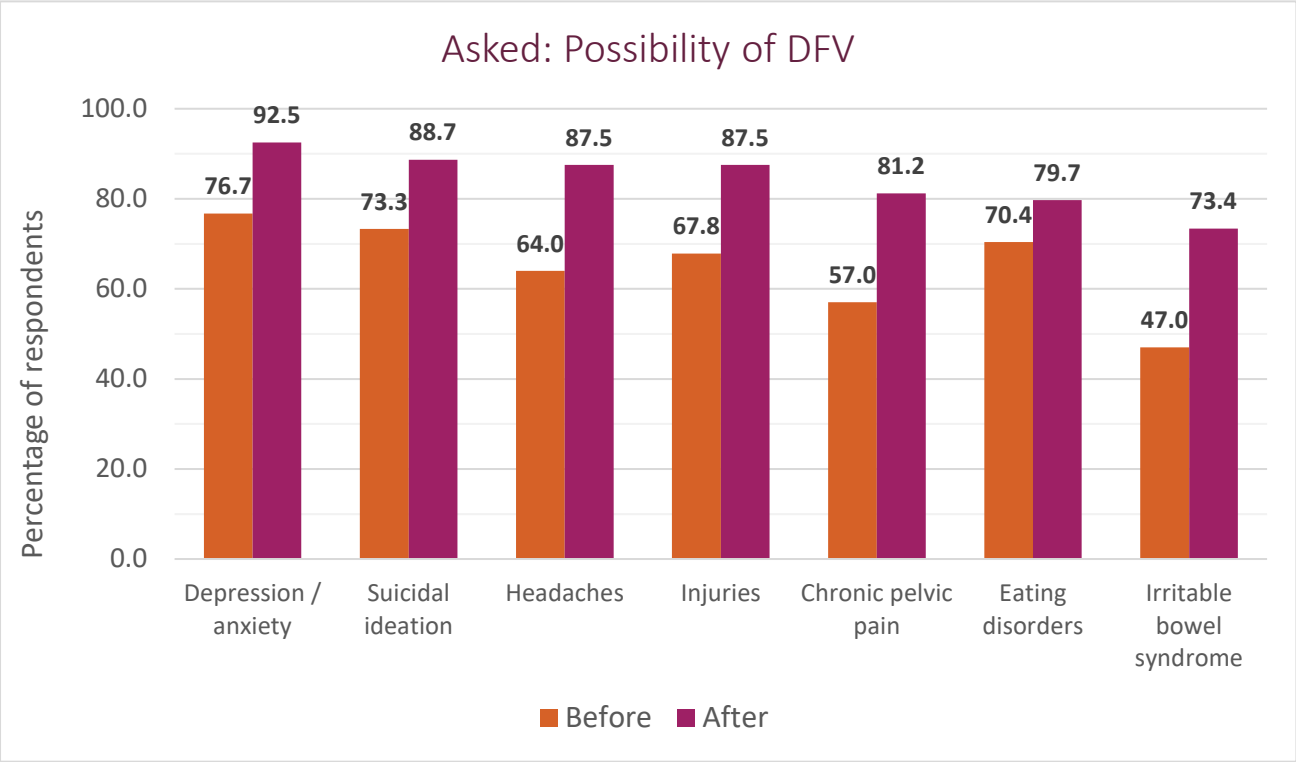
Figure 19: Level of comfort asking about problems



Asking about the possibility of DFV

Figure 20 presents the percentage of respondents who asked about the possibility of DFV when seeing patients with a variety of different presentations before and after the training. This shows there was an increase in the proportion of participants who asked about DFV for all presentations. The change was greatest for 'Irritable bowel syndrome' (26.4% increase) followed by 'Chronic pelvic pain' and 'Headaches' (24.2% and 23.5% increase respectively), and least for 'Eating disorders' (9.3% increase).

Figure 20: Possibility of DFV when seeing female patients



Before: n = 121, After: n = 84; denominators vary

Readiness Scale

The readiness scale comprises three sections – 'Self-Efficacy', 'Motivation Readiness' and 'Emotional Readiness'. Scores for each section were calculated for participants who completed the *both* the before *and* after survey questions with the mean (average) and range for each displayed in Table 11. Whilst there was an improvement for all after training, this was greatest for 'Self-Efficacy'; there was only a small improvement for 'Motivational Readiness' and 'Emotional Readiness'.

Table 11: Readiness Scores

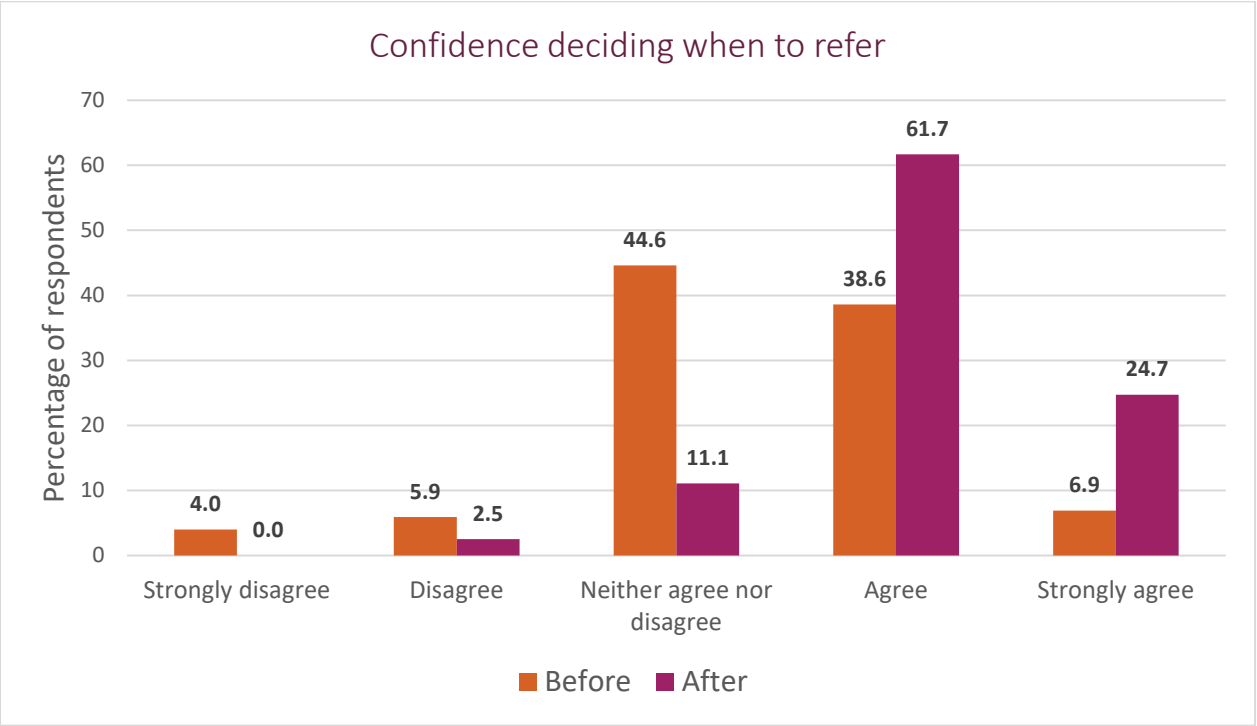
Scores	**Maximum Score possible**	**Before**		**After**	
		Mean	*(Range)*	Mean	*(Range)*
Self-Efficacy	65	40.9	*(19 – 56)*	50.2	*(34 – 65)*
Motivational Readiness	35	29.0	*(21 – 35)*	30.4	*(23 – 35)*
Emotional Readiness	50	33.5	*(23 – 42)*	34.2	*(24 – 46)*

Matched for individual before and after responses: n = 60, denominators vary slightly
Scores based on a 5-point Likert-type scale

Referral

Overall respondents' confidence in deciding when to refer a patient for support services was enhanced after the training compared to when they had not been trained. After undergoing training, the percentage who 'Strongly disagreed' or 'Disagreed' they had confidence dropped from 9.9% (before) to 2.5%; those who 'Neither agreed or disagreed' fell from 44.6% (before) to 11.1%; and those who 'Agreed' or 'Strongly agreed' they had confidence increased from 45.5% (before) to 86.4%.

Figure 21: Confidence deciding when to refer

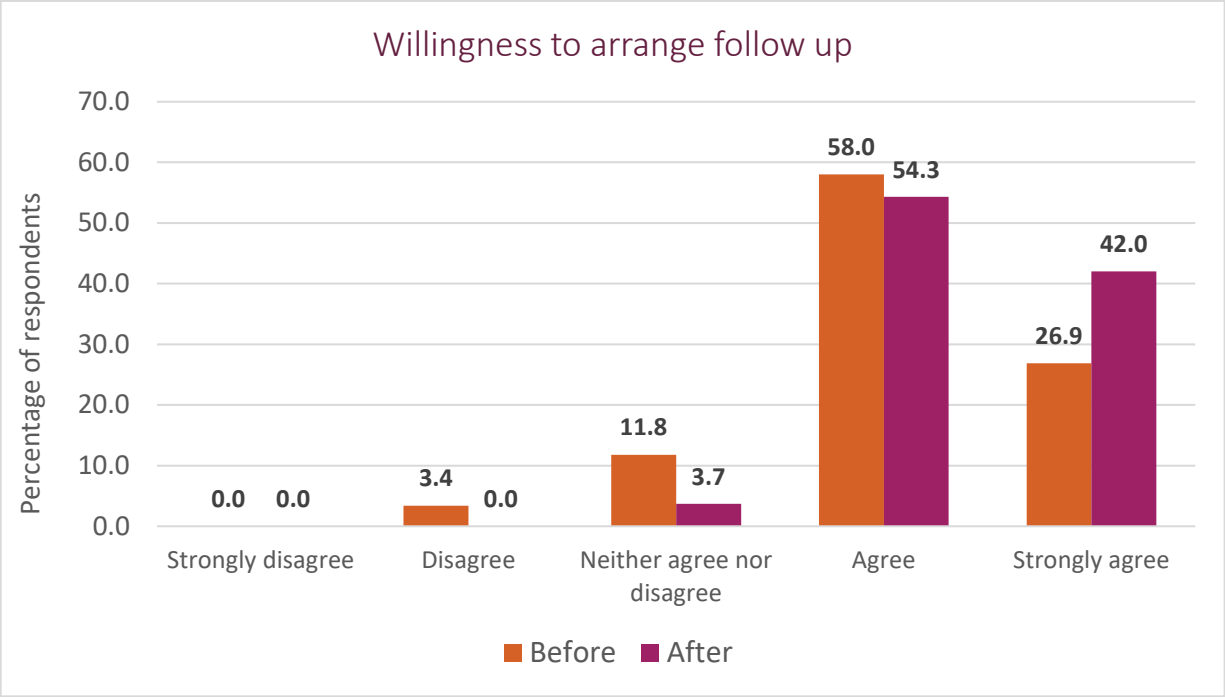


Before: n = 101, After: n = 81

Follow up

Respondents were asked about how willing they were to arrange a follow up appointment to provide support to patients experiencing DFV (see Figure 22). Overall, 84.9% 'Agreed' or 'Strongly agreed' that they were willing to follow up pre training compared to 96.3% willing to do so post training.

Figure 22: Willingness to arrange follow up



Before: n = 119, After: n = 81

Post training staff participant reflections on participating

As part of the evaluation the participants were asked in a post survey to further elaborate on the Program and reflect on any changes they experienced in relation to knowledge, skills and attitudes around family violence throughout the delivery of the training and after.

In general practitioners spoke very positively about participating in the education program finding it relevant, informative, helpful, and practical. There was also frequent mention of the benefit of undertaking the training as a practice.

'Extremely useful. It brought us together as a practice and gave valuable knowledge and information for us to use practically. I think it has changed all of our practice.' GP

'The programme is excellent, self-learning, interactive and very insightful to staff and Doctors' GP

A few spoke about the quality of the program and presenters.

'Very informative and interactive. The program was structured well and made everyone attending feel very comfortable to discuss family violence.' GP

'Well designed, right duration, informative. Excellent communication and coordination.' GP

'Good having the GP facilitator and the domestic violence social worker' GP

Some participants wrote about what they had gained from the program and/or how it had encouraged them or built their confidence around working with patients experiencing family violence. This included the prevalence of family violence, and identification and management of family violence.

'As an Allied Health professional, it can be daunting to ask questions about DFV. As I work with pregnant and new mums, I am aware that this can be a difficult time in a relationship. I try to find

ways to ask questions such as: how is life at home? is dad coping? acknowledge that a child can change a relationship. The training has encouraged me to continue this practise and trust my gut if I think things may not be ok. Accept that it may take a couple of appts to build up a relationship to get the information. Then if I need to see them for longer than normal to assist them to seek alternate services that's ok.' Allied Health professional

The program was very practical. I liked the data on DV which then put context around the prevalence of DV. I am a visual person so liked the graphs etc. Possible clinical presentations of a woman or child who is experiencing DV and a man who is using violence was very helpful. Practical models were great tools for future use: LIVES, Safety plan, CARE model.' Allied Health professional

'The programme was very educational increasing my awareness of the prevalence of DV. The format was clear and comprehensive. I feel much more aware of the issues and will ask more of my patients. I feel more familiar with inquiry pathways and avenues to get advice and information.' GP

However, most participants found helpful the information concerning referrals and resources.

'The overall training was very educational and refreshed a lot of knowledge. It also helped us to get access to more pathways of referral and the resources.' GP

Most participants wrote positively about the program, although it was recognised that it was undertaken by people with a wide range of prior knowledge and skill in the area of family violence.

'The educational program was somewhat new to me. As a recently graduated nurse in a general practice, this educational session was very beneficial. The confidence in asking questions, the support services which I wasn't aware of were of a great knowledge. At least, now I know, what skills I can use, assessments, and responses I can practice, to help to prevent further abuse by placing barriers between victims and the abuse' Nurse

However, some respondents felt it was going over material they were already familiar with and were putting into practice.

'I think that there was a varied skill mix of staff attending the training and it was pitched at an entry level. Many of us attending are working in this space and asking the direct questions on a regular basis.' Nurse

The next section provides more detail from a small group of participants who were interviewed about their experiences.

Staff participant reflections

Themes

The four main themes derived from the interviews around staff participants views on the training were: benefits of the innovative approach to meeting a knowledge and skill gap; valuable doing it as a team with the whole of practice approach; confidence building to start the conversations; and training components and design were engaging.

Theme: Innovative approach to meeting a knowledge and skill gap

All participants reported that the training was worthwhile to them and their practice. There were related comments about the program design, that is, being conducted in a way that took cognizance of specific GP or primary care practitioners' needs. These included the length of the workshops, the scheduling of it in the day, the engagement of both a GP and a FV support workers as co-facilitators (combining valuable expert knowledge for the target population) as well as the option to consult with or follow up with FV specialist services after the training, when needed. A bonus gain was the 40 Continuing Professional Development points for undertaking the training.

> *'There were a number of workshops - I must have attended two or three - I would have been one of two or three male doctors out of 30 who attended the workshop. So, I thought - so the reason for participating in this is now, five six years have gone by, and I was interested to know what has transpired in this space. So, when I saw the nature and the quality of material that was being offered and the approach that was being provided through both a patient-centred, doctor-centred but also clinic-centred approach, I thought this was very sensible, and I'd like to learn more about it. …I think it's probably one of the most comprehensive and well-presented programs that I've ever attended, to be honest, because it's extremely well organised. It has an awful lot of resource material. The resources handbook is 80 pages, and it's packed full of information and material, but it also has these valuable vignettes, these clinical scenarios which I know some of the people who feature in them, but the clinical scenarios really bring it to life. The integration of the theory with practice, the inclusion of a clinical audit, the checklist for the practice checklist and the actual workshops, the two workshops that we had, it's a beautifully integrated program, and I think is quite unique.' P11, GP*

> *'I think that the program's got a lot in it and so there's the potential to learn all sorts of things and that domestic - it's scary how common it is and how unrecognized it is, so it's definitely worth having your eyes open to. Having the right tools to go about it in a way that is not going to make things worse, and then knowing what to do like being linked in with some services that can assist the women, I think is very powerful. The number of hours wasn't particularly onerous for the 40 points, so I think that people wanting to get their 40 points, it's a really good way to do it.' P1, GP*

Theme: Valuable doing it as a team with the whole of practice approach

Overall, participants were very positive about various aspects of the program, particularly, the whole-of-practice approach adopted in the training. Although identifying and responding to DFV is usually within the scope of practice only for clinical staff, participants felt that training all staff meant that everyone was on the same page in terms of the practice' strategy towards DFV. Further, non-clinical staff would be alert to or aware of signs to look out for, and DFV became a topic that was much easier to discuss within the practice.

> *'Well, this was quite novel, and I don't think we knew exactly how this would go. The doctors in the practice had had obviously experience in around the area of domestic violence, but we'd never approached this from a whole of practice - in the whole of practice setting, involving the practice*

nurse and the receptionist. It actually opened my eyes to the importance of the whole of practice setting, especially in the small practice where very often, as is the case here, the receptionist in our practice has been working in the same practice for 35 years. She has intimate knowledge of almost every patient who is a regular attender of the practice, and so she probably carries more knowledge than I do and possibly more than our software program. So, bringing her in and using that knowledge and getting her involved was really quite enlightening and quite meaningful, and meaningful for her, too, because it validated her role.' P11, GP

'I actually think that was a really good idea to be able to do it with my colleagues. I think one of the things that facilitates is you're open to participating. I think if you had to sort of warm up to a group of people you weren't particularly familiar with, or didn't work with, I think it would have been a slower progress in terms of getting in there and participating, and actually doing the role plays and things like that. I think I would feel a little bit more hesitant and maybe just stand back a little bit and just go oh, you guys go ahead and do it. So, I think doing it as a group of people that you know, I think is good; I think it's a good one to do as a small group activity. …Yes, so off the top of my head, so again, speaking from a participant point of view, I like the idea that we had both the GP and [name of FV worker] there as well. So having both of them, because they provide different perspectives, so that's really, really useful. I think the other facet of it that I think is really, really good, is that it's multidisciplinary. So, it wasn't just clinicians, that we were – particularly in the first session because we were able to engage our clerical staff in that as well. Because like I said, we like to think we're a team. We all function inter-dependently of each other, not separately. So that was really good to do that together with everyone including clerical staff. So, I think that's a really key part of the thing itself.' P3, GP

Theme: Confidence building to start the conversation

Participants reported positive impacts of the training on their individual practices and on their clinics as a whole. It was evident from several participants that the training had provided essential information and skills about FV and boosted the confidence of clinicians on identifying and responding to FV.

'Yes. The practice and me as well. It helped me to be better in conversing, in starting the conversation, in talking, in approaching someone and be confident in doing it. Yes. I'm actually able to recognise subtle signs. I am able to, in a subtle way, confidentially, offer or educate that there's resources out there. Even in my community, when I see it, I'm able to recognise it.' P9, Nurse/Practice Manager

'Yes – the entire team has felt very positively since the training was both arranged and completed. We feel more confident in how to ask about DV, when, how, and how to also approach this issue via Telehealth consultations.' P5, GP

'Yes, I feel a bit more confident in asking the question and you know especially being from another culture, you have to be more careful how you question something like that. Especially for me, especially with my cultural background and stuff like that. So, I think I'm a little bit more confident and also that the patients know me a bit better, so I'm a bit more comfortable in asking that question.' P15, Nurse

'But certainly, I have picked up on other cues in people who again I have a telephone consult. …I obviously picked up on a cue that there was something that wasn't quite right, and I don't think I would have pick up on that otherwise. I felt much more confident in, again, being able to assess

someone's safety. I think from my point of view as a GP, their safety is – that's the most important thing and there was a lot of lines. Like I had the idea of the use of a line, you know you've got a line that you say to someone because I do like things to be natural. But certainly, I had more tools in my backpack in terms of things like being able to say, you know it's never okay for someone to feel threatened or harmed by their partner. Having those kind of – feeling the confidence that that was the right thing to say, like you always feel like oh, I don't want to say the wrong thing, so then we don't say anything.' P4, GP

Theme: Training components and design were engaging

Views about various aspects of the training program were shared. These included the module content, structure of the program (including provision of resources and opportunities for follow up with specialist FV worker/service).

Content

The practicality of the training content resonated with a lot of the participants. It was clear that they could relate to the discussions, particularly the variety of examples of what they might seek out when working with patients in their practices.

'I think just being made more aware of how common it was, was really very powerful. ...that just being aware of it and being aware of why it's so difficult for women to bring it up and why it's so difficult for them to extract themselves from the situation, I think it's - all you guys do is increase awareness of that, that's a really huge start, isn't it. But that was just generally interesting, those sort of, that mind map of what's going on in your life at the moment, I hadn't seen that, and I think that's a really good thing that you [unclear] whole mental health consults or someone comes in for a mental health plan, we do that - a bit of that at any rate, but just having that formalized is quite good. Being reminded about [readiness] to change, those sorts of principles are good. There's been a lot more stuff about trauma-based care and so that was something I haven't done much training in and so that was there - you know, resources to read about.' P1, GP

Different aspects of the content also opened up new ways of thinking for several participants. The subject matter was articulated in a manner that participants found illuminating. A significant outcome of the training was that some potentially inaccurate notions held about victim/survivors regarding why women stayed in abusive relationships, likely symptom-related presentations of FV to clinics and assumptions about socioeconomic status of affected women were changed.

'I feel the program has really opened my eyes as to the inequalities many women face and the huge variety of reasons for not seeking help/change, as well as looking at the reasons why women can find themselves in situations where they are more likely to be a victim of IPV.' P5, GP

'I liked everything – I mean obviously the program is very well done, everything linked in, so it was kind of – I don't know why this is stuck in my head, but that thing about women who present with headaches and that – and I don't know why that stuck in my head. I think it was all of the different presentations that family violence could come to you with, and I thought oh, that for me was very practical. Because that was like okay, these are the places where you should be looking for the cases, and I liked that, yeah.' P4, GP

'Even when I was doing the modules, there's certain things that I'm like, okay, I as a nurse thought that sexual coercing is just a form of abuse; coercing someone to do something that they're not willing to. I hadn't realised that it's really out there. Even in my community when I see it, without

putting someone in danger or anything, I'm able to educate them, I'm able to bring it up in the conversation.' P9, Nurse/Practice Manager

'It was just - you mightn't expect this to happen in these particular socioeconomic strata, but it does. …But it came as a bit of a shock. You don't expect to get a [name of profession] having this problem.' P11, GP

Structure

Most participants were pleased with the structure of the program which combined activities that made it both engaging and effective. The training plan included some pre-activities (including an audit), role plays and videos. Comments were also made about the handbook provided.

'Yeah, so oh well I did them [pre-activity]. I found them really useful, and again it was a good – it got you thinking straight away, so that when you went to the actual sessions, you had already been thinking about it, and you'd already been thinking about what are the things that you felt uncomfortable with. Because a lot of those questions within that module was asking you about what would you do …So, for me it [pre-activity] was, yeah, it was just sort of highlighting what already I was worried about, which is I don't have the confidence and sometimes I feel like I don't have enough knowledge to be able to do this.' P3, GP

'…but we did a bit of role play, which nobody likes doing a role play but it is actually good to do it.' P3, GP

'They were very, very helpful especially the three-minute video. I knew my strengths and my weaknesses, and the video helped.' P9, Nurse/Practice Manager

'Then the handbook, a wealth of information and knowledge. There's the what ifs, the grey areas that you think, what should I do in this situation? It's clear. Lots of reading but it's there.' P9, Nurse/Practice Manager

'… And then of course the handbook as a good reference point. I think the other thing that we got that we all really liked too was a number of – especially for the doctors – was that there were various websites that they could save to desktop that they could quickly access if they needed to or wanted to give a patient some sort of hard copy information or direct them somewhere. I think that was really useful too.' P2, Practice Manager

The next section provides some feedback from the facilitators involved in delivering the program followed by some suggestions for improving the education program.

Reflections from GP and FV support worker facilitators

Themes

Analysis of the five facilitator interviews yielded five themes: professionally rewarding, intersectoral approach created connections, valuable to clinicians and the whole practice, program implementation, and additional training needs.

Theme: Professionally rewarding

Overall, the facilitators demonstrated an earnest interest in the area of FV and in the idea of training others. They mostly found it both enjoyable and rewarding as it provided them an opportunity to learn and increase their own knowledge and professional skills while imparting some of that knowledge and skills to others.

> *'Yeah, it was. Um. It's been a good learning curve, because I think when you become educator, you're also forced to learn more about it. So, I think that's been really helpful for my own learning, and it's been good to share that learning and the experience with other GPs who are keen and interested. So, overall, I'd say it's been a positive experience.' P3, Facilitator*

> *'Yeah, I've loved being part of the pathways to safety program. Um, for several reasons. One, I think it's fantastic to seeing it rolled out so many GPs across so many regions now. Um! And it's exciting to say that there'll be so many GPs that are exposed to this content, because I think that this is content that's not covered elsewhere, for doctors very well, not much in medical school, and there's not much post graduate, either, so it's an area that doctors often don't have any training, and so I'm excited to see all that happening, and it's also been great for me, just growing as a both a clinician and educator and researcher. …I think first of all, just giving them an understanding of the dynamic of family violence. A lot of them, a lot of participants may not have actually understood what it was about being about power and control and so forth. I feel that a lot of participants come being a bit of a blank slate with that, or just having some preconceived ideas about what family violence actually is, and it's right to actually be able to teach an understanding of what it's actually all about um, and why it occurs, and so forth, so that that I think is really good.' P4, Facilitator*

Theme: Intersectoral approach created connections

The team approach adopted in the delivery of the program was greatly valued by facilitators regardless of their professional background. Participants acknowledged the unique knowledge and skills team members brought on board as a result of their professional backgrounds and experiences.

> *'...not only have we got a GP facilitator, we've got a family violence worker as well. And I think that teaming with them, I find extremely helpful, because they'll fill in the gaps for us, especially when it comes to more systemic issues and things so, and they also know a little bit more about what happens on the ground that we, as GPs don't necessarily have experience with. So, I really like having the family violence worker. I don't think it would be as rich if it was just a GP presenting to the GPs.' P3, Facilitator*

> *'So, a GP working with a family violence connector is a really great combination, because you've got that rich wisdom that the family violence connector has from all their years working in that sector. Um, and particularly when it comes to doing things like risk assessments and an understanding of the system, and all that sort of thing, and understanding the dynamic of family violence, I guess as well. And then you've got a GP clinician who understands what it's like to be sitting in a GP Practice and asking these questions and having responses and um, I think that's really powerful.' P4, Facilitator*

It was also recognized that the initial connections created from participating in the program were likely to yield further outcomes in the future, even if clinicians had not made contact or followed up with FV support workers in the short term.

> *'I think it was a fairly unique opportunity to reach out to GPs. I think that it's probably a pocket that we don't often get access to, and to be able to um talk to GPs about the impacts of family violence with victim survivors and children as well as. You know what kind of things they could do with perpetrators, or you know, kind of like things to look for, and I in my experience with the clinics that we went to, there was some really good will. I think that even if a clinic doesn't reach out, I think there was some disappointment in the program that clinics didn't follow up um with FV worker, and you know the FV worker reached out to them a few times, and sometimes they didn't get any uptake. The[name of service], did information packs because, even if a clinic never contacts again, at least you've got some information that they could give to their clients. I think that people attended the training is the real golden nugget here. You know whether they choose to do anything with that or not. So the clinics in the West that we saw some of them had never heard of FV service, so that we could connect with them, but also then I think sending information packs to them, so that they had posters from different languages But then, if they ever, if they ever see someone and something connects, then they can go oh, actually, I know the service, and I've got a pamphlet. So yeah. And I think, having that opportunity to create connections is probably the great thing about the pathways to safety.' P1, Facilitator*

Theme: Valuable to clinicians and the whole practice

Participants identified the value of the training to staff in terms of providing a more in-depth understanding of the nature of FV and equipping them to be able to identify and respond to it in their practices. The potential benefits of the whole-of-practice approach employed was also important in participants' assessment of the program.

> *…But then I think, giving them the tools so that they're able to then start asking and responding in their own practices. Um. as they begin to realize that this is actually really common. I probably see this all the time without realizing I'm seeing it. The next step is, well, what do I do next? How do I go about it, and to be giving them tools to make that happen. I think that the training does that really well, so it starts from the - this is the dynamics of family violence, this is how it works. So, what can your practice do to be a more trauma informed environment? And then to how do you ask and how you respond and how you refer? So, I think it's quite nicely follows that pattern. Yeah, what else did they get out of it? Well, I think a deeper confidence in being able to ask about it and respond to it. I've asked many participants at the end how they're feeling about it about the training, and you know pretty much all of them say they feel more confident now to ask about family violence. …Yes, I love the whole of practice approach. I love the including, I think, in that first visit, including all of the non-clinical as well as the clinical staff, I think really I've loved seeing the non-clinical staff get so passionate and enthusiastic about this topic, and I think it's great for the clinicians to see this, and realize that they can actually include their staff in making a trauma-informed environment, and it's not just about what happens in the clinicians room. It's about what happens in the whole um the whole surgery. So, I like that aspect of it a lot. P4, Facilitator*

Theme: Program implementation

Opinions were shared regarding different aspects of the training program. There were mixed views about delivering the modules online compared to face-to-face. Participants identified pros and cons for both options. While the online mode offers the advantage of convenience including remotely engaging educators and clinic staff, in-person sessions provide better communication and group dynamics during sessions.

Mode of delivery of training

> *'Being online, it seems to work. I don't know if the outcomes will be as good. But again, at the end of the day you'll tell us that by uptake or referrals. I find some of the sessions depending on how they've done. I mean, if each one comes individually in their own video, it's a little bit easier to manage. But sometimes when you have groups around one laptop it can be a little bit more difficult. And you know, when it comes to doing some of the breakout groups or asking them to do the interview. It gets a little bit… I mean it works, but it, I think, having done them face-to-face where you actually have the actress in front of you, I think, gives you that real experience. So, I think online is adequate, I think face-to-face is better. But I understand that circumstances, money and time can be all impact upon that. …I think being online probably makes it more accessible to a lot to a greater group of people, because I imagine, if you tried to do this, all face-to-face, the rollout would be much slower and much harder and moving facilitators around be more difficult. So, I think that is a plus for the online. I think the online version has come at a time when people are actually getting quite used to doing it online. So, I think that's also been a plus.'P2, Facilitator*

> *'Yeah. So, I think the zoom setting is good …Because I think if you tried to do it in person, you probably get less people because it would be harder for things. Necessarily, you know, people don't find the time in their schedules, and it's hard for them to get there and hard to get everyone in the same place at the same time. There are a few downsides to having it in the Zoom setting. It is that as a facilitator, it can be a little bit harder to read the room. So, to understand what you know people's body language, and how they're feeling about the topic, for instance. It's much better when everyone has their own individual screen. And then also, you've got their name on the screen. So, it's much easier to interact with people. You have their names written directly underneath them. So, I guess one of the benefits is you, the facilitator doesn't necessarily have to be in the same place as the people that you're training. Um So you can have someone from the city training someone in the country, and vice versa. You could even have someone from interstate training. The downside, I guess with that is that would they have local knowledge um of you know services and things like that. So, it's better If you can have facilitators who are more local. It is better if you can, I think? But there is scope for facilitators from further away to you know. Be able to take sessions as well.' P4, Facilitator*

> *'Well, when the practices come online with everybody on the same computer that doesn't work very well, right. You can't hear what people are saying. You can't tell who's talking, so you It doesn't work well unless you've got the right sort of set up. So, one or two people on a computer is okay. But and then you know, so some of their setups haven't been very good, and that's much more difficult to deliver it. P5, Facilitator*

Use of role plays

The use of role plays was viewed positively by most of the facilitators.

> *'I love the role play. I think it gives GPs an opportunity to practice things and hear about how other people do things. … you know, sometimes, because I mean some of the GPs felt as if they're being*

judged, and I did wonder whether, on one of those days when we were being a bit rushed, whether it may have come across being brusque, you know whatever, you know.' P2, Facilitator

I also like the way that a simulated patient is used in session Two. I think that this is a really useful tool for teaching um, not just having slides on a screen that someone's talking to, which I think people tend to switch off when that's happening, and we know that that's not, you know, the most effective way to teach, but using other methods like having a simulated patient where they actually get to put it in action and practice. What they've learned, I think, and watch other people have a go as well and get feedback. I think it's really powerful. So, I love those sorts of tools being used. Yeah, P4, Facilitator

Time constraints

Although the FV support workers were eager to expand the program in terms of encouraging more discussions as well as the program content, there was no room to accomplish within 90-minute sessions.

'It can be a little bit pressed for time, and so keeping an eye on where things are. So, if you get a larger practice who are quite interactive, it can make you fall behind and in within the delivery of the program. The times are very tight, so you don't get a lot of room to manoeuvre, and so, you know you sometimes have to shut down some of the discussion to make sure that you keep the time. And yet, and I look I'd be very interested. I would suspect that often it's the discussion that really helps people move along a line of saying, oh, this is really important, and they're actually engaged. Um! So, you know, if there was a little bit of leeway. But again, the competing thing there is it's already one and a half hours.' P2, Facilitator

'What are the things that I'll change? I suppose it's probably going to be an expansion. But yeah, um, I it's hard, because I feel like we're hacking an awful lot into two ninety-minute sessions, and I feel like there's so many things that I'd love to be able to cover.' P4, Facilitator

Theme: Additional training needs

Participants identified a number of related topics they felt should receive a bit more attention as clinic staff would benefit from those in their practice. Despite the suggestions to place more emphasis on these areas, it was recognized that it could be challenging to fit it all in without running the risk of negatively influencing the program's uptake due to time pressures. Particular areas of concern were dealing with perpetrators, child abuse cases, people in the LGBTIQ community, and people from diverse cultural backgrounds.

'…Like we don't, we only briefly touch on child abuse. Um, and we really barely touch on perpetrators, either. Um and you know, GPs are managing whole families, and they need to know how to manage perpetrators as well as um victim/survivors of family violence, and they need to know how you deal with both at the same time, and you know they often have lots of questions surrounding all of that, and there's often not enough time to go into those things. Now it's tricky, because would you add a third session, or make the sessions longer? There's lots of downsides to doing that. It would be harder to get people along for three sessions, and also, if you make the session longer, um people feel overwhelmed signing up for something that's more than ninety minutes, and they're less likely to join. So, it may simply be that there's just no room for those topics, and that they need to um participants need to get it from the modules rather than from the um training sessions. But you know I feel like it's a bit of a shame that we don't get a chance to talk about them, those things in more detail.' P4, Facilitator

'I'm thinking they needed some cultural training. So, working with CALD people from a CALD background or people um from an indigenous culture.' P1, Facilitator

'Well, GPs definitely need more training, and how to deal with perpetrators? …So how GPs identify and deal with child abuse. Elder abuse is a huge problem in our society. That latest statistics show that fifteen percent people living in the community without dementia are being abused. … and so, training in dealing with these issues, and knowing also how to do it better with certain groups like people with disabilities, LGBTI. How to understand what's happening with Aboriginal and Torres Strait on the Peoples Um, you know migrants and refugees. Yeah, So, there's the nuances also of the different sort of groups, um that we need to understand and be able to work with.' P5, Facilitator

The need to ensure ongoing training and support of staff was seen as an important step in reaching more clinicians and in meeting identified needs.

'Yeah, I think it was a really great program. I wish that um, I wish it was something that was running ongoing, because I think, even though we targeted so many medical clinics in the West, I think there is, we would probably just scratch the tip of the iceberg.' P1, Facilitator

'..if they've done this amount of training, then you know they need in three to six months to, you know, to review that and see how it's going and see what else people need.' P5, Facilitator

'People need um more, I think, need more follow up, and I think need to have some form of ongoing supervision to deal with some of this difficult stuff.' P5, Facilitator

Performance feedback and trainer support

It was suggested that in order to improve practice, some feedback on performance would be very valuable for both experienced DV educators and newly trained ones.

'And one thing that I would like to see more of is feedback from the sessions that we give. So, I've never received feedback from practices about how they thought the session went. Did they think it was worthwhile? Um, do you know, would it lead to change? What things would they like to do more from this? What sort of things would they like to see improved? …So that lack of feedback, so it's not feeding into our learning needs as to how we're going, and how you know if we do make changes, because when you're doing the same thing over and over, invariably, things change a little bit. And are we changing for the worse or not? …But you know, even if we had a monthly newsletter about you know what's new, what's coming, what's changed? Has this helped them identify family violence, and will it make them more comfortable referring family violence? I just I just really want to know, because what if I sat there for you know three hours, and at the end of the day they rated two out of five in terms of changing practice?' P2, Facilitator

' I wonder whether the first time one of the people who've just done a train-the-trainer they're trying to do this session whether they might like to have someone more experienced sit in with them and just give them some feedback that might potentially help them in running the sessions. Maybe I don't know if it's possible to do that. But it's just something that might work.' P4, Facilitator

This section has provided detailed evaluation of the training program. The next section outlines evaluation of the linking of primary care and family violence services.

Linking of primary care and family violence services through secondary consults

This section outlines the local resources developed, the use of health pathways by trained practice staff, including their confidence accessing and usefulness of health pathways before and after training. This is followed by the role of the FV support worker and the evaluation of this role through secondary consultations and perception of the role through interviews.

Referrals and resources

An extensive referral resource list and links for the NWMPH region was integrated into a Participant Handbook so all the staff registering for the training received a comprehensive and current list of referral resource support services. They received pamphlets, brochures, fact sheets and safety planning booklets that could be used in consultations. Posters were also made available to all clinics on request.

Participants were also asked to refer to the GENWEST website for more information on other support services. Northern Integrated Family Violence Services Partnership for services website was also available to all in the northern region. On this website, there were interviews with service providers and links to resources to help improve responses to family violence. The website provides workers with an understanding of the family violence system in the northern metropolitan region and consists of an introduction presentation, interviews with service providers and links to resources to help improve responses to family violence.

- Northern Integrated Family Violence Services Partnership (NVIS)
- Quick Reference Guide to Family Violence Services (NVIS)

HealthPathways

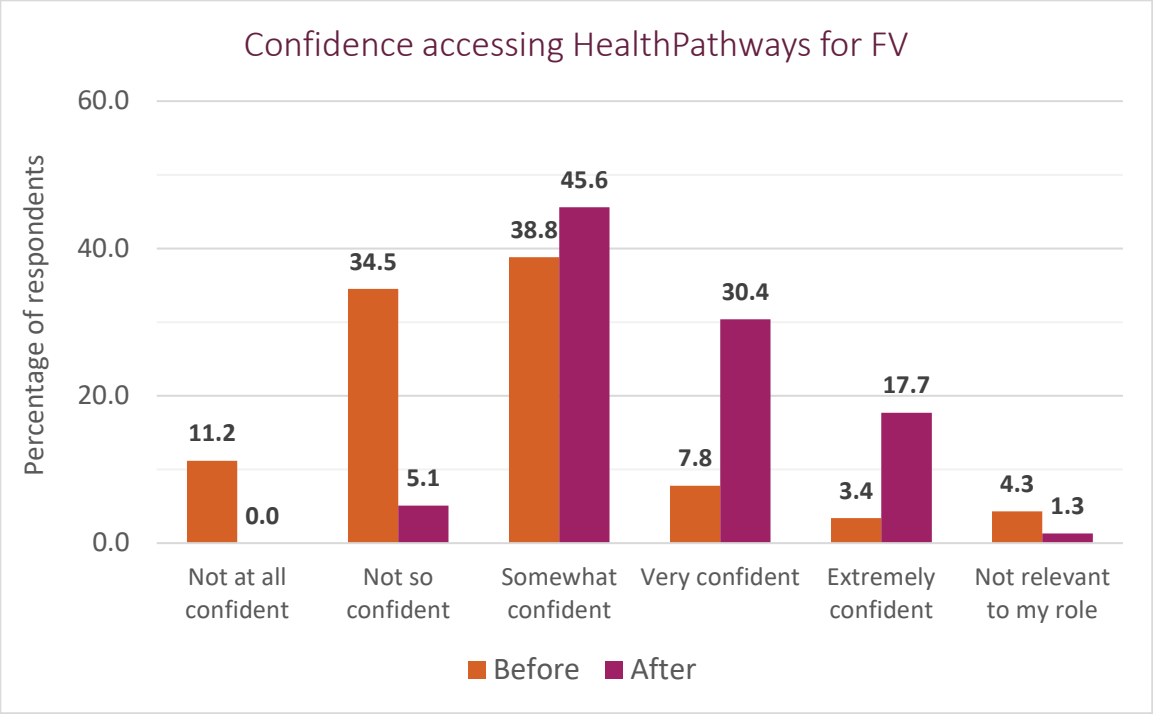
The majority of practices had accessed HealthPathways:

- 85% of practices (22/26 practices) on the Primary Care Pathways to Safety program used Unique URL to access HealthPathways
- 50% of practices (13/26 practices) on the Primary Care Pathways to Safety program used Unique URL to access Family Violence HealthPathways.

Survey participants confidence in accessing HealthPathways before and after training is shown in Figure 23. Amongst respondents:

- Percentage who were ‘Very confident’ to ‘Extremely confident’ rose from 11.2% before training to 48.1% after training
- Percentage who were ‘Not at all confident’ to ‘Not so confident’ fell from 45.7% before training to 5.1% after training.

Figure 23: Confidence in accessing HealthPathways for FV

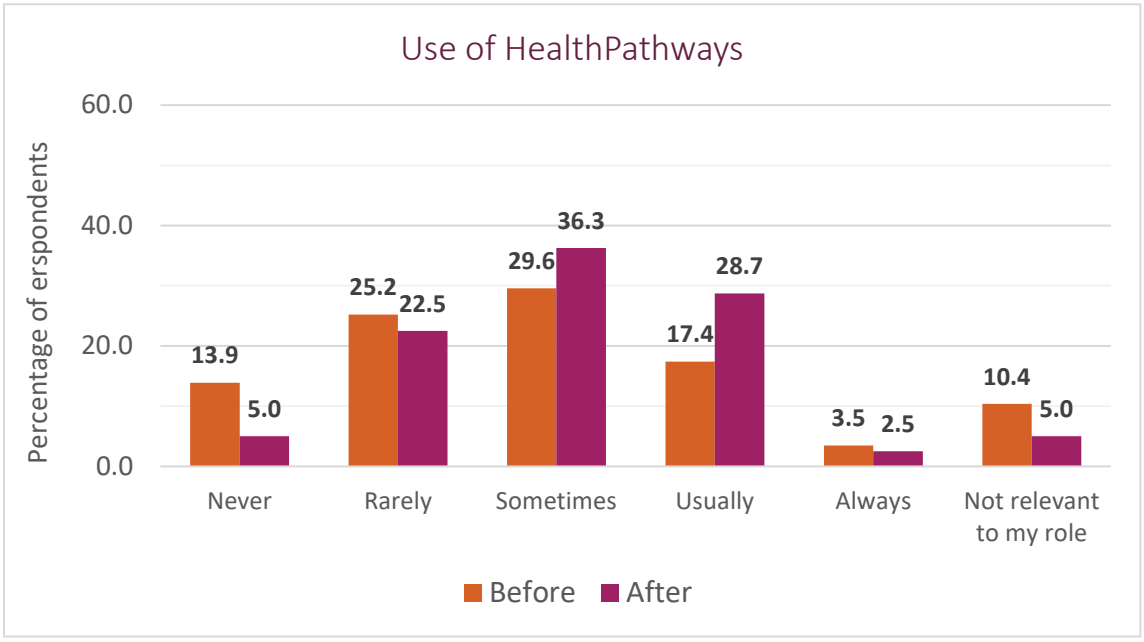


Before: n = 116, After: n = 79; denominators vary slightly

Participants use of HealthPathways for referral information and to support clinical decision making is shown in Figure 24. Overall, use increased after training in how often they accessed HealthPathways:

- percentage who 'Usually' to 'Always' rose from 20.9% before training to 31.2% after training
- percentage who 'Sometimes' rose from 29.6% before training to 36.3% after training
- percentage 'Never' to 'Rarely' fell from 39.1% before training to 27.5% after training.

Figure 24: Accessing HealthPathways to support clinical decision making/for referral information



Before: n = 115, After: n = 80; denominators vary

Role of the FV support workers

The FV support worker was fully engaged in supporting the training and assisting in building up the capacity of the practices. Although the crucial role of the FV support worker was to facilitate the sessions, they were also vital in developing strong links with the FV services in the catchment area to ensure adequate service linkage and direction would be available to the practices.

The FV support workers skills and expertise enabled them to provide secondary consultations, referral pathways according to the specific needs around culture, language and diversity and any resources the practices needed. They:

- Co-delivered (with a trained GP facilitator) a practice-centred training module to participating GP practices and other primary care providers
- Supported clinical and non-clinical staff to strengthen their skills, knowledge and confidence in identifying and responding to family violence and streamline referrals
- Provided secondary consultation and act as a 'local link' or "connector role" to help build pathways between primary care and the wider specialist service.
- Liaised and collaborated with the trained GP facilitator and the staff at University of Melbourne. This included contributing to the training design and content.

Follow up clinic sessions

The FV support worker engaged with the practices after the training and made themselves available to attend staff meetings via ZOOM (due to restrictions face-to-face meetings were not permitted during Covid pandemic) to discuss the services and any issue that had come up in the practice, or to debrief on a specific case. The Program set out to establish strong connections between the FV support worker and the practices. However, this was limited by the constraints of the practices during COVID-19, and the pressures and demands of the senior clinical staff and practice managers.

What was achieved was strong connections even if the practices did not use their expertise and there is great potential for growth in time and given different circumstances it would have had different outcomes. The University of Melbourne liaised extensively with FV support worker and practice staff to support the relationship. Each practice had details of the FV support worker in the catchment area and were encouraged to contact them. GENWEST developed clinic packs for the region and the communication with practices *during this time was very positive.*

Issues encountered:

- Regular check ins were established but FV support workers were often unable to connect as practice mangers were often replacing sick staff and therefore unavailable
- Practice managers working remotely and not contactable, or were unwell and would be away from the practices for lengthy periods, making it very hard for the FV support worker to engage
- Regular meetings with PHN and University of Melbourne were held to discuss different ways of engaging more successfully – the FV support workers were frustrated at their inability to connect, but mindful that they did not want to damage relationships they had established when the practices were struggling.

Outcomes of role of FV support worker

Initially, due to the impact of COVID-19 and the vaccination rollout, practices were reluctant and too hectic to seek secondary consultations. However, by mid-2021 the NWMPHN initiated a concentrated engagement campaign with the FV support worker who telephoned practices, checking in and making themselves available to attend meetings and discuss any concerns.

Final Reports

From the final reports of the QI activities the following patient data was gleaned:

- 13 practices used secondary consult support, and 2 cases were escalated by services and police were called (unexpected)
- 531 people were asked about FV per month and 52 disclosures were made within 3 months after training

Interviews

In the interviews with 14 staff participants the following theme was described:

Theme: Support and relationship building with FV support workers and specialist services

As part of the training program, participants could contact a FV support worker after the program and this was greatly appreciated. It created some awareness among clinicians of the available services to which they could refer or who they could contact for additional support. Another positive outcome was that it opened the door to developing a sustainable professional relationship with specialist FV support workers or services. These views were shared by participants whether or not they have already used those services.

'Yeah. [name of FV support worker], she called me. She gave me other resources which I can use. It's good, if anything we have her contact, I have your contact, so we can always ask any questions. I get the feeling that [name of FV support workers] is very hands on and very interactive and really does a lot of follow up with her practices. She invests a lot in the practices that have come on board, I feel.' P8, Practice Manager

'Yeah, I think we had another meeting with [name of FV support worker] from [name of FV specialist service].' P13, GP

'Also being very clear that there was help down the end of the phoneline, that ringing up the [name of FV specialist service], those marvellous women can - are a real asset, and I wasn't very strongly across which organization I'd ring, so that was ...I think that's the thing.' P1, GP

'No. I haven't contacted the service at all. Well, I haven't had the need to. Look, I think - well, I think it opened up our eyes to the role that this person plays. I think the critical thing for any practice is to know where you go.' P11, GP

'No, I haven't needed to, but I think it was really good to know there was that resource there and that if you got something where you really felt like, oh I really need help with this or I'm really out of my depth, that there was that person that you could kind of reach out to.' P12, GP

'I didn't. I know she sent some resources through, but I didn't personally follow up with her. I'm pretty sure one of the GPs kept in touch and followed up to get some more resources from her.' P6, Nurse

'I was excited to have access to so many experts, resources and information that the program offered. It is brilliant to be able to contact [name of FV support worker] and her team at [name of FV service]. It really feels like a wonderful clinical/professional connection has been made and that our clinic will make the most of her support.' P5, GP

'Well, the doctors would have done more of the follow-ups with her. So, I didn't really have to much of that one on one with her. I do believe that [name of clinician] did reach out to her with the scenario, and I believe she was guided appropriately to whatever she needed. So, we've got the

number there, and we do encourage the doctors that, if there is anything, I'm sure she's always going to be - I know that there was, like, a timeframe that she was able to be utilised, but I believe that they've got that resource now, and I'm pretty sure...' P7, Practice Manager

This section has overviewed the QI initiative and the next section will outline, challenges, enablers and suggestions for improvement.

CHALLENGES, ENABLERS and SUGGESTIONS for IMPROVEMENT

This section outlines the challenges and enablers to the Program. This data comes from across the Program evaluation.

Challenges

From a review of the processes during the project, and from practices 'Final Report's', the following challenges were identified:

Challenges in recruitment and project progression

- Challenges in recruitment of practices to participate in the Program were negligible as there was a very positive response to the invitation email. This might have been partly because of the funding that was available to undertake the Program to compensate the general practice for the time involved ($3,000).
- Once a practice was interested, the majority were pleased to commit without a practice visit. However, it could be up to two months delays before training was scheduled/QI activities implemented due to staff shortages during pandemic. In order to keep practices engaged it was essential to have regular contact with the project leads.

Challenges in delivery of training

A number of challenges were identified:

- Speaking to the practice manager or the principal GP was often difficult and time consuming
- Coordinating a time that the practice, GP facilitator and FV support worker were all available to deliver the training
- Organising training in a busy practice to ensure optimal numbers and confirming final numbers
- Covid impact, with training being online via zoom (vs face-to-face)
- Practice shutdowns due to COVID pandemic with limited staff capacity
- Getting the staff to complete the reading, online modules and pre-survey before the sessions
- Scheduling the sessions with the practices due to COVID restrictions, and changes sanctioned by the Victorian government without notice, was challenging over the past 12 months
- Staff isolation and being absent for long periods, or staff leaving the practices, caused difficulties
- Staff not working their usual hours has impacted scheduling
- The need to be flexible and reschedule sessions at the last minute because the practice was unable to participate impacted the smooth delivery of the sessions
- The cancellation of sessions and needing to reschedule the Facilitators and FV Workers was time consuming and disruptive for them – not always easy to reschedule
- The vaccination roll out caused additional delays and stress for practices as many wanted to be involved but needed to concentrate on this.

Challenges of implementation of identification and response to domestic and family violence

- Staff burnout and workforce shortage
- Working via telehealth
- Identifying and working with perpetrators
- Creating a culture that promotes disclosures of family violence cases.

Challenges of evaluation

- Use of online surveys
- Recording appointment types and also keeping a tally of secondary consultations.

From the open-ended questions in the pre and post surveys the following challenges were identified. Many respondents indicated that they did not think there were any aspects of the program that they would find personally challenging, others were not sure. However, for some challenges were described. A few respondents, predominantly practice managers, indicated finding time to participate in the program was challenging.

'Time will always be the challenge and co ordinating doctors time.' Practice Manager

'Finding time to attend meetings. Wish they were recorded videos which were accessible whenever we have time.' Practice Manager

Others described the nature of the content and hearing the impact and effect family violence has on people as difficult.

'It is always difficult to hear of violence, esp. that which affects children/those that are vulnerable. Not [challenging] on a personal level though.' GP

'Hard to hear about the abuse of women, children and the elderly.' Allied Health

'It is inevitable that we will likely hear stories of FV and personally as hard as that may be to listen to, the trauma these individuals must have faced does not compare. It may be confronting however this is a very important topic, and [a] project I'm happy to be a part of.' Administration

Some people reflected on the potential challenges of providing caring for patients experiencing family at both a personal and practice level.

'How to address and question if they are going through domestic violence without making them uncomfortable.' Nurse

'How early and how far can I be involved as a GP in solving the problem and preventing further harm.' GP

'How to deal with children involved in family violence.' Nurse

'I may find it challenging to implement changes in the practice.' GP

A couple mentioned that dealing with perpetrators was personally challenging.

'I think this program will make me confront some of my own unconscious bias and stigma that I hold towards family violence and who I believe family violence affects. As a female myself, I may find it challenging to hold compassion for perpetrators of FV and would value some tools to help me to work on this. In our service it is not uncommon for victims and perpetrators to be members of our

service and concurrently receive health support. This can be challenging when I am biased towards empathizing more with victims and am still required to provide the same level of care, compassion and professionalism to their perpetrator.' Nurse

A small number of respondents disclosed their own experience of family violence and while some recognised that this made discussions concerning family violence triggering, one participant described how this made them more motivated to do something for others:

'I have a lived experience of DVF when I was a child. I don't find talking about it challenging, but I am personally as well as professionally motivated to improve things for affected families.' GP

Participants responses to the role-play component of the education program were somewhat mixed. While a few mentioned they were useful or would have liked more included:

'Role playing component was really beneficial' GP

'More role plays involved in training.' Nurse

Others commented on the challenges of this aspect of the program, one person indicating this was heightened as they came at the end of a working day.

'I know a couple of our new staff members felt uncomfortable in the role playing as a group as we hadn't known this was going to happen. They may have felt more comfortable attempting it in break out rooms as one on one.' GP

'The role plays were intense (after a day's work of similar confronting consults) - without a good chance to de-brief.' GP

Interviews

From the staff interviews one theme was developed.

Theme: Covid made it more challenging

Mandated public health restrictions and other changes to patient care delivery during the Covid-19 pandemic had a significant impact on practitioners' ability ask DV related questions or to respond adequately in some instances.

'Telehealth makes it a lot more difficult to engage with the patients in the way that you would face-to-face. [During] COVID the people that I was dealing with that I knew about was face-to-face consults that I'd been having with the people. Once we got the video, video's better, better than the phone for chatting to people. But I had someone who was from a non-English speaking background, I just said to her to come in, that was much better than the phone.' P1, GP

'But you did do a lot of through telehealth, and I think that was tricky at times because there's a lot of stuff you don't recognize with telehealth, I find. … I've now - once again, from the training I'm now better at asking people when I talk to them, 'is this a private situation'? Because I had found the other thing that happened a lot is, you would think you were in a - because I would say, is this an okay time for us to talk, and they'd go yes, and then you'd realise there was someone else there partway through. …Yeah. Just also you realise that people - some people where there was significant

- I don't know, I wouldn't - maybe borderline family violence, like situations where partners are particularly say controlling with money but that's the main thing. But you realise it is harder for the person to talk about it when both of them are at home and they can't express their frustrations and their difficulties until you see them on their own in the clinic and they can talk freely.' P12, GP

'I think just making sure people were able to speak freely. Yeah, and there were a few people who I spoke to on the phone, who I said, look, when I call you back, do you want to just make sure you go for a walk or something?' P13, GP

'So, it's really, really difficult, but I would suspect there would be. I mean just this anecdotal rather than anything sort of concrete, but I've heard a colleague sort of saying things like they've had patients who for months on end didn't see their doctor. Finally came to see their doctor and then, when they unravelled that there was partner violence there, it had become so obvious because it had escalated. Because they were in the same house for a protracted period of time, so there was no escape from it.' P3, GP

'Look, I think – I mean it increased it – it makes it easier to have conversations with people, but it makes it more difficult to pick up on cues with people …so you don't get that visual representation. You don't get the fact that they're sitting in the waiting room having an argument with someone on the phone. Like you don't get that kind of context stuff, and certainly we do both – we do Zoom or telephone, but mainly telephone. But yeah, I think that – I think in terms of responding, it probably makes it easier because in some ways you can – you can arrange a follow-up very easily with someone, look I'll call you again tomorrow, and you can actually get paid for that time. Because this takes time. So that's what I've been able to do. I've been able to say, look I'll put you in for another appointment tomorrow, and we can have a chat or a phone call then. But yeah, certainly I think it's obviously very important to make sure that someone is safe to talk, yeah.' P4, GP

Enablers

The program was patient centred, doctor centred but also clinic centred approach.

From the final reports the following themes were developed:

Theme: Whole of practice approach

The training created opportunities and made participants realise how the whole of practice approach made it easier. The whole of practice meetings was a great chance for participants to get onboard and kept the issues at front of mind to implement during consults. Each staff member had a unique perspective, which helped creating a well-rounded approach and ensuring the team was on board to work towards a goal.

In one practice, the reception helped with marking out appointment types e.g. mental health reviews. Practice managers assisted with making the prepopulated notes. Nursing team assisted with promotional material and keeping a tally of the appointment types. The doctor was then able to use the skills taught in practice with the patient.

Theme: Training delivery was effective

This included feedback that the training had:

- good facilitation of workshops
- beneficial role playing concerning how to approach patients
- actual case studies
- opportunities for getting feedback from the FV worker
- lived experience feedback
- discussion among practitioners, communication and sharing stories
- effective educators and support from PHN and FV support workers.

Theme: Clinic Leads

Not all practices identified clinic leads but those who did found this helpful.

> *identified key passionate stakeholders who drove the implementation, i.e. a nurse, a refugee health nurse, receptionist etc*

Theme: Team building

- A good team building exercise
- Teamwork culture; identified a few areas of improvement
- Increase in discussion amongst staff, general enthusiasm.

> *We have been able to come together as a team to listen to the workshops to help us learn how to identify and support victims and perpetrators to get the help they need.*

> *As we are a very new practice, still focussing on establishing routine practice systems, we have not had any opportunity to come together as a team before, so this was a new experience for us and much appreciated.*

Theme: Feedback from patients and resources

Several clinics described more patients disclosed than they anticipated, and that they had positive feedback from patients when they asked about domestic and family violence. Resources in waiting area, treatment rooms and GP desks helped spark conversations which led to disclosures.

Finally, it should be noted from feedback that strong co-ordination by the PHN staff enabled the Program to run smoothly and effectively.

The next section makes suggestions for improvement to several aspects of the Program.

Suggestions for improvement

From the staff interviews and staff surveys, several suggestions were made in two areas: to enhance the Program as a whole and the intensive training component. These two areas were synthesized and described below thematically. In addition, a collated list of suggestions from the multidisciplinary family violence networking sessions and QI final reports are presented at the end of this section.

Improvements to the Program (as a whole)

Clinical champions

To ensure sustainability of the program, suggestions were made about identifying and utilizing clinical champions within clinics or geographic areas to continue driving people's interest in identifying and responding to FV.

'Yeah, I think it needs reinforcement, and that really requires a champion within the practice to initiate and to drive that. Look, I think - well, I think it opened up our eyes to the role that this person plays. I think the critical thing for any practice is to know where do you go?' P11, GP

'Yeah, that's right. That's right. So, I was impressed to see an elderly experienced GP commenting on the program, and he was largely - he had a very small segment on you can start the conversation. It was about starting the conversation. But I think it helps to have a number of familiar faces in particular geographic locations that the doctors can identify with. …When you're talking about finding champions, they need to be people that are recognised in a particular geographic area, so if - you can get agreement for some of these doctors to give a 30-second commentary, it's a face which will be recognised.' P11, GP

Extended follow up

Although the three-month follow up period with a FV specialist worker built into the program was very much appreciated, some participants suggested that an extended arrangement might be valuable in enhancing their practice.

'Yeah. absolutely. I'd love for – and I don't know how much this could be done, but I'd love to maybe just have like a check-in, maybe once a year, or a couple of times a year, with a contact from someone that we spoke to, just to see how things are going, or if anything's changed, or just to have some follow-up, if we needed. Maybe a new case had come up, or something like that. I think that might be quite good.' P6, Nurse

'Well, I think if the practice is once a month running a lunchtime session on family violence, then the family violence worker should attend that session. I think in a way, what we're trying to do is provide GPs with a semi-structured CPD point-gathering program that is based around the existing material and extends for a whole 12-month period. So over 12 months, there may be 10 one-hour sessions with the involvement of external parties like the family violence worker'. P11, GP

A few participants were of the view that it might be a good idea to have the FV worker visit their practice during scheduled meetings to discuss cases of interest or provide some guidance or insight where needed.

'I guess one thing would be if - it might even be good for her to do a follow up visit where she came to one of the meetings like we're having and then she was able to give some feedback on one of the cases that we were discussing. ...without needing - it's not necessarily like you're going, oh I really need to contact this person, but to get a different perspective from someone who works in the area and just have that. Because we're all - we've all done this training and then we're all kind of thinking it through together, but then to have someone who actually this is what they do all the time, you just automatically get a different insight. I think that would be - that would actually be a really valuable kind of thing.' P12, GP

Improvements to the intensive training program

Interviews

From the interviews, staff participants made specific suggestions for improving the program.

Need for more preparation

It was mentioned that there was not enough prior information about the nature of the program including the time commitment it required. They suggested that they would have appreciated some information on what to expect, what was expected of them, as well as some guidance in fulfilling those expectations.

'Yeah. One thing, I didn't really know what it was, we were just told there's a couple of Zoom meetings booked, and I had no idea what was involved. I think that was a bit hard because I didn't quite know how much time I might need to prepare for the sessions and what my time commitment was going to be, so I would have liked - that was probably an issue at our end rather than your end, but it's always nice when you're agreeing to do an education thing to know what might be involved, how long it might take you, all of that sort of thing. But because I thought it was such an important topic I just thought, well, I'll just go with it and work it out as I go along.' P3, GP

'Yeah. In fact, the module was great, you know that module with the videos, it was just fantastic, I thought it was really - I did it, I did all the stuff, but I just didn't quite know what I was going to be needing to do until it got started. The audit, again, I - this might be just a useful piece of feedback for you, I sort of saw the attachment that you sent and I sort of read it as a word document and when I was just looking at it before I realised - or when I saw [name] discuss hers, she'd done it on her phone or something, and I thought that's incredibly clever, I wouldn't have a clue how to do that. Then I realised it was a spreadsheet, which I'm not very good at, but once I sat here and double clicked a couple of things, I could actually see how [name] had filled it in. Maybe you guys stepping us, all the GPs, through the some of that stuff.' P1, GP

Extended time for role play and e-learning module

Some suggestions were made for further improvements of how various aspects of the program are structured. These included having additional time dedicated to discussing the role play and also breaking up some of the material in the handbook so that it is covered over a longer period of time.

'The role play was really good, but I also felt there wasn't quite enough time for discussion. I feel like there was a lot of giving information, a lot of which was in the module, a lot of it overlapped a lot with the module and then I was like, it would have actually been nice to then take it to the next level or by discussing it with situations that we'd had rather than just kind of go over what - I felt, well I just read this in the last kind of few... I thought the practicing was really good, but I thought it would have been nice to have more time for discussion and we didn't seem to have much time for discussion. …The other thing that I guess wasn't entirely clear to me is did we do the audit as individuals or did we do the audit as a practice and when was that meant to be done in relation to the training, like was it before the first session? Those bits I found a little bit confusing.' P12, GP

'Yeah, yeah, I didn't have any trouble working through that [the e-learning module] at all. I think, look, as you said a minute ago, this is something that you come back to from time to time. When you're doing it as part of a course, like we did, you do as much of it as you can over a period of a couple of months. But I think the real benefit is reinforcement, and I think that in the clinic setting, that needs to be organised in some kind of systemic way. It really should be organised around clinical cases that either the doctor - one of the doctors during a lunchtime presents a case, and then there's reference to the module or the handbook. …I think for some people, it can be a bit daunting, because there's so much material there, and I think maybe trying to identify ways where it can be easily - it can be done very much piecemeal, so over a longer period of time,

interspersed with case studies, as you've done with the vignettes. So, time is set aside during lunchbreaks for doctors to do one or two aspects of the program as part of a group discussion. In that discussion, to bring in the reception staff, to bring in the nursing staff, so that it's done piecemeal over the course of a year rather than three months.' P11, GP

Handbook

It was suggested that the handbook could be restructured by condensing the most relevant information into fewer pages for ease of use by often busy practitioners.

'I also wondered whether, the handbook, whether it might have been better split into two things because the whole thing was 100 pages, I started scrolling through it and it's got all the, you know, it's got this workshop. If you sort of separated it into the tools, got the sort of first 20 pages in what the training's all about. Have it separate, that would have worked better for me because by the time I flicked through 20 pages and it's like, oh this is a bit dry, but then there really is stuff that was - I thought was really good was pages 25 to 40, and that was the stuff that was really very relevant to the training. …At the end of it, after you've packed up your stuff and then you've got someone in consult six weeks later, it's like where is that stuff, and if you've got to flick through a 100-page document or the College document's 500 pages.' P1, GP

'It's 90 pages [the handbook], so whatever is important to you to get out, you need to get out in the training. Because people - I'll go to the resource book if I want to find out about resources, probably, but I'm unlikely to go through 90 pages.' P13. GP

Mode of delivery

In recent times, the Pathway to Safety program has been delivered virtually via Zoom. Participants felt that in-person sessions would have worked better given the nature of the topic discussed.

'I think it was a little bit difficult on video. We're a new practice and when I thought about it, we've actually never had a practice meeting where the admin, nursing and doctors were all together.' P1, GP

'Especially me, I am old school. I like workshops and I like the classroom environment. Everybody learns differently, but majority of the feedback that we have received in this is, majority of the people do like these workshops, like a face-to-face interaction, to be able to ask question and scenarios and those things, which really happens in a workshop.' P9, Nurse/Practice Manager

'In terms of the actual program, and maybe program delivery, I think for me one of the things that I felt could be better would be, I guess, the modality that the program was [given]. So, it was all Zoom, and with COVID and so on, Zoom is this common thing that everyone uses. But I think for a topic like this, I think face-to-face is probably a better way of doing that learning. Particularly with things like when we're doing the role playing and [not] with the patient or the actor, but also with each other. Like the discussions I think would be a little bit more free flowing in a face-to-face setting. I think that's probably the biggest one I would probably say about the program. Mm-hm. Because I think we are finding that certain topics require you to be in-person, right. It's just so much harder and you don't get as much value from the course through Zoom.' P3, GP

Surveys

From the survey open ended questions, several of the suggestions offered by staff participants in the survey overlapped with those reported in the individual interviews.

Many clinicians indicated they were happy with the program and did not suggest any improvements.

'It was a very organised and informative programme I don't have any more suggestions to improve.' GP

'Covered all aspects. I have nothing to suggest for improvement.' GP

Where respondents did provide suggestions, they were diverse but could be summarised as follows.

It was acknowledged that conducting the sessions via ZOOM was a requirement given the program operated during the COVID pandemic, and this worked well; however, there were comments that they would have had even greater impact if they were conducted face to face.

''I think considering it was conducted over zoom the facilitators managed to engage everyone very well. I imagine that the program would have an even greater impact on participants if we were all able to be in the same room.' Nurse

Frequently people indicated they would like more case studies, including participants' own case studies, with (group) discussions. One person suggested the inclusion of scenarios with patients from different cultural backgrounds.

'… portraying different presentations, how it varies in patients coming from different cultural backgrounds.' GP

'Invite participants to present cases and discuss their management.' GP

Further some mentioned wanting more role-playing cases.

'More role plays involved in training.' Nurse

Additional areas suggested for training

From the networking sessions and final reports, the areas that they requested extra input included:

- Responding and managing perpetrators who attended the clinic
- Further role play, having more practice with case studies to increase skills in recognising and responding to family violence
- Having a better understanding of dealing with different cultural populations
- A more detailed session on the Information Sharing Entities system
- Update key local family violence services i.e., The Orange Door
- Child abuse and elder abuse.

This section has outlined the improvements suggested for the Program, the whole of practice intensive training program and the practice as well as other areas for training. The next section makes specific recommendations.

RECOMMENDATIONS and CONCLUSION

This Program was designed to respond to a need for practice staff to be able to recognise and respond when dealing with family violence. The Program clearly did this with staff gaining an understanding of their roles and responsibilities in relation to family violence, and an understanding of essential processes and practices. Clinical and non-clinical staff were keen to respond effectively however, responding appropriately is influenced by a staff member's knowledge and level of confidence and the systems and resources in place in the practice setting to support them. The Program provided them with skills, confidence, links to support and services for those patients experiencing family violence. More of course needs to be done to provide a comprehensive program.

Recommendations include**:**

- Continue offering whole of practice training sessions when delivering family violence training
- Offer more role play work, to develop skills in interviewing
- Training content needs to include issues around emotional labour and readiness to undertake this work, and there is a need for additional support for the staff who might be experiencing DFV
- Continue to build capacity within clinics through follow on activities – this will enhance program outcomes
- Offer more than the two interactive sessions, including videos of consultations and additional sessions on perpetrators and children
- Have follow up sessions in 6 months to refresh and discuss what they have learned
- Offer further opportunities for specialised services to visit the practice for education
- Continue to support Clinical Leads through mentorship by scheduling videos or face to face meetings
- Support the Clinical Leads in fostering the links between the specialised services and their clinic
- Ensure all clinics have the most up to date resources
- Continue to get support, visit and updated resources from FV services.

Conclusion

Primary care settings have been identified by the World Health Organization as suitable for early intervention for domestic and family violence. Although a large proportion of women experiencing abuse seek help at some point from general practice, they do not always receive appropriate responses. The Primary Care Pathway to Safety Program was designed to provide direct tailored support to primary care providers, build internal capacity within practice to respond to FV presentations, improve collaboration and build greater cohesion and coordination across the range of local health and family violence services. A whole of region communication campaign raised awareness about the role of general practice in the response to family violence and promoted relevant resources. The place-based initiative comprised QI activities that led to increased patient identification via effective and sustainable change in the area of family violence response: intensive in-practice education that increased knowledge and confidence, promoted the whole team approach and linked primary care with family violence services.

The evaluation used mixed methods including online data from awareness campaign, multidisciplinary communities of practice, surveys before and after networking sessions and training, final reports from clinics and interviews with staff and facilitators. Like the Program as a whole, the Evaluation was strengthened by the willingness and diversity of practices who participated, and support from the NWMPHN. However, there were limitations, including the response rate to the surveys which may have affected results as staff who were particularly engaged with the program might have been more likely to respond. Furthermore, the survey for clinical staff was conducted three months after training was completed, and while this provided them with the opportunity to reflect on how the training had affected their practice, it may have affected

their recall of the training sessions. In addition, the number of interviews that could be conducted in the timeframe were limited which in turn potentially limited breadth the data collected.

The integrated approach adopted by combining a successful awareness campaign, networking sessions, and development of coordinated referral pathways were important to ensure that a basic structure was in place to help embed the knowledge and skills acquired from the QI initiative and the education program. The intensive training employed engagement of GPs and FV specialist workers as facilitators. This enabled the Program to harness the expertise of GPs, on one hand, with knowledge of the practicalities of attending to DFV patients in a primary care setting, as well as FV specialist workers with broader experiences and knowledge in the dynamics of FV and available resources.

The whole of practice approach of training all staff in practices was key in generating interest among staff. These directly fed into follow on QI initiatives that health practitioners adopted to ensure sustainability of trauma-informed practices in identifying and responding to DFV. The appreciation of each primary health worker's role and potential team contribution to efforts was a significant motivator for clinical and non-clinical staff alike. However, the interlinking of FV specialist workers and GPs for secondary consultations was limited by the Covid-19 pandemic and associated restrictions.

The Program's success was largely attributable to its unique approach, strong co-ordination from the NWMPHN along with the Pathways to Safety Education Officer, and a recognition of the multifaceted and collaborative efforts required to tackle the complex issue of DFV.

'As I reflect on this program, I think it's probably one of the most comprehensive and well-presented programs that I've ever attended, … because it's extremely well organised. The integration of the theory with practice, the inclusion of a clinical audit, the checklist for the practice and the actual workshops, … it's a beautifully integrated program, and I think is quite unique.' P11, GP

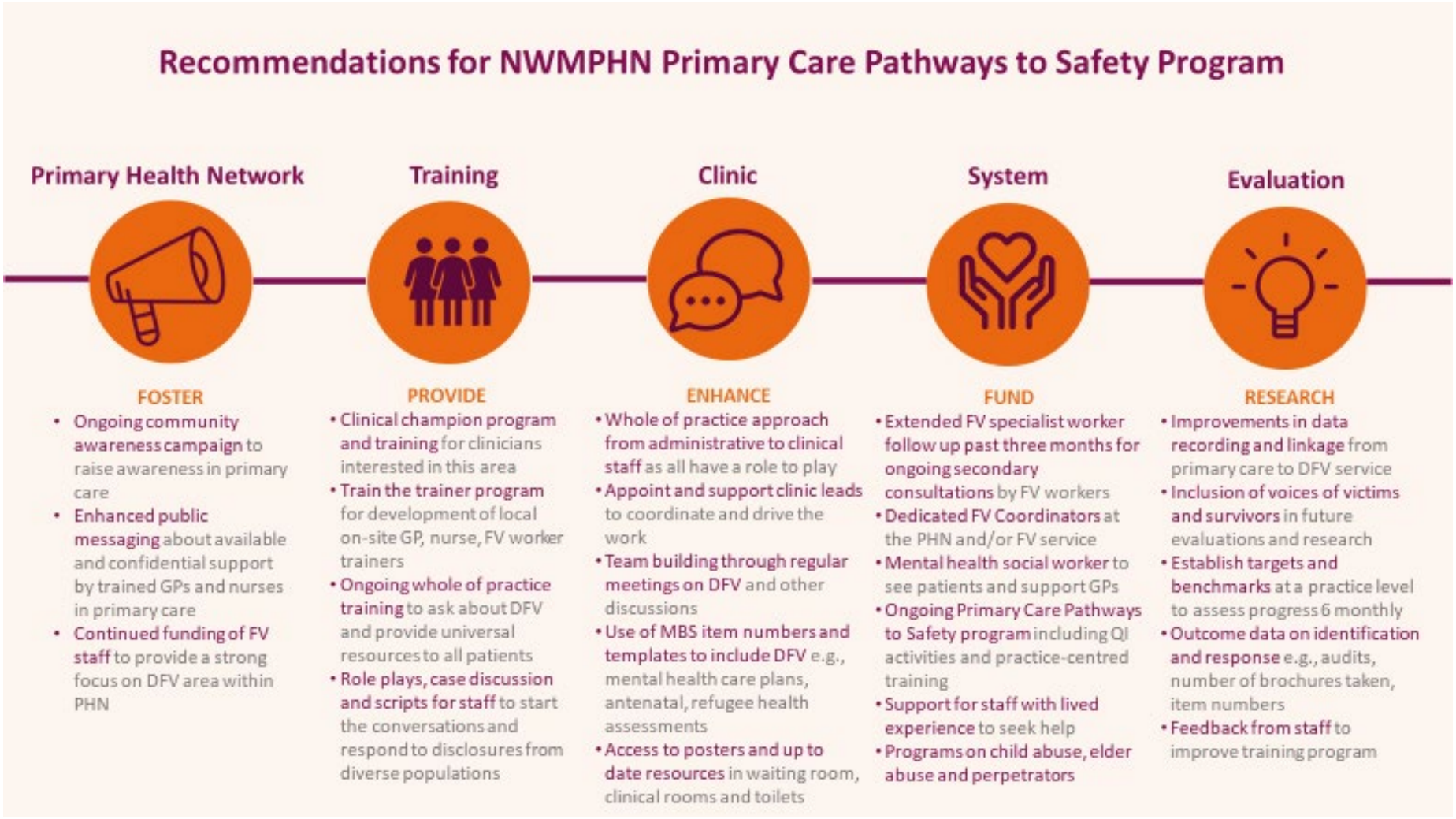
'I was excited to have access to so many experts, resources and information that the program offered. It is brilliant to be able to contact [name of FV support worker] and her team at [name of FV service]. It really feels like a wonderful clinical/professional connection has been made and that our clinic will make the most of her support.' P5, GP

'A beautiful program. We were able to get a lot of support, resources and a lot of advice as well. Even doing this program went hand in hand to be able to make changes, implement changes, start the process, documentation, information, education. just to get the ball rolling. It just went hand-in-hand.' P9, Nurse/Practice Manager

'I had more tools in my backpack in terms of things like being able to say, you know it's never okay for someone to feel threatened or harmed by their partner. Having those kind of – feeling the confidence that that was the right thing to say, like you always feel like oh, I don't want to say the wrong thing, so then we don't say anything.' P4, GP

Recommendations are made below after a synthesis of the data at the PHN, Training, Clinic and System levels and for future evaluations.

Figure 25: Recommendations



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APPENDICES

Appendix 1: WEAVE and IRIS Trials

Women's Evaluation of Abuse and Violence care (WEAVE) – This is an educational program which trains General Practices to improve responses to primary care to women and children experiencing domestic and family violence. It supports an early intervention approach and supports health professionals to deliver a brief counselling intervention.	**University of Melbourne Study -**This project was a cluster randomised controlled trial testing the effect of brief women centred care counselling by trained Victorian GPs for women afraid of a partner/ex-partner. The study involved 272 women attending 55 GPs. Half the GPs were trained to provide supportive counselling, and their participating patients were invited to attend this counselling. The other half received a basic resource kit only and provided usual care to their participating patients. **The study found that trained GPs enquired more about safety of the women and their children, and that depression outcomes were better for women invited to attend the counselling.** There were no significant effects on women's general quality of life or a general mental health score. The WEAVE study also showed that GPs could be trained to respond in a supportive, woman-centred way, and that their knowledge, skills and attitudes were improved. WEAVE has been expanded to include male perpetrators and with a greater focus on children in these families. Furthermore, PHN partnerships with the University of Melbourne have supported the recruitment of 11 general practices in the two regions and delivery of training to 70 staff.
Identification and Referral to Improve Safety – This is a training and education program which incorporates care pathways and enhanced referral pathway to local specialist services. A key feature of IRIS is the strong collaboration between primary care and family violence specialist services, with a lead role of a local specialist family violence worker in partnership with a local clinical lead to co-deliver training.	**The Identification and Referral to Improve Safety – Leading research** This project was a randomised trial in the UK testing the effect of integrating a domestic violence advocate into primary care through training and referrals to that advocate. Training consisted of two sessions with all staff (four hours total) with content covering clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. The focus was women who experience domestic violence and information and signposting for male victims and perpetrators. **The study found training primary care practitioners and integrating specialist advocates into primary care increased identification of women experiencing domestic violence and referrals to the family violence specialist service.** Based on the IRIS experience, of two-family violence educators working with 50 medium to large practices can result in the following over a 6-month period: • 200 primary care professionals trained and supported • 50 administration and reception staff trained and supported • 600 disclosures of domestic violence • 200 direct referrals to FV educator. Professor Kelsey Hegarty is involved as an investigator in the expansion of IRIS (referred to as IRIS Plus) which involves all members of the family.

Pathway to safety

Supporting primary care providers to help people experiencing family violence.

CASE STUDIES

Primary Care Pathways to Safety: Family Violence Quality Improvement Program

Family violence is the leading contributor to ill health for women under 50. GPs may be seeing up to 5 women per week who have experienced underlying partner violence, one or 2 of whom will have experienced severe abuse.

General practitioners and other primary health services are well placed to be able to respond to family violence as they see victim-survivors, perpetrators, children and intergenerational groups. Studies indicate that women are twice as likely to disclose family violence if asked by their GP or a primary care provider.

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Primary Care Pathways to Safety Program

North Western Melbourne Primary Health Network (NWMPHN) is one of 6 PHNs in the Commonwealth-funded initiative called the Primary Care Pathways to Safety Program. The program supports primary care providers to assist in the identification and intervention of family and domestic violence, and improves coordinated referrals to support services.

Designed in collaboration with the University of Melbourne's Safer Families Centre the Family Violence Quality Improvement Project set out to build the capacity of general practice to recognise, respond to and refer patients who are at risk of or experiencing family violence.

Over 179 GPs, practice nurses, practice managers and reception staff completed the training. Here are some case studies illustrating the results.

Resources and tools

There are a range of resources and tools for GPs and health care providers to use when supporting people experiencing family violence.

1. HealthPathways Melbourne's suite of family violence pathways include referral to local services and clinical support, and can be used at the point of care. Pathways are developed by GPs for GPs to identify, complete risk assessments/provide timely referrals; learn about local referral options and familiarise themselves with the process. Pathways include:
    - Disclosure of domestic and family violence
    - Domestic and family violence community support
    - Perpetration of family or domestic violence.
2. A range of local services and support information for providers and patients, and interviews with practices that participated in the Family Violence QI project can be found on the NWMPHN family violence page.
3. Self-directed quality improvement templates are available to help the whole practice approach identifying, responding and supporting patients experiencing family violence.

For more information visit nwmphn.org.au/family-violence

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CASE STUDIES

CASE STUDY 1: Ms CT

Ms CT is a 34-year-old mother of a 3-year-old daughter. Both live with the daughter's 36-year-old father.

The daughter has a long history of poor health, mostly respiratory infections. She has needed many visits to a GP, hospitals and a paediatrician.

After her daughter was born, Ms CT developed a major anxiety disorder. She always attributed this to the daughter's poor health.

Talking to her GP, she casually mentioned relationship difficulties with the father – who appeared jealous that she spends a lot of time with the child. Intimacy had decreased and some verbal threats were frequently uttered. She minimised the impact of the threats, and even indicated they did not contribute to her illness.

After the GP attended a Family Violence QI training session the GP talked to Ms CT at her next appointment and revisited the history of threats. Ms CT accepted that they were contributing to her poor mental health. Options were offered to her, including contacting the agencies that deal with domestic violence.

She decided to talk directly to the partner about the abuse. He recognised how his actions were adversely affecting her mental health, and changed his behaviour.

He became less verbally abusive, and Ms CT reported great improvement in her mental health. She specifically thanked us for pointing out the unacceptability of family violence, and explaining that verbal abuse is a form of violence – a fact she had not previously recognised.

CASE STUDY 2: Ms Y

Ms Y is a practice nurse at a busy clinic.

"I listened to a female patient who shared her emotional story of dealing with physical pain from endometriosis, and also psychological pain from being physically abused by her partner," she said.

"This was my first encounter of a family violence disclosure. I felt out of my comfort zone, but the training and resources that we had recently received gave me some confidence in approaching the situation.

"I listened empathetically to her story. She already had some supports in place, but I still gave her the 1800RESPECT fold-out card and reassured her that she is not alone and there is always help.

"She said she felt much better after sharing with me and was grateful for my support. I felt good that I was able to offer support and that the patient was responsive to the support offered."

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CASE STUDIES

CASE STUDY 3: Dr P

Dr P is a GP in a community health centre.

"We had a patient who presented as extremely agitated and distressed. She wanted a referral for a psychologist and to discuss some medications for anxiety," he said.

"On further questioning she disclosed that she was in a physically abusive relationship and that her partner had severe alcohol abuse problems. I listened to her concerns, and she stated that she had already reported the physical abuse to police and was safe and had family support.

"However, she also was very worried about her partner's wellbeing, and wanted to support him from a distance. She said she would like to see if he would like an appointment to discuss any options open to him. She was referred to a psychologist. She was also referred internally to the alcohol and other drugs counsellors for support as an affected family member.

"Her partner was specifically offered to see someone else to avoid any conflict in having me treating both, but was firm he wanted to see me. He has done very well, he is now taking medication for his mood, has been linked in with his own psychologist, has alcohol and other drug counselling and is taking medication to treat his addiction.

"There have been no further cases of violence or abuse towards his partner, and, although they are not living together, she feels supported and her anxiety is now well under control. His mood is much improved, too. He has stopped drinking and is reconnecting with his family, and, slowly, with his partner in a way that she feels is safe.

"This case highlights the goals of providing safe, timely care and meeting patient and family needs. The implementation of Family Violence QI project meant that her needs could be met immediately. Family violence was on top of my mind when I saw her with her presentation. The training led me to be open to asking if she needed support with such issues.

"Also, working within a community health service, it was very helpful to be able to so easily refer to alcohol and other drug counselling support and advice for them both."

CASE STUDY 4: Dr R

Dr R works at a local suburban general practice.

"During a clinical discussion I advised my team members about a case that had arisen," she said.

"A woman came to the clinic with dizziness and head injury. She disclosed that it was actually her partner who had assaulted her. She was able to open up to me, and I was able to use the techniques and strategies we'd been taught to support my patient in making decisions and developing a safety plan."

For more information visit
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Expression of Interest

THE UNIVERSITY OF MELBOURNE

phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

Family violence in Melbourne's north west: The vital role of general practice

Would your practice like to be involved in improving how you identify, respond and refer your patients experiencing family and domestic violence?

IN BRIEF

North Western Melbourne Primary Health Network (NWMPHN) is partnering with Professor Kelsey Hegarty from the University of Melbourne Safer Families Centre to offer practices an opportunity to participate in a fully supported five-month quality improvement activity. The approach is to build and sustain greater internal capacity within primary care providers to respond to the high prevalence of family violence-related presentations in primary care. The project team will deliver a comprehensive, practice-based education program tailored to overcome challenges affecting your capacity to respond to family violence.

This opportunity is open to the whole NWMPHN catchment; the initial phase will start with practices in the northern suburbs. Rolling recruitment will occur with the first wave of practices beginning the project between November and December 2020. Project waves will continue to commence throughout 2021. Interested practices with work with our project lead to determine the best starting time for them.

WHAT'S INVOLVED?

- Support throughout the project from the NWMPHN project lead and a family violence support worker from a local service.
- Three in-practice education sessions delivered by clinical GPs from the Safer Families Centre and a family violence support worker from Northern Specialist Family Violence Services.
- Two virtual workshops with other participating practices to provide an understanding of quality improvement methodology, and to support sustainability of practice improvements.
- Secondary consult/mentoring support from the Safer Families Centre's family violence support worker.
- Monthly visits from the NWMPHN project lead to support your practice's selected quality improvement activities.

You will be supported throughout the project by a dedicated NWMPHN relationship manager.

Background

Family violence damages the social and economic fabric of communities as well as the mental and physical health of individual women, men, adolescents and children.

We understand the current pressures facing you and your staff and we know how busy practices can be. However, evidence shows that you have a crucial role to play in preventing family violence. **Estimates are that each full time GP will see up to five women per week with underlying intimate partner violence (for example: presenting with mental health symptoms or chronic pain) but you may be unaware violence is happening in these families.**

Research has found that there is a spike in family violence during major crises and disasters, including the current pandemic and resulting lockdown.

Benefits for your practice

- Incentive payment of $3,000 (+GST) for participating practices that complete the program.
- RACGP-accredited CPD activity opportunity (previously 40 Category 1 points).
- Facilitated learning workshops with subject matter experts.
- Dedicated support from the NWMPHN project lead and a local family violence support worker to help you complete this quality improvement activity.
- Opportunity to share, network and connect with other practices involved in the project.
- Participation in this facilitated quality improvement project will help to meet the requirements for the Practice Incentives Program Quality Improvement Incentive.

How to apply

Please complete the attached application form and email to primarycare@nwmphn.org.au

If successful, our project lead will work with you to determine when your practice would like to start the project.

Please direct all queries to:

Irina Basanko
IQI Project Lead – Family Violence
North Western Melbourne Primary Health Network
Phone: (03) 9347 1188
Email: Irina.Basanko@nwmphn.org.au

ABOUT PHNs

Funded by the Commonwealth Department of Health, Primary Health Networks (PHNs) began operation on 1 July 2015 and are responsible for coordinating primary health care and facilitating improved health outcomes in their local community. Melbourne Primary Care Network operates the North Western Melbourne Primary Health Network (NWMPHN).

EXPRESSION OF INTEREST: Eligibility

Primary care pathways to safety

You must be able to tick each of these boxes to be eligible to nominate. Your practice must:

☐ Be located within the NWMPHN region.

☐ Your whole of practice project team available to complete the program for a five-month period (flexible start date – see below*). These staff will actively participate in the learning workshops, complete quality improvement activities and champion the program in the practice. **Note: Family violence projects are more successful when the whole practice team (including administration, clinical and allied health staff) can be involved in the education and quality improvement activities.**

☐ (**OPTIONAL**) Have a clinical and billing system that is compatible with the PEN CAT data aggregation tool (or agree to have PEN CAT installed), and a data sharing agreement in place (we will arrange this for you).

☐ Have the capacity to undertake whole-of-practice activities that support improvement in family violence detection and support.

☐ Agree to allocate protected time for your project team to attend the CPD workshops, complete quality improvement activities (as chosen by your practice) and to participate in monthly visits from our project lead.

☐ Agree to complete required surveys and reporting.

** The first wave of practices will begin the project between November and December 2020. Practices can nominate their preferred start time between November 2020 and October 2021.*

EXPRESSION OF INTEREST: Application

Primary care pathways to safety

Applicant name:		
Name of practice:		
Practice address:		
Company name:	**ABN:**	
Applicant details:	**Phone:**	**Email:**
Practice manager details:	**Phone:**	**Email:**
Practice principal details:	**Phone:**	**Email:**

EXPRESSION OF INTEREST QUESTIONS	WEIGHTING
1. **Please provide a brief overview of why your practice would like to participate in this project:**	30%
2. **How will your practice team benefit from participation in this quality improvement project?**	20%

3. How will your patients benefit from your practice's participation in this project?	20%
4. What barriers do you think may limit your participation in and successful completion of this project? How will you seek to overcome them? (please include the risk/barrier and how you plan to mitigate/overcome the barrier)	15%
5. How will you plan to make changes sustainable beyond the project?	15%
ADDITIONAL QUESTIONS	**NON-WEIGHTED**
Please list the name and profession of participating staff members:	-

Please provide any additional information to support your application:	-

Please return the completed application form to primarycare@nwmphn.org.au

As this project will work in a rolling recruitment fashion, applications will remain open until all project places are full. Please submit your application as soon as possible to avoid disappointment.

We acknowledge the peoples of the Kulin nation as the Traditional Owners of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

T (03) 9347 1188 | **F** (03) 9347 7433 | **E** nwmphn@nwmphn.org.au | **W** nwmphn.org.au
ABN 93 153 323 436 **Level 1, 369 Royal Parade, Parkville VIC 3052 | PO Box 139, Parkville VIC 3052**

Appendix 4: Expert panel participants

EXPERT PANEL PARTICIPANTS	
Dr Jennifer Neil	GP, senior lecturer at Monash University, Trainer Pathways to Safety
Daisy-May Carty Cowling	Senior Lawyer, Family Violence Program, Victoria Legal Aid
Brigid Jenkins	Program Manager Family Law Services, Victoria Legal Aid
Ahalya Thiru	Deputy Managing Lawyer, Family Law Melbourne, Victoria Legal Aid
Matt Addison	Research Advisor, Department of General Practice, University of Melbourne & Senior MARAM Program Development and Training Officer, Department of Justice and Community Safety
Hai Nguyen	Senior Clinician Men's Family Violence Services at Melton Western Health, Registered Psychologist
Michelle Perry	Family Violence Practice Manager, Magistrate Court Victoria
Kaye Frankcom	Clinical and Counselling Psychologist at Frankcom Consulting Clinical and Counselling Psychologist, MAPS
Assunta Morrone	Project Lead - Strengthening Hospital Responses to Family Violence Sunshine, Footscray and Williamstown Hospitals
Patrick Birtles	Senior AOD Outreach Clinician at Odyssey House
Joanne Doherty	Specialist Family Violence Advisor at North Western Mental Health
Dani Gold	Specialist Family Violence Advisor, Mental Health & Senior Social Worker, RCH Family Violence
Natalie Wallace	Clinical Practitioner at Caring Dads Anglicare Victoria
Mary Karambilas	Capability Building Co-Ordinator at InTouch Multicultural Centre Against Family Violence
Marianne Crowe	Registered Nurse: Project Lead, Safe Communities and Equitable Health | Strengthening Hospitals' Response to Family Violence (SHRFV) at St Vincent's Hospital
Denise McAloon	Services Team Leader at No to Violence (NTV); Men's Referral Service
Narelle Trewin	Specialist Practitioner at Good Shepherd – Crisis Service
Zanetta Hartley	Specialist Family Violence Advisor at North Western Mental Health
Jac Dwyer	Family Violence Practice and Development Officer, Berry Street
Denise McAloon	Services Team Leader at No to Violence (NTV), Men's Referral Service
Dave Kwame Arthur	Senior Clinician from Odyssey House Victoria and AOD system representative
Lived Experience Representatives	WEAVERS UoM

QI Activity

phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

Identify people at risk of or experiencing family violence

First steps

1. Nominate a lead person for this activity.
2. Decide how you will communicate with your practice team and patients about the improvement you're working on.
3. Meet with your practice team to discuss how you will implement this activity
4. Decide on your target (%) improvement. Write it in **Goal** below.
5. Refer to our quick guide for more ideas to increase the success of your improvement activity.
6. Check the relevant HealthPathway for this condition to ensure your team is up to date with best practice management guidelines.

Setting up your QI activity and PDSA.

Goal	***What are we trying to accomplish? By when?***
	Increase the number of family violence assessments in the practice. *Aim to do ____ family violence assessments by [date] _____.*
Measure	***How will we measure this?***
	• Record the number of family violence assessments. • Decide the best way to do this for your practice, you may wish to code family violence discussions in your practice software, or GPs and nurses could manually record each time they ask the question.

Improvement ideas	• Discuss the practice's approach to family violence at a clinical meeting. It might be useful to review the following resources:
	  • The White Book, 5th Edition, RACGP
	  • 'Starting the conversation about Family Violence'
	  • HealthPathways Melbourne, which includes some example questions that can be used to screen for family violence

- Family violence resources and additional training
- Decide how your practice will record if a patient discloses family violence. Consider using a code to record when family violence is asked (for example: FVA), disclosed (FVD) and when patients are referred (FVR).
- Look at including family violence assessment into specific types of appointments, such as mental health appointments, antenatal appointments and postnatal checks, and add specific family violence questions to the templates for these appointments. Consider the following questions or similar:
  - Examples of broad or general questions:
    - *How are things at home?*
    - *How are you and your partner getting along?*
    - *What happens when you and your partner (or family member) argue?*
  - Examples of direct questions:
    - *Do you feel safe?*
    - *Are you afraid of your partner (or family member)?*
    - *You seem very nervous and anxious. How is everything at home?*
- Include information in the practice to promote open discussion. For example:
  - Provide brochures and information in waiting room, see the RACGP Family Violence Toolkit for some resources.
  - Run an awareness campaign in the practice, use practice website and social media.
- Communicate the changes and improvements you make to the team.

PLAN **Identify who will do each step, how they will do it and by when. Plan the test, including a plan for collecting data.**

Step 1	**Who will do this?**	**By when?**
Step 2	**Who will do this?**	**By when?**
Step 3	**Who will do this?**	**By when?**
Step 4	**Who will do this?**	**By when?**

DO **Who is going to do what? Run the test on a small scale. Carry out the plan. Record data. Record any unexpected outcomes.**

What we did:
By *[insert the date stated in **Goal** section [number] ____ Family Violence assessments by [date] _____.*
Unexpected outcomes:

STUDY  **Analyse the results and compare them to your predictions.**
Does the data show a change?

Write your responses to the following questions to reflect on your activity and what you learned.
Did you achieve what you thought you would? **Did your strategy work well? If yes, why? If no, what needs to be changed?** **What challenges or barriers occurred?**

ACT  **Do you need to make changes to your original plan?**
Based on what you learned from the test, plan for your next step

What next? Will you implement the change or try something new? *What idea will you test next? What will you take forward; what is the next step or cycle?*
What will you do now? Will you continue with the activity, change or improve it? **Does this activity need to be repeated in the future? Could a reminder be scheduled for this?** **What improvement activity will your team focus on next?**

Next steps

Try out another QI activity

After completing this activity, you may wish to consider another QI activity:

- Increase the confidence of your practice team to identify and respond to family violence

Visit nwmphn.org.au/qi to download templates for these activities.

Celebrate your work

We would love to publish your quality improvement story on our website and share it with other practices. We encourage you to share your completed template and any photos from the project with us.

If you would like to tell us about your outcomes, please contact primarycare@nwmphn.org.au

Support

If you need any support to implement your activity, if you had any difficulties, please contact us. Email primarycare@nwmphn.org.au or call (03) 9347 1188 to speak to your practice's quality improvement program officer.

We acknowledge the peoples of the Kulin nation as the Traditional Custodians of the land on which our work in the community takes place. We pay our respects to their Elders past and

T (03) 9347 1188 | **F** (03) 9347 7433 | **E** nwmphn@nwmphn.org.au | **W** nwmphn.org.au

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QI Activity

phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

Increase the confidence of your practice team to identify and respond to family violence

First steps

1. Nominate a lead person for this activity.
2. Decide how you will communicate with your practice team and patients about the improvement you're working on.
3. Meet with your practice team to discuss how you will implement this activity
4. Decide on your target (%) improvement. Write it in **Goal** below.
5. Refer to our quick guide for more ideas to increase the success of your improvement activity.
6. Check the relevant HealthPathway for this condition to ensure your team is up to date with best practice management guidelines.

Setting up your QI activity and PDSA.

Goal	***What are we trying to accomplish? By when?***
	Increase confidence of the practice team to identify and respond to family violence by ____ [date]
Measure	***How will we measure this?***
	Pre- and post-survey measuring practice staff confidence in identifying and responding to family violence pre and post activities.

Improvement ideas	• Discuss the practice's approach to family violence at a clinical meeting. It might be useful to review the following resources:
	  • The White Book, 5th Edition, RACGP
	  • 'Starting the conversation about Family Violence'
	  • HealthPathways Melbourne, which includes some example questions that can be used to screen for family violence
	  • Family violence resources and additional training
	• Consider developing an internal family violence policy outlining the practice's approach, including roles and responsibilities. The NWMPHN family violence policy (.pdf) may help you.

- Introduce training for all new staff members on family violence. For example: RACGP Family Violence GP Education Program or the Safer Families Centre's Readiness Program.
- Consider inviting a family violence worker from your local Orange Door service to come to the practice, provide education and discuss the services available.
- Provide an overview and update your practice with resources and referral options such as:
    - **Resources to promote referral options available on the NWMPHN website**
    - **RACGP resources**
    - **The Orange Door resources**
- Add family violence case discussion into your monthly/fortnightly (clinical) team meetings. Use your meeting as an opportunity to debrief and discuss family violence cases. Practitioners can call The Orange Door to make a warm referral or for secondary consultation. Consider external supervision from other services.

PLAN  **Identify who will do each step, how they will do it and by when. Plan the test, including a plan for collecting data.**

Step 1	**Who will do this?**	**By when?**
Step 2	**Who will do this?**	**By when?**
Step 3	**Who will do this?**	**By when?**
Step 4	**Who will do this?**	**By when?**

DO  **Who is going to do what? Run the test on a small scale. Carry out the plan. Record data. Record any unexpected outcomes.**

What we did:
*[insert the date stated in **Goal** section] we increased the confidence of the practice team to identify and respond to family violence in your practice by ____ [%]*
Unexpected outcomes:

STUDY **Analyse the results and compare them to your predictions.**
Does the data show a change?

Write your responses to the following questions to reflect on your activity and what you learned.
Did you achieve what you thought you would? **Did your strategy work well? If yes, why? If no, what needs to be changed?** **What challenges or barriers occurred?**

ACT **Do you need to make changes to your original plan?**
Based on what you learned from the test, plan for your next step

What next? Will you implement the change or try something new? *What idea will you test next? What will you take forward; what is the next step or cycle?*
What will you do now? Will you continue with the activity, change or improve it? **Does this activity need to be repeated in the future? Could a reminder be scheduled for this?** **What improvement activity will your team focus on next?**

Next steps

Try out another QI activity

After completing this activity, you may wish to consider another QI activity:

- Identifying people at risk of or experiencing family violence

Visit nwmphn.org.au/qi to download templates for these activities.

Celebrate your work

We would love to publish your quality improvement story on our website and share it with other practices. We encourage you to share your completed template and any photos from the project with us. If you would like to tell us about your outcomes, please contact primarycare@nwmphn.org.au

Support

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Appendix 6: Summary of QI activities/tasks implemented at practices

Goal	Activities	Measures	Results and comments from 26 practices
Increase awareness, early patient identification	Patient awareness **posters in the waiting room and/or pamphlets in the bathroom** **TV Tonic** (TV in waiting room): added **a slide** on Family Violence stats **on repeat in the waiting room** **Posters** gathered and **added to practice virtual noticeboard** including questions and details of SafeSteps; **A variety of resources**, including cards, posters, safety plan brochures, etc **at the point of care**: resources at GP's desk; at Nurse Station at the breastfeeding room for new mums; A reminder on the computer screen to ask questions;	Tally number of pamphlets taken in toilet Number of disclosures Feedback from patients via questionnaires and verbal feedback	**26 practices upgraded their resources**. • Practice that implemented this activity reported up to **40 pamphlets taken per practice per month.** • One practice reported **2 disclosures**, each patient specifically mentioned seeing the poster in the bathroom which prompted them to initiate a conversation about family violence. • Resources at hand in clinic give good introduction to Family Violence and has been well received by practices and used on several occasions to open up concerns during consults.
	Family Violence Awareness materials in: - **Banner** on the website - **Social Media (Facebook/Instagram)** - **Email signature banner** - **Online Practice Newsletter**	Number of views Number of likes Reach via emails Feedback from patients via return emails and verbal feedback	A number of practices added information about Family Violence on practice website • One Dr added an article on their **blog**; One practice had posts on **Facebook**; • One practice did a community awareness campaign around Christmas on their **Instagram page**; • One practice created an email banner saying **'everyone has the right to feel safe at home'** 
	Cards with resources in English and other languages	Number of cards taken per month Number of handouts taken by patients	• Practices reported using resources in **English, Arabic, Hindi, Burmese, Punjabi, Vietnamese and Dinka**. Practice that implemented this activity reported from **3 to 17 cards taken from each practice per month**
	Pregnancy handouts - added information on family violence		• Implemented by one practice, no disclosure were recorded while on the project
	My Safety Plan brochure		• One practice recorded **4 brochures** taken a month

Increase early identification	**Mental Health Plans/Reviews** – amended template to include questions about family violence; Clinical team decided on questions they are comfortable with. Reasons for activity: a longer and reoccurring appointment, patients expect personal questions, research shows FV affects mental health.	Number of patients asked per month; Number of patients disclosed - via a paper pad (manually) - a code (for example SS for safer steps) on the clinic software Survey of MHP per month per GP; review how many discussed family violence and survey post implementation of plan;	• **17 practices** implemented this activity and reported from **6 to 192 patients asked (screened) per month; Number of patients disclosed varied from 1 to 5 per month** Added questions included: 1. Do you feel **safe** in your current relationship? 2. Are you **afraid** of your partner? 3. What happens when you and your partner argue? 4. Have you ever been **hit, kicked, punched or hurt** by someone (family or partner) in the last year? 5. Is there a partner from previous relationship who is making you feel **unsafe** now?
Increase identification	**Antenatal appointments** - amended the template to include questions about family violence. Reason for activity was as intimate partner violence may increase during pregnancy and postnatally Clinical team decided on questions they are comfortable with. Questions can be added autofill in Clinical Software	Number of patients asked per month - via a paper pad (manually) - a code on the clinic software	. **7 practices** implemented this activity and reported from **2 to 36 patients asked per month** Added questions included: - Has your relationship changed since you became pregnant? - Are you feeling frightened? - Are you worried about your children's safety?
	6 weeks post-natal checks - amend the template to include questions about family violence; Clinical team decided on questions they are comfortable with. Questions can be added as autofill in Best Practice	Number of patients asked per month - via a paper pad (manually) - code the reason for visit	**9 practices** implemented this activity reported from **2 to 36 patients asked per month.** One practice suggested a specific code 6/52POSTNATMT autofill as a help, so that these consults can be 'found' later for audit. Negative findings documented, as deferral of questioning (e.g. when partner is present ad not able to have mother alone). Added questions included: - Is there anything else going on in your life that you'd like to talk about? - Are you feeling frightened since the baby was born? - Are you worried about your children's safety?

Increase identification	**Refugee Health Assessment;** **Risk assessment form** **GPMP, HA: ATSI, 75+, 45-49 HA** **Counselling/ Annual executive health assessment** **Aboriginal Assessment appointment –** an opportunity to ask about family violence	Number of patients asked per month; Number of patients disclosed	Depending on the demographic, practices choose other MBS claimable items as an opportunity to ask about FV. **1-20 patients were asked per month** as part of these appointments
	Chronic Disease Care Plans - amend the template to include questions about family violence; Nurses decided on the questions they are comfortable with.	Number of patients asked per month; Number of patients disclosed	One practice recorded **3 disclosures** through Chronic Disease Care Plans
	Cervical Screening Appointment – as an opportunity to ask about FV	Number of patients asked per month; Number of patients disclosed	Acknowledging that screening everybody is not best practice.For some practices this was an only opportunity to ask as it could be the only appointment type when female patients attend without their partners. **1-10 patients per month** were asked by **4 practices**
	Vaccination Appointment – as an opportunity to ask about family violence **Baby Vaccination Appointment** - as an opportunity to ask about family violence	Number of patients asked per month; Number of patients disclosed	One practice reported **a disclosure** at a Covid vaccination appointment.
Team support and provider satisfaction	Discuss difficult cases including family violence, share resources and help manage families as **monthly in practice staff meetings**	Number of participants at the meetings Number of cases discussed	Some practices introduced family violence discussion as a protected item on their monthly meeting. **6 practices** reported this activity. One practice invited Family Violence Worker to their meeting
	Regular Clinical Meetings MBS item 747 can be considered for MULTIDISCIPLINARY CASE CONFERENCE	Number of participants Number of cases discussed Journal of skills developed	**5 practices** reported this activity with up to 11 participants and **1-2 case discussed each time**
Up-to-date	Usage of **HealthPathways** Melbourne to clinical and referral pathways platform.	Number of computers installed	Practices were given a unique URL to use the platform without logging in for family violence related and other issues (i.e. Covid vaccinations, etc)

		Number of times used for FV related presentations	As a result, **50% practices (13 practices) used the platform to access Family Violence pathways** and 85% of practices (22 practices) used the platform for other reasons.
Delegation of FV work	Hiring **Mental Health Social Worker** to work with patients and support GPs	Number of patients screened/supported a month Number of supported GPs	**One practice** employed a Mental Health Social Worker to work with patients and support GPs.
	A Nurse Lead Model		This model was implemented at **2 practices**. Male doctors would refer their patients with FV issues to the female nurse or GPs hand the patient over to the PN for support in a designated private room.
Resources to support the team	**Updated address book** **Shared Drive with resources** **Emergency Plan** in case of escalated threat Development of **internal FV Policy** **Mandatory FV training** for new staff **Info sheet** for nurses; **Links to safety plans and assessments** added to Clinical Software	Number of staff members supported Number of times utilised, etc	A number of practices implemented some specific resources to support their team.

Training resources

This included staff needed, materials and external resources

Staff

The overall management of the project was coordinated by Irina Basanko, Project Lead, Primary Care Pathways to Safety North Western Melbourne PHN. She was supported by Bianca Bell, Director, Primary Health Care Improvement, Michaela Lodewyckx, Manager, Primary Health Care Improvement and Stephanie Germano, Manager Quality Improvement Partnerships, North Western Melbourne PHN.

The intensive training and the evaluation of the project was undertaken by Safer Families Pathways to Safety staff, The Department of General Practice, The University of Melbourne. The work was led by Professor Kelsey Hegarty, Professor Family Violence Prevention, The University of Melbourne and The Royal Women's Hospital, and the day-to-day management undertaken by Kitty Novy.

Additional experts were employed to facilitate the training, assist in the development of the program and training material and support the participants undertaking the training.

The staff table below details the staff and their role in the project

Staff	Background	Role in Project
Prof Kelsey Hegarty	• Manager of the program and chief investigator of both **weave** (primary care intervention with an educational program element) • Manger of the **Sustainable Primary Care Family Violence Model** (general practice educational program regarding family violence) • Leads the Safer Families Centre of Research Excellence • Holds the joint Chair in Family Violence Prevention at the University of Melbourne and the Royal Women's Hospital • co-editor of book on "Intimate partner abuse for health professionals" • Editor of the RACGP's White Book and gplearning module 'Domestic Violence' • Director of the Postgraduate Primary Care Nursing Course in the Department of General Practice at The University of Melbourne • Providing regular expert advice to the World Health Organisation	• Providing training to GP facilitators and FV support worker Providing training for simulated patients • Developing the facilitator and Participant Program • Facilitating intensive train, the trainer session • Providing debrief support for GP facilitators • Facilitating meetings throughout program with FV support worker and GP facilitators
Jac Dwyer	• Practice Development & Training Officer at the Northern Specialist Family Violence Service (NSFVS), Berry Street	• Providing consultative input into the program and material • Facilitating intensive training sessions • Providing scondary consultations with the practices in the NWMPHN Northern Melbourne catchment area
Megan Perry	• Advanced Family Violence Practice Lead at GENWEST • Development & Training Officer	• Providing consultative input into the program • Facilitating intensive training sessions • Providing secondary consultations with the practices in the NWMPHN Western Melbourne catchment area

Christina Hotka	• Training Officer GENWEST	• Providing consultative input into the program including LGBTIQA referrals and advice • Facilitating intensive training sessions • Providing secondary consultations with the practices in the NWMPHN Western Melbourne catchment area
Dr Ralph Audehm	• A practicing GP with 30 years in general practice • A member of the NWMPHN Peak Clinical Council. • An honorary clinical Associate Professor with the Department of General Practice, University of Melbourne • Facilitated programs on domestic violence for GPs previously	• Providing consultative input into the program Facilitating intensive training sessions
Dr Deepthi Iyer	• A practicing GP in Melbourne • Lecturer at the Safer Families Centre of Research Excellence • Deepthi's PhD explored Australian young women's perceptions of dating and dating violence. • An author and expert advisory group member for the RACGP White Book	• Providing consultative input into the Program • Facilitating intensive training sessions
Dr Jennifer Neil	• A practicing GP Melbourne,where she works with survivors of family violence, has interests in mental health and chronic disease management • Curriculum and Assessment Lead Monash University • GP educator in family violence, having taught hundreds of health care professionals and students since 2015 • Co-author of two chapters and a MARAM supplement of the RACGP White Book - guideline on abuse and violence	• Providing consultative input into the Program • Facilitating intensive training sessions • Facilitated the Community of Practice
Dr Magdalena Simonis	• A practicing GP and a general practice researcher with the University of Melbourne • She has been involved in the development of 'Take A Stand', a primary prevention of violence against women program, developed and piloted through Women's Health Victoria and the Victorian Government • She has a Master's in Health and Human Services, is involved in delivering the family violence training program with the RACGP Family Violence Department of Health program • Expert Advisory Group reviewing the 5th edition of the RACGP White Book	• Providing consultative input into the program • Facilitating intensive training sessions
Dr Elizabeth Hindmarsh	• A GP Educator and the past Chairperson of RACGP Special Interest Group on Abuse and Violence • Co-editor of the RACGP's guidelines "Abuse and violence: working with our patients in general practice" (White Book) 5th edition • She pioneered the first GP training on domestic violence over twenty years ago • A practicing GP working in General Practice for over 40 years	• Senior mentor to the GP Facilitators, and FV support workers • Facilitating intensive training sessions • Providing consultative input into the program development • Providing intensive training to GP Facilitators and FV support worker
Kitty Novy	• Extensive experience in working with general practice in recruiting and support of research projects	• Administrative assistant • Responsible for management of the Program • The first point of contact for queries relating to the program • Organised training sessions and follow up sessions

Role of the FV Support workers

The FV support worker was fully engaged in supporting the training and assisting in building up the capacity of the practices as well as improving the knowledge, skills and confidence of the participants. The FV support worker worked with the GP Facilitator to deliver the training.

Although the crucial role of the FV support worker was to co-facilitate the sessions, they were also vital in developing strong links with the family violence services in the catchment area to ensure adequate service linkage and individual direction would be available to the practices. The FV support workers skills and expertise enabled them to provide secondary consultations, referrals according to the specific needs around culture, language and diversity and any resources the practices needed. They:

- Co-deliver (with a trained GP Facilitator) a practice-centred training module to participating GP practices and other primary care providers
- Support clinical and non-clinical staff to strengthen their skills, knowledge and confidence in
- identifying and responding to family violence and streamline referrals
- Provide secondary consultation and act as a “local link” or “connector role” to help build pathways between primary care and the wider specialist service.
- Liaise and work closely with the trained GP Facilitator and the staff at Safer Families Centre, University of Melbourne.

The FV support worker was fully engaged in supporting the training and assisting in building up the capacity of the practices as well as improving the knowledge, skills and confidence of the participants. The FV support worker worked with the GP Facilitator to deliver the training.

Role of the GP Facilitators

The GP Facilitators delivered the training and were directly involved in capacity building within the 26 practices. They were selected because of their expertise

- Strong communication skills
- Skills and experience in training small groups on sensitive issues
- Prior training, experience or an interest in addressing domestic and family violence or trauma informed care
- Experience engaging with services such as DFV, mental health, AOD, or sexual assault services

They worked in a collaborative way with the FV support worker and the staff building the participants confidence to take back the skills to the consultation room. The sessions were used to brainstorm scenarios that the staff might encounter, discuss resources and concrete management strategies that would work in their practice. The GP Facilitators provided an opportunity for the practice to discuss issues in an individualised way.

An important aspect of the program was to ensure that all the GP Facilitators were all given support and mentoring throughout the delivery of the training.

- Clinical training and meetings were conducted throughout the year. After the initial training the existing GP facilitators were given further training on cultural competency
- The Facilitator training handbooks was updated throughout the training period, incorporating the feedback from the participants and integrating what they had learnt from the sessions.

Training Sessions

The training was conducted via ZOOM over two sessions, with duration of ninety minutes per session. The sessions would often last longer as the staff were encouraged to discuss with the GP facilitator or FV support worker any concerns. The training sessions were delivered by a GP facilitator and FV support worker with administrative support. The FV support worker and GP facilitator worked together in a collaborating manner to deliver the interactive session. The training session was offered to all general practice staff.

Train the Trainer Sessions

A total of 5 GP facilitators and 3 FV support worker participated in two Train the Trainer workshops to familiarise themselves with the material in the program and also to incorporate their expert advice into the content of the program. Regular educational sessions were held over the period to update material, and brainstorm feedback collected from the training sessions.

Materials

The following resources developed for the comprehensive educational program included:

- Revising Train the trainer package for the GP facilitators and FV support worker
- Revising Facilitator handbook, Administrator handbook, Participant handbook with additional extensive resources for the two regions
- Updating of presentation slides for the training session one and two
- E- learning modules

Participant handbook and Facilitator handbook

These were updated by Professor Kelsey Hegarty with consultative contribution provided by Dr Elizabeth Hindmarsh, Dr Ralph Audehm, Jac Dwyer (Berry St), Christina Hotka and Megan Perry (GENWEST)

The handbook addressed the following activities:

- How to undertake counselling during a consultation
- Tools for use in consultations, which were updated and added during training
- Counselling resources, including risk assessment and safety planning, problem solving motivational interviewing
- Localised referral pathways and resources
- Cultural competency and cultural sensitivity in their approach to family violence

The training handbooks were updated during the delivery period to incorporate cultural competency and cultural sensitivity in approaching family violence. Further revision of the handbook was undertaken to include the updated MARAM, (The Family Violence Multi-Agency Risk Assessment and Management Framework).

The Audit tool

This tool was distributed to each of the participating GPs and nurses to complete before the training began, the aim of which was for them to:

1. Undertake an audit of 10 consecutive female patients
2. Self-reflect on own consultations and reflect on the strengths and areas requiring improvement
3. Analyse psychological issues underlying presentations (including family violence)
4. Identify the reasons why certain consultations can be difficult and how to reduce the degree of difficulty

The Whole-of-practice checklist

The document was sent to all the staff to enable the staff to reflect upon what their practice already does in terms of its readiness to respond to women and children experiencing family violence. Specifically, it asks participants:

- To examine current systems within the organisation
- Identify areas for change
- To look at what support given to staff experiencing family violence in the practice

Online modules

- Prior to participating in the training, the '**Identifying and Responding to Domestic and Family Violence**,' module was made accessible to the clinical the staff as pre-learning to enable the staff to reflect upon and increase their skills in identifying and responding to domestic and family violence.
  The Safer Families Centre developed an additional suite of 6 E-learning modules which were also available for the staff by accessing the Safer Families website: www.saferfamilies.org.au/readiness-elearng:
  E-Learning modules available:

- Identifying and Responding to Domestic and Family Violence
- Identifying People who have used Domestic and Family Violence
- Identifying and Responding to Child Abuse and Neglect
- Providing Trauma and Violence Informed Care in Primary Care
- Addressing Family Violence: Aboriginal and Torres Strait Islander Peoples
- Six Steps to Support you to Assess and Respond to Elder Abuse
- Supporting Primary Care to Implement Family Violence Information Sharing

The RACGPs online gplearning module. The module provided additional interactive and self-reflective learning for the GPs and covered similar topics to those presented in the White Book but focused on domestic violence

- '**Domestic Violence'**.https://www.racgp.org.au/education/education-providers/curriculum/contextual-units/presentations/av16-abuse-and-violence

The White Book

The White book is a manual for GPs in Australia on working with patients who have experienced or are currently experiencing abuse and violence. Those participating in the program were requested to read parts of the manual. Royal Australian College of General Practitioners (RACGP) Abuse and Violence: Working with our patients in general practice Manual.