THE AUSTRALIAN CENTRE FOR SOCIAL INNOVATION

Recognise, Respond, Refer: An integrated health response to domestic & family violence

Developing a model for an integrated response to DFV

Prepared with care for BSPHN by TACSI

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Contents

We pay respect to the Traditional Custodians of all lands, past, present and future. Honouring our Elders and nurturing all young people.

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Glossary

DFV	**Domestic and family violence**
DFVSS	**Domestic & family Violence Service System**
TACSI	**The Australian Centre for Social Innovation**
CQU	**Queensland Centre for Domestic and Family Violence Research, CQUniversity**
ISSR	**Institute for Social Science Research, University of Queensland**
GP	**General Practitioner**
BSPHN	**Brisbane South PHN**
HRT	**High Risk Teams**

A note on language

We recognise the gendered nature of violence and have referred to women as victim survivors throughout the document in recognition of the disproportionate effects on women. We also recognise that gender diverse people can feel invisible in a gender binary system, and that gender-binary practices need challenging.

Whilst we feel the term perpetrator may get in the way of effective behaviour change, we've used the term throughout for ease and brevity - interchangeably with men who have used violence, or those who have used violence.

Instead of using the term victim, we've used victim survivor to recognise the strength and resilience of people experiencing violence.

Introduction

What underpins the model?

Context

Primary Health Networks (PHNs) have been established by the Australian Government with the key objectives of increasing the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes and improving coordination of care to ensure clients receive the right care in the right place at the right time.

Domestic and Family Violence: The Role of Primary Health Care

Domestic and Family Violence (DFV) is recognised as a significant problem at national, state and local levels. It was once thought that the prevention and amelioration of DFV resided within the confines of the judicial system. It is now widely acknowledged that any potential solution to DFV is exceedingly complex and requires multi-disciplinary collaboration between a number of government and community agencies. The World Health Organisation and Council of Australian Governments have cemented the role of health by prioritising an effective primary health care system as one crucial element in any proposed multi-sectoral response to DFV. This is further supported in the Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland report, released in 2015. It contains recommendations that specifically pertain to the crucial role of an effective primary health care system, hence this current project.

On a local level, the 2018 Brisbane South PHN Needs Assessment identified DFV as a priority area for intervention. Treatment for the physical and mental health impacts of violence is the obvious intersection between DFV and the health care system. However, for many individuals affected by DFV, contact with a primary health care professional can be their only link to a community based service, with an average of seven to eight visits occurring prior to disclosure. Unfortunately, the evidence suggests that once a disclosure is made, the responses received are frequently regarded as inappropriate and poor in quality. In addition, specialist service providers continue to report a disparity between the high prevalence of the DFV identified within the

primary health care environment and the number of referrals received from the sector. The existing referral mechanisms are becoming increasingly convoluted and fragmented which can make appropriate referral challenging for overstretched GP's.

Due to the level of interaction people experiencing DFV have with the primary health care sector, and the interdisciplinary nature of the issue, it is clear that potential solutions to this epidemic will require innovative responses from all sectors.

With the above in mind, Brisbane South PHN developed the'Recognise, Respond, Refer': An integrated health response to domestic and family violence (RRR). The RRR program was designed and commissioned based on the IRIS (Identification and Referral to Improve Safety) trial in the UK and the WEAVE (Women's Evaluation of Abuse and Violence Care) trial in Victoria. These trials both demonstrated the benefits of building capacity of primary care providers to respond to DFV.

The focus of this work is the third part of the RRR program which involves bringing primary care into the wider service system by developing a model for an integrated health systems response to DFV for the Brisbane South region.

The model should:

- Identify the most appropriate and effective role for primary health care within the DFV service system
- Create a culture of reciprocity between the primary health care system and other services, ensuring the person/family are at the centre of the care
- Support services within the DFV system to provide seamless, safe and timely support to people experiencing DFV, to ultimately improve their outcomes
- Be cost effective, evidence based and sustainable
- Be adaptable to the specific needs of DFV sub-systems across the Brisbane South region i.e. service and supports for priority populations and the differing geographical areas
- Aim to reduce spending on tertiary health and human services by integrating primary care into the DFV service system.

The implementation and evaluation plan for the model should include clear processes for further detailed design, development, establishment and sustainability of the proposed response. This should include processes for appropriate implementation in the different sub-systems in the region.

Brisbane South PHN commissioned The Australian Centre for Social Innovation (TACSI) to lead the model development process whilst working collaboratively with Brisbane South PHN. As a national centre for social innovation, TACSI is passionate about uncovering new and better ways to create social good. From systems innovation through to unlocking the assets and potential of our communities – we are determined to move social innovation from the margins to a national priority. Our main focus is to maximise co-production opportunities and action in order to represent priority populations and consumer voices in all aspects of design and evaluation. Find out more at www.tacsi.org.au

Summary

‘The causes and contributors to domestic and family violence are extremely complex and are founded in cultural attitudes and behaviours, gender inequality, discrimination and personal behaviours and attitudes’

QLD DFV Prevention Strategy

The Problem

Violence against women and their children is not an inevitable or intractable social problem. Rather, it is the product of complex yet modifiable social and environmental factors. Gender inequality is the core of the problem and it is the heart of the solution (ANROWS, 2015 p.3). The annual cost of domestic and family violence to the Queensland economy is estimated to be between $2.7 billion to $3.2 billion (Not Now Not Ever, 2015 p.6).

There is already a passionate, dedicated service sector, and the people who provide the services work tirelessly under difficult circumstances to support and protect victims of domestic and family violence. Unfortunately, as passionate and dedicated as this sector is, victim survivors and service providers consistently raised concerns about significant gaps in services across the state and a general lack of a unified or coordinated response (Not Now Not Ever, 2015 p.11).

Internationally, the World Health Organisation's 2013 report on the prevalence and health effects of intimate partner violence and non-partner sexual violence found that violence against women is pervasive globally, describing it as "a global public health problem of epidemic proportions, requiring urgent action" (Not Now Not Ever, 2015 p.77). Research indicates that the response to support social change in the context of DFV needs to be a broad and shared effort, one that involves individual women and men, whole communities, and diverse organisations and institutions (Our Watch, 2015).

One part of the solution – The aim

The AMA has adopted the World Medical Association's (WMA) Declaration of Geneva as a contemporary companion to the 2,500-year-old Hippocratic Oath for doctors to declare their commitment to their profession, their patients, and humanity. One section states:

> *I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient*

(https://ama.com.au/media/ama-adopts-wma-declaration-geneva)

'There could be so much more that health could be doing... to create cultural change - they are in a unique position.'
DFVSS Informant

The *Not Now Not Ever* (2015) publication recommends that general practice needs to be more prescriptive and provide more definite advice and pathways for patients. Brisbane South PHN is supporting Primary Care to formalise its role and interventions in response to the effort required.

The model presented is not a specific service, but rather a number of identified functions and influencing activities operating across individual practice, local practices and a PHN led systems level that will enable primary health, particularly GPs and their medical centres, to play a visible and deliberate role within the domestic and family violence ecosystem that supports an integrated systems response to DFV. The model will aim to increase accessibility to appropriate support for people experiencing and using violence within a domestic and family context. It is based on literature and what victim survivors, GPs, practice staff, domestic and family violence service sector representatives and other key informants told us.

This model comprises six core activities all of which are dependent on one and other in order to create maximum positive impact:

1. **DFV Local Link (DFVLL) –** The DFVLL primarily focus on integrating a local DFV response playing a connector function between primary care, DFV services and influential systems stakeholders.
2. **Recognise, Respond, Refer Training –** Continuing to support GPs and practice staff in our communities to expand DFV understanding and capabilities to intervene.
3. **Primary Care's Role –** From creating the climate for disclosure to staying involved post disclosure/ referral, there are practical ways primary care can support an integrated DFV response when properly supported to do so.
4. **Locality Integration –** Creating time out of business as usual for stakeholders to connect, name shared challenges, identify opportunities, explore alternative solutions and build the foundations of a united response at a local level.
5. **System Influence –** Convening influential system stakeholders to address structural and relational conditions which are preventing current problems being overcome and alternative solutions being adopted and scaled.
6. **Evaluation, Design and Iteration –** Building measurement, evaluation, co-design and prototyping approaches into the fabric of the model will ensure that it keeps evolving and improving the lives of people affected by DFV.

All elements of the model will operate within the spirit of the principles (p.13) and mindsets (p.14) identified for this project specifically based on what key informants and victim survivor insights and existing evidence told us.

We make note that in implementing this model certain preconditions must be in place in order to ensure traction, investment and ongoing success. These preconditions are detailed on p.47.

We propose the model to be tested in areas where there is current need and/or pockets of motivation to be involved.

The Approach

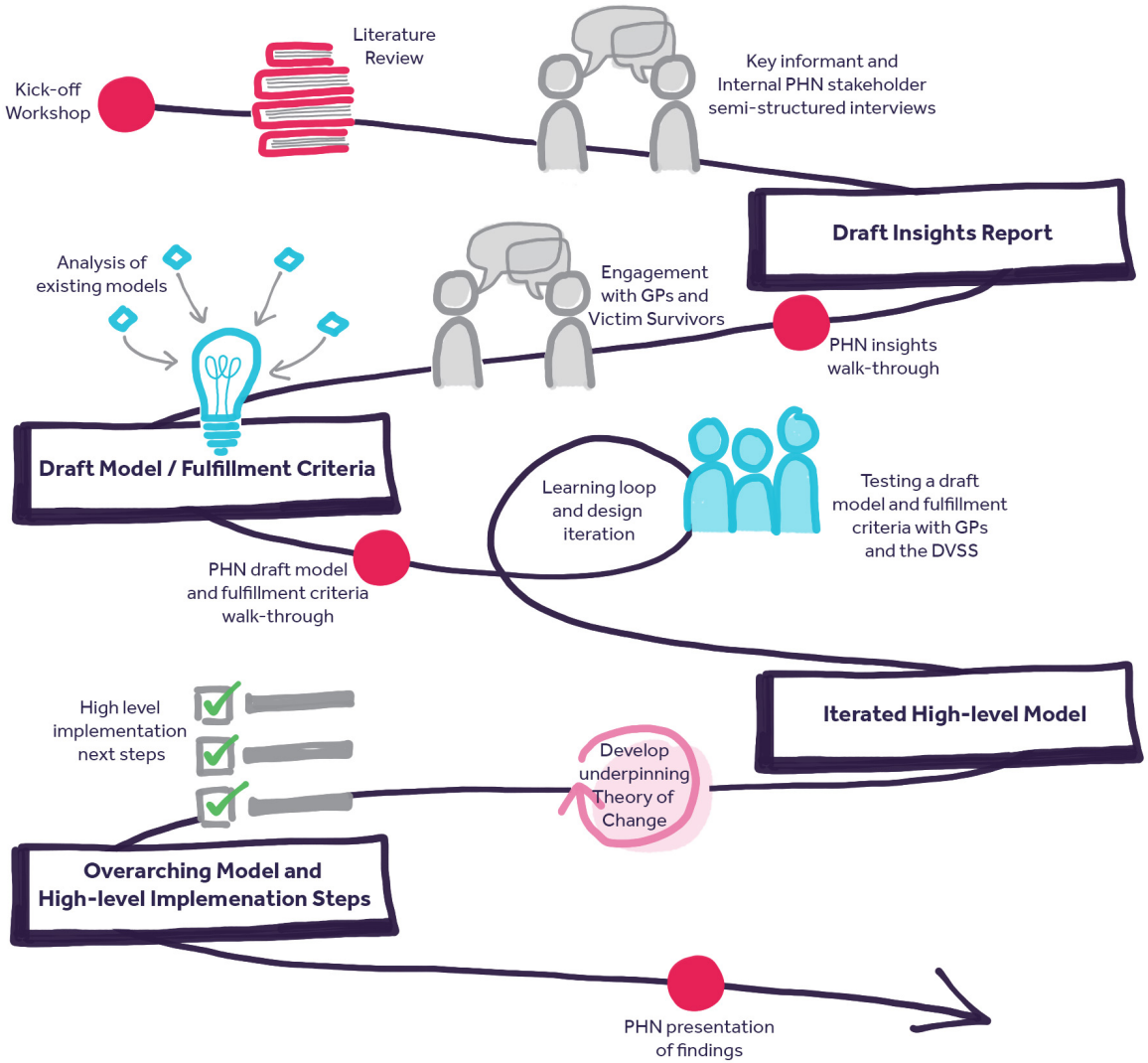
To develop the high-level model we have worked in 2 phases:

Phase 1

- Carried out a broad literature and information review
- Met with a broad range of key informants such as representatives from the DFV service sector, other key stakeholders such as Queensland Aids Council and Awakening Cultural Ways.
- Met with those delivering the RRR Training (CQU – QCDFVR), and those evaluating it (UQ – ISSR)
- Met with a range of internal stakeholders at BSPHN
- Presented a draft insights report that began to:
  - Frame the key criteria for a model to respond to (the model brief)
  - Frame the role of primary care in recognising and responding to DFV
  - Frame some of the barriers and issues to general practice staff adopting the role, particularly GPs
  - Frame issues and opportunities for GPs and in some instance other relevant general practice staff to work across four phases:
    - Creating a climate for disclosure of DFV
    - Supporting disclosure
    - Supporting referral
    - Staying involved post-disclosure/referral

Phase 2

- Met with GPs & practice staff
- Met with victim survivors of family and domestic abuse
- Refined the draft model criteria
- Developed a first high-level draft of the model
- Tested it with GPs and informants from the DFVSS
- Iterated the next version of the high-level model
- Defined high-level implementation steps



High-level Discovery

Across the 2 phases of work we have come to understand much about the complex intersection that is, and will be, between primary care and the broader DFV eco-system.

Table 1 – Opportunities for Change in the DFV System, p.11
Names some of the opportunities that have the potential to create meaningful change in the DFV system.

Table 2 – Model Fulfilment Criteria, p.12
Shows the model fulfilment criteria which have been defined as measures of success for this DFV model. They have been drawn from both academic evidence and key informant interviews.

Table 1 – Opportunities for Change in the DFV System

Names some of the opportunities that have the potential to create meaningful change in the DFV system

MOVING FROM...	MOVING TO...		
Current State	**Enablers to aid progress**	**Emerging short term goals**	**Emerging future state**
Varying levels of interest and expertise in recognising, responding and referring amongst GPs. Many GPs motivated to improve their practice but lack resources to do so. Diversity of interest in DFV within medical practices poses a challenge for any model that focuses on a 'whole of practice' approach. System change required to make the safety of victim survivors priority. **Areas that need to be explored and addressed:** • Clarity around the role of GPs and how they can most effectively recognise, respond and refer. • Addressing practices that can be unproductive and potentially increase risk for victim survivors, such as minimising disclosure of harm, seeing victim survivors as difficult and non complaint, seeing services as the only response to DFV and applying universal and homogenous responses. • Understanding of the concept of collusion with perpetrators and how best to manage perpetrators use of violence alongside their health needs. • Clarity around the role of the other practice staff • Creating a climate for safe disclosure of both DFV or diverse identities (eg. LGBTIQ) - provision of clear information and visible invitations.	**Primary care must be supported by and work with specialist family violence services.** *(*Cameron, 2016, piv). **Consistent, standardised, high quality and integrated practice** to support universal services in family violence early intervention. (Cameron, 2016, pv). **There is a need for family violence training** for universal services to be consistent across the state and based on specialist expertise to ensure that early intervention is effective and does not increase the risks to women and children. (Cameron, 2016, p.3). **Specialist family violence practice needs to underpin all aspects of early intervention work.** Specialist family violence practitioners employ a sophisticated understanding of the complex nature and dynamics of family violence that prioritises the safety and the agency of women and children. Without this, interventions can increase the risks for everyone, including workers. *(Cameron, 2016, p.iv).* **Priority Population Considerations -** GPs must have the opportunity to increase their knowledge around the needs of the most vulnerable members of their communities. **It is necessary for GPs to identify and confront their own belief systems** and values to understand how these impact upon their clinical decision making. Just as GPs develop clinical skills, they must also develop their cultural competence and sensitivity. GPs must examine their own attitudes about abuse and violence in their own and other cultures (Abuse and violence: Working with our patients in general practice, 2014, p. 90).	• Build a shared view of the role of primary care in responding to DFV. • Increase effective, locally based responses (local systems of care). • Improve the presence of 'invitations' within primary care settings. • Increase meaningful responses at the point of disclosure. • Reduce GP collusion with perpetrators. • Strengthen ties between primary care and the broader service system. • Create and maintain locally based and population specific responses. • Identify and begin working to address systems gaps and issues (e.g. service provision for a particular population).	Recognition of the impact of trauma, and symptoms as adaptive/protective. Acknowledgment and reduced tolerance of practice gaps, for example: • Inappropriate referrals (e.g. anger management and couples counselling) • Minimisation of disclosure by GPs • Use of family and friends as interpreters Increased numbers of GPs that stay actively involved with patients post-disclosure/ referral. Build relationships of reciprocity and respect between primary care and the broader system. A re-orientated focus to protecting women and children first and foremost (without marginalising or harming those working with the system). Preventing violence towards women and children alongside emergency/safe housing as the solution to the problem rather than looking at the root causes. Participating in holding perpetrators to account and recognising the complexity of domestic violence. Established DFV responses within the positive and powerful interactions that occur within primary care settings. Offering universal responses, alongside highly adapted responses that take into account people's diverse and legitimate identities and experiences

Table 2 – Model Fulfilment Criteria

Shows the model fulfilment criteria which have been defined as measures of success for this DFV model. They have been drawn from both academic evidence (Working Together to Produce Whanau Wellbeing in Waitematā, 2016), (Lankelly Chase, 2019) and key informant interviews.

Primary Care Role			
Builds a shared view of the role of primary care in responding to DFV and keeps the conversation alive	Strengthens ties between primary care and the broader service and support system. Connects to locally based responses	Improves the presence of 'invitations' creating a climate for safe disclosure	Addresses and improves practice *e.g. inappropriate referrals, minimising disclosures, collusion with perpetrators, forcing action etc.*
Increases referrals to effective and appropriate services	Adopts a trauma-aware approach, including giving people choices	Adopts a culturally and identity aware response	Reduces collusion, supports primary care to hold perpetrators accountable and to access support

Locality Integration			
Creates and maintains locally based responses	Builds relationships of reciprocity and respect between Primary Care and the local service and support system	Spots and addresses local gaps *e.g. service provision for a particular population*	Provides flexible funding to address issues of access and geography (e.g. Bay Islands)

System Influence			
Spots and addresses systems conditions keeping problems stuck *e.g. service provision for a particular population, relationships/power dynamics and mental models that support the status quo etc.*	Builds relationships of reciprocity and respect between Primary Care and the broader ecosystem	Works with the existing system maximising opportunities to transform, adapt and/or accept the need for change and alternative ways of being and doing	Practice, locality and system responses are informed and evaluated with victim-survivors at every stage

Principles

These principles have been developed based on what we have learned, from both data and lived experience evidence, to help govern and shape the fundamental intentions and actions of the model.

It is essential that they are embodied within each element of the model in order to maintain integrity when progressing forward. They act as a guiding force for the interactions and decision making that occurs across day to day practice and system change.

Principle	In action example
TRAUMA-AWARE	A trauma-informed practice commits to and acts upon the core principles of safety, trustworthiness, choice, collaboration & empowerment.[iii] It values and respects all individuals, along with their choices, autonomy, culture and values, while building hope and optimism for a better future. (Blue Knot, 2016. Trauma-informed Practice: How important is this for domestic and family violence services?).
ACCESS & EQUITY	DVNSW recognises and values diversity and is committed to promoting access to and equity of services for all women. DVNSW also recognises that additional disadvantage and barriers are experienced by particular groups and that these communities are more vulnerable because they are less likely to seek help, identify family and domestic violence in their relationships, or may perceive that their needs might not be met by mainstream services or dealt with sensitively and in confidence. (Domestic Violence NSW, 2019). Domestic and family violence is a breach of human rights. Domestic and family violence is a fundamental violation of human rights. It is a crime against the individual and impacts broadly on communities and the whole of society. It is not just an individual or private problem (Domestic Violence NSW, 2019).
PRIORITISING IMMEDIATE SAFETY FOR WOMEN AND CHILDREN	The safety and wellbeing of adult and child survivors of domestic and family violence (DFV) is the first priority of any response. Risk must be identified, comprehensively assessed and appropriately responded to by holding the perpetrator responsible and accountable for their behaviour and actions (Toivonen, C., & Backhouse, C, 2018).
UNDERSTANDING OF COMPLEXITY & DIVERSITY OF DFV, 'RIGHT TIME, RIGHT ACTION' APPROACH	Responses to violence must recognise that people have different experiences and needs due to their gender, race, class, age, cultural background, sexuality, and/or disability and other individual factors. Victims should be supported no matter how they choose to respond to the violence (including if they decide to leave a relationship or stay, if they want to pursue legal charges or not. (Domestic Violence Resource Centre Victoria, 2013).
PROMOTING GENDER EQUITY AND CHALLENGING VIOLENCE SUPPORTING ATTITUDES	Workers are aware of their own professional limitations and self-reflect regularly to uncover unconscious bias. In this way, workers consider how their beliefs and values inform their words and actions and in what ways they are inclusive or exclusive of others (Domestic Violence Resource Centre Victoria, 2013).

Mindsets

We refer to mindsets as a way of being and thinking, rather than a tool or method.

Throughout this project we have heard that there are some mindsets that may prevent meaningful intervention such as some GPs positioning DFV as a challenge separate from their domain *'I only deal with medical issues – DFV is a social problem. Not my job to solve the social problem. I will however do whatever is medically possible. I cannot create a safe environment. They cannot move in to the medical centre'.* The mindsets detailed below are for guiding what medical centres and the model in its entirety needs to live by and promote when dealing with DFV. They provide a foundation, complimentary to the principles, that enables GPs to embrace their role and to be persistent in times of uncertainty (Klein et al, 2017, Mindset for Social Innovation, Grow your Mindset). Mindsets prompt us to think about 'who' we are and 'how' we are while doing the 'work', in contrast to the practices, methods or tools we're using to get us there.

Mindset	What do we mean...
OPEN, WILLING AND RESPONSIVE	Open to new ideas. Willing to listen to others. Responsive when I have an opportunity to improve practice.
LEARNING AND ADAPTING	Willing to learn new ways of approaching problems and adapting my practice when needed for the benefit of the patient.
COURAGE, PERSISTENCE AND BEING IN THE GREY	Acknowledge the discomfort that I may feel, accept that I may not always know what to do and be willing and open to ask for help when I am unsure.
SEEING DFV AS A PUBLIC HEALTH AND SOCIAL HEALTH ISSUE	Acceptance of the harm DFV causes to the whole person.
BELIEVING AND SUPPORTING WOMEN, ALWAYS	Validate the disclosure without hesitation.

'Respond to the harm, [this is] not an investigation of the truth'

Key Informant

High-Level Model

A practical role for primary care to support an integrated DFV response

Unique Value Proposition for the High-Level Model

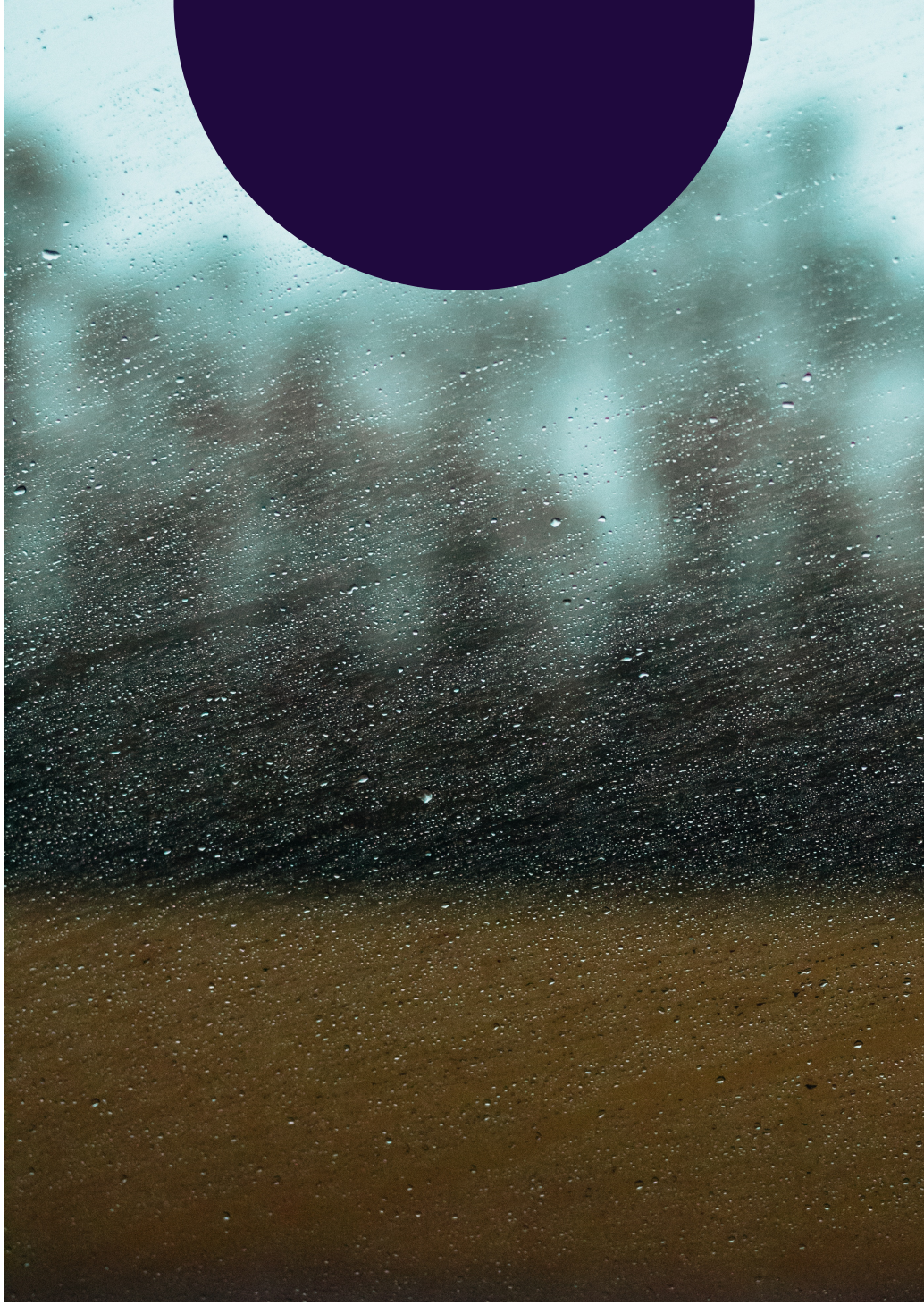
The model uniquely focuses on taking action *in the spaces between* what already exists in the DFV ecosystem. It articulates a role for primary care within an integrated response meeting GPs where they are as opposed to getting them to do more.

It does this in two ways:

1. Articulating clear roles for GPs and Service Providers at practice, locality and system levels allowing eco-system actors to see themselves in the broader context
2. Inserting a connective function to assist the trusted triaging of meaningful referrals in multiples directions (GP to Service Provider, Service Provider to GP and Service Provider to Service Provider)

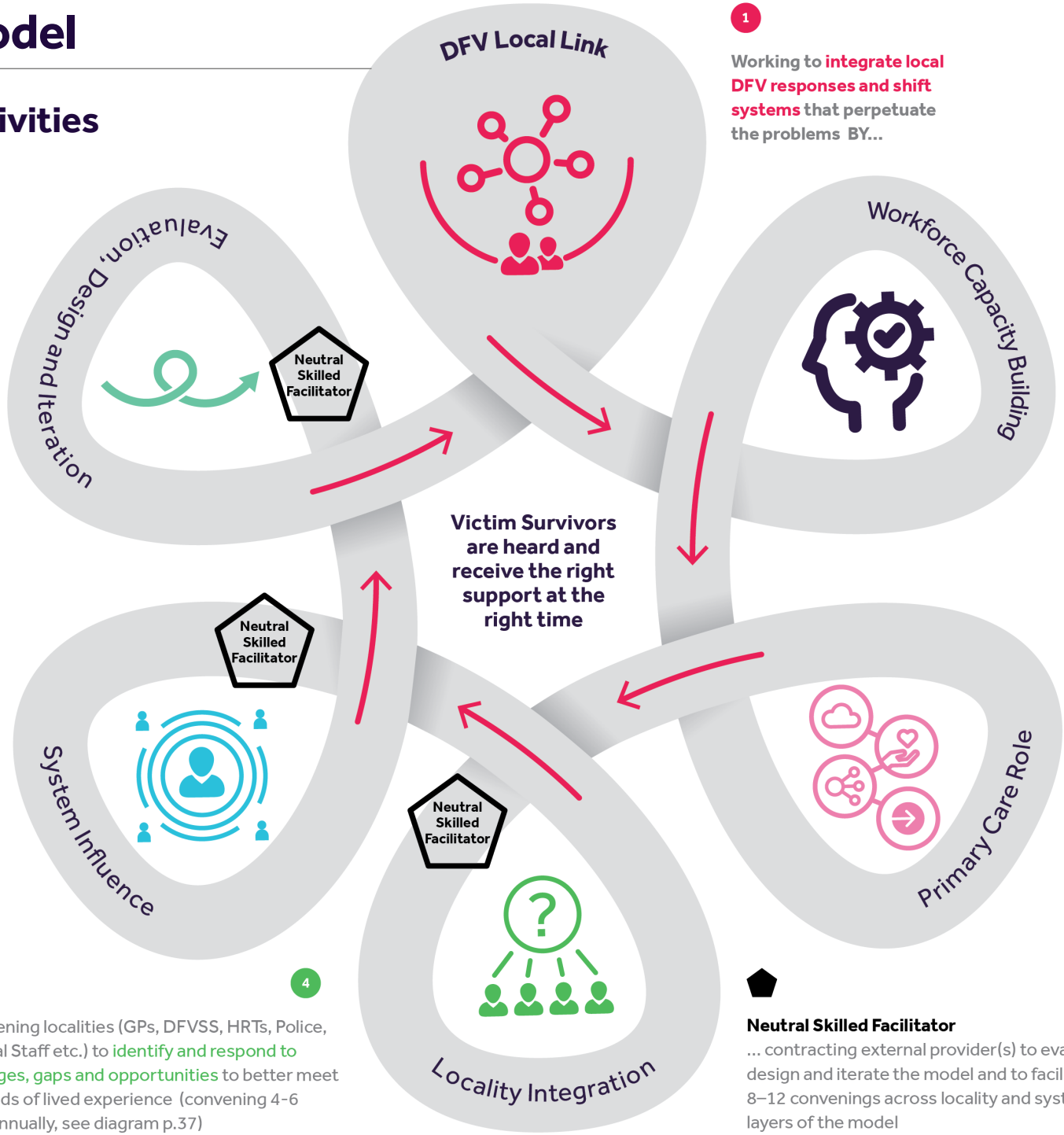
'... meeting GPs where they are as opposed to getting them to do more.'

Additionally, through on-going training the model builds the capability of the system and improves the experience from disclosure (being 'asked' in a safe space) through to a meaningful outcome (safe and supported healing) for victim survivors.



High-Level Model

Six Influencing Activities



1

Working to **integrate local DFV responses and shift systems** that perpetuate the problems BY...

2

... coordinating RRR Training for medical centre staff (including GPs and practice nurses) and mental health professionals (including psychologists and counsellors)

3

... supporting a practical role for Primary Care to play in DFV responses within their locality (see diagram p.28)

4

... convening localities (GPs, DFVSS, HRTs, Police, Hospital Staff etc.) to identify and respond to challenges, gaps and opportunities to better meet the needs of lived experience (convening 4-6 times annually, see diagram p.37)

5

... amplifying the voices of lived experience and from across localities to inform and influence the systems debate and action. Seek to shift conditions holding the problems stuck in place (convening 4–6 times annually, see diagram p.40)

6

... collecting evidence to inform and support the on-going iteration and delivery of activities and functions across all aspects of this model

Neutral Skilled Facilitator

... contracting external provider(s) to evaluate, design and iterate the model and to facilitate 8–12 convenings across locality and systems layers of the model

Influencing Activities

The six core components

1

Domestic Family Violence Local Link (DFVLL)

The DFVLL primarily focus on integrating a local DFV response playing a connector function between primary care, DFV services and influential systems stakeholders.

The Vision

There is a divide between primary care and the DFVSS that is not practically filled by training or the invention of universal referral pathways alone. GPs have legitimate limitations on their ability to ensure meaningful referrals into the DFVSS directly and the DFVSS have service criteria that are detailed, deliberate and often need specialist comprehension to navigate.

It is envisioned that the introduction of a DFVLL will:

- Bridge this divide by working as a supportive conduit between the two worlds
- Support people affected by DFV to access the right help at the right time
- Support GPs to build confidence and capability in intervening
- Elevate and amplify the needs and voices of the frontline to influence change at the systems level.

What's possible?

Evidence suggests that in order to support universal services such as general practice to play a role in family violence intervention the guidelines, training and processes that underpin the response must be consistent, standardised and of high quality (Cameron, 2016). Evidence also suggests that healthcare professionals do not currently intervene effectively in family violence due to barriers such as time constraints, frustrations with perceived 'non-compliant' patients, a lack of awareness of the conditions required to support people to disclose, ineffective or harmful (unintended) responses and a general lack of knowledge surrounding the complexities of DFV (Cameron, 2016).

The IRIS trial showed that by providing a resourced training and support program for general practice, doctors were three times as likely to identify women experiencing family violence and seven times more likely to refer a woman to specialist family violence services compared to the control (Cameron, 2016).

Extensive insight gathering and testing of this models intent and capability has strongly suggested that in order for general practice to play a deliberate and impactful role to support an integrated, non fragmented response to DFV, simply looking at creative ways to do this within the general practice context, where resources are already strained, is ineffective and unrealistic.

What we read & heard (Literature, DFVSS & other relevant Stakeholders, GPs including practice staff)

Within this component of model the following three key themes emerged:

1. The importance of warm referrals
2. The complexities and constraints of the DFVSS
3. The need for a broad and shared effort

The themes are evidenced separately from p.21-23

What roles are required

DFV Connectors

specialists who will drive and coordinate the locality activities and functions and act as a conduit between practice and system.

RRR Trainers

Delivering on-going training to GPs, practice staff, counsellors and psychologists.

What activities/actions are encouraged

Overarching

- Demonstrate and commit to best practice and applying the models principles, mindsets and lenses

Relationships & Networks

- Seeks to support, build trust with and educate medical centres at every interaction
- Identifies and supports the practice 'go-to' person
- Identifies and supports practice champions (usually a GP)
- Facilitate trust and relationship building between champions
- Identifies and connects into existing DFV networks such as HRT, IRT & VPU
- Identifies and connects with counsellors and psychologists who have received RRR Training and are equipped to work in a DFV context
- Coordinate the convening across locality to identify challenges and opportunities

What does this mean?

The importance of knowing who to refer to benefits and puts at ease both victim survivor and GP. Without this a disclosure may go no further than a disclosure. After many informant discussions, it does not seem feasible or necessary for GPs to understand the specialist nuances of the DFVSS and may even lead to overwhelm and no, or, incorrect action being taken. For primary care to genuinely support an integrated response a broad and shared effort spanning across a locality is needed in order to identify gaps, properly consider and implement considerations for priority populations and truly instigate a meaningful introduction into the supports that are available. It does not seem feasible that primary care and the DFVSS as it stands to date could do this alone.

Next steps

What needs to be detailed and tested

- Role description(s) for DFVLL Connectors
- How many of each role are required per locality?
- Who does what activities?

Managing Referrals

- Define and maintain referral pathways including those for priority populations
- Execute referrals directly into the DFVSS
- Service a hotline function that GPs can call directly and be given advice OR refer patient to call the DFVLL to initiate supports
- Produce and distribute practice materials that support creating climates for disclosure

Training

- Work to increase the uptake of RRR Training
- Schedule and inform ongoing training needs and content focus
- Support ongoing capability building for primary care, leveraging the knowledge of specialist DFV services, and specialist services for priority populations
- Works to coordinate accredited annual RRR Training for whole of practice, counsellors and psychologists

Systems Activities

- Coordinate convening across the system to address explicit and implicit conditions keeping problems stuck
- Advocate and amplify voices of the locality to the systems level

Evaluation

- Ensuring that evaluation involves victim survivors as the main stakeholder and evaluative resource
- Links victim survivors with the neutral skilled facilitator

1. The importance of warm referrals

Literature	Victim survivors	DFVSS & other relevant stakeholders	General Practice (GPs and practice staff)
Literature expressed the power in 'warm referrals' and that a victim survivor is far more likely to engage in suggested supports if the person referring can display confidence in who it is they are referring to (Cameron, 2006).	*'Please don't just send me somewhere where you know nothing about it.'* Victim Survivor *'Put me in touch with the services I need – I had no idea that BDVS (Brisbane Domestic Violence Service) existed'* Victim Survivor *'I wanted to be referred to places where I can get support on how to leave, housing etc. as I did not know about any of this.'* CALD Survivor	Victim survivors have expressed that GPs need to know who to refer to and be able to provide some relational legitimacy of 'who' this is. *'Not only women and their children but also perpetrators are making pretty clear disclosures and it's... they're not being acknowledged.'* *'I think GPs knowing who are really well qualified counselors for domestic violence would be a good thing for both respondents and victims.'* *'If GPs could refer to a... [intermediary] role [they] may support referral to services'* **Aboriginal & Torres Strait Islander Consideration –** *'Women are far more likely to follow through on a referral if a person referring can say "I know this person who works there, this is what they can offer, they are very good at what they do" – Relationships are key.'*	*'I need to know the who and how through a very clear and effective process, because without this GPs are far less likely to ask and secondly are limited in their ability to effectively respond when needed.'* *'I love to know where I can send people safe in the knowledge they'll properly take care of the person I'm referring'*

2. The complexities and constraints of the Domestic and Family Violence Service System

Literature	Victim survivors	DFVSS & other relevant stakeholders	General Practice (GPs and practice staff)
The complexity of referral pathways and specialist family violence services lack of visibility in the broader service system can make it difficult for general practitioners to know how and when to make referrals (Cameron, 2006)	*'I called that number and it was a waste of my time as they could not help me'* Victim Survivor	There are also service concerns about the resources in the current DFVSS being at maximum capacity. Informants we spoke with from the DFVSS expressed legitimate concerns of a model encouraging more referrals into the DFVSS without the prior knowledge of the intricacies and service provisions provided by the DFVSS. From their point of view increasing referrals would also only further impact the current bottleneck of the DFVSS as well as result in referrals not being acted upon or at worst rejected due the having been referred incorrectly. The DFVSS spoke of the importance of any new role needing to add to and be a part of the actual response. *'If doctors simply just refer here for all DV related instances referrals will be rejected.'* DFVSS	*'The gaps in service provision in DFV make this impossible so I can't make referrals.'* GP

3. The need for a broad and shared effort

Literature	DFVSS & other relevant stakeholders	General Practice (GPs and practice staff)
Research indicates that the response to support social change in the context of DFV needs to be a broad and shared effort, one that involves individual women and men, whole communities, and diverse organisations and institutions (Our Watch, ANROWS & VicHealth, 2015). The Not Now Not Ever (2015) publication recommends the undertaking of an immediate audit of services to ensure adequate resources are available to meet demand for specialist domestic and family violence services, including perpetrator intervention initiatives and specialist shelters. The locality activities conducted by the DFVLL will support this undertaking and take the information to the system stakeholders. **CALD Consideration -** The problems for women from a non-english speaking background are often compounded by social isolation, language barriers, the migration experience, cultural differences and for some, their religious beliefs. They may be less aware of the resources that exist within the community and how to access them (Abuse and violence: Working with our patients in general practice, 2014) **People with Disabilities Considerations -** Health practitioners should be aware that people with disabilities, particularly those with a mental illness, are at a much greater risk of violence – physical, sexual, or intimate partner – than those without a disability (Abuse and violence: Working with our patients in general practice, 2014) **LGBTIQ+ Consideration -** As the RACGP states "diverse sexual orientations and gender identities require specific knowledge and skills of the GP. It is particularly important for us to understand the impact of societal homophobia, biphobia and transphobia (prejudice against gays and lesbians, bisexual, and transgender people respectively)."(Abuse and violence: Working with our patients in general practice, 2014, p. 17)	From speaking with many of the informants it seems that by simply asking current services, general practice and DFVSS, to do more or to work together better without an additional resources and supports seems counterproductive and unreasonable. A number of informants also spoke of the importance of appropriately trained DFV counsellors and psychologists for victim survivors to have access to as a complimentary or stand alone addition to the services they would receive from medical centres and/or the DFVSS. *'Having appropriately trained counsellors and psychologists would take an enormous strain off of our service and enable us to do what we are in existence to do."* It also seems that the referral into the DFVSS has to come from a place that holds specialist DFVSS knowledge in order to be meaningful and effective. The DFVSS have expressed the importance of a primary care effort to become a part of the networks that are already in existence rather than simply create another isolated network: *'A seperate network would only exacerbate the fragmentation already in existence'* *'There's a lot of responding already happening, where are the connections?'* *'I'll never forget this, that a GP called, this is what he said, "I just want to put it on the record what's been happening for this woman because I just don't know what else to do. She does not want to involve police, she just doesn't want to get a protection order." He felt a huge responsibility and the risk was just sitting with him.'* *'Referrals have to be supported pathways so we don't lose anyone.'*	*'No doctor has an hour to dedicate to a patient. We are not remunerated or recognised for doing that. Someone needs to control this.'* GP

2

Recognise, Respond, Refer Training

Continuing to support GP staff in our communities will expand DFV understanding and their capabilities to intervene. Seeking to get RRR Training program accredited would build on its current success. Offering QI&CPD points is a huge incentive for GPs to undertake training.

The Vision

Building on GP knowledge and capability to date –through ongoing RRR Training– has been formally incorporated into this model creating the opportunity to not only increase the effectiveness of a patient and GP interaction but start and maintain conversations within primary care that impact all citizens and contribute to the social change required to combat DFV. The training also has an opportunity to support the realities of vicarious trauma on GPs as well.

What's possible?

Enabling the RRR Training to become an official part of this model suggests a possibility of meeting capability where it is at in a locality and having a targeted plan towards increasing that capability.

What we read & heard (Literature, DFVSS & other relevant Stakeholders, GPs including practice staff)

Throughout this work the majority of GPs and practice staff spoke of their openness and desire to play a part in responding to DFV. For the GPs we spoke to who had participated in the recent RRR Training some spoke of it enabling them to be more aware of DFV as a problem that affects their patients and that they could see they had a role to play. A couple of GPs advised the recent training had encouraged them to be more prepared when needing to ask their patients about possible DFV. Considering the training had only been recently rolled out and sessions had been quite brief this feedback is promising and shows the potential of training moving forward. Insights from GPs, DFVSS and victim survivors all spoke of the importance of building upon knowledge and increasing capability for all people involved.

Supporting evidence can be found on p.26.

What does this mean?

The insights explored indicate that RRR Training needs to be robust and consistent for the locality and citizens it is designed for. Training needs to build knowledge and capability and be delivered in a way that overcomes the barriers that get in the way of putting theory/knowledge into practice. It is suggested that if the RRR Training is supported by and is an integral part of the model as a whole, greater impact and learning outcomes could be achieved.

What roles are required

RRR Trainers

Incorporating victim survivors

Practice 'Go-to' Person

Scheduling and coordination with DFVLL

Practice Champions

Peer to peer learning - A GP or practice staff member who champions best practice across their site and into the locality

What activities/actions are encouraged

- Build upon the recent work of RRR
- Develop training that is specific to a locality
- Seek RRR Training accreditation
- To continue sharing and spreading best practice through training activities
- RRR trainers and DFVLL work together to schedule and inform ongoing training needs and content focus

Next steps

What needs to be detailed and tested

- New innovative ways to educate GPs and practice staff about DFV not limited to conventional training formats
- Consider how to incorporate the model in to the training
- Consider training packages that inform and build capability - 101/intermediate/champion
- Incorporate the training into broader training packages where a number of topics may be covered to increase attendance and decrease training fatigue
- The possibility of victim survivors being a part of the training

Supporting Evidence

Literature	Victim survivors	DFVSS & other relevant stakeholders	General Practice (GPs and practice staff)
Evidence has suggested that family violence training for universal services such as GPs needs to be consistent across the state and based on specialist expertise to ensure that early intervention is effective and does not increase the risks to women and children (Cameron, 2006). In Australia, training received by general practitioners in responding to family violence is varied. Most Australian medical students receive only two hours or less of family violence education (Cameron, 2006) There are some significant challenges to GPs playing a greater role in recognising domestic and family violence, responding to it, and referring safely all of which have an opportunity to be exposed, overcome and considered through training (Cameron, 2006). **Examples to tackle via training could be:** • Understanding violence-supporting attitudes & personal bias. In particular, attitudes that: excuse the perpetrator and hold women responsible, and attitudes that mistrust women's reports of violence (ANROWS, 2017) • The reality and often unintentional collusion of GPs with perpetrators, including support of their legal defences and that rather Perpetrators are held accountable and responsible for their violence (Cameron, 2006) • Cultural competence • Trauma (Aware & Vicarious) In light of the positives of training there are however a number of studies that argue that despite training, clinicians do not feel confident to ask about family violence (Cameron, 2006). Within a primary care context only one in ten women experiencing family violence are asked about it directly by their general practitioner. (Cameron, 2006)	*'I got the sense from most staff of – what are you doing to cause this and what are you doing to solve it.'* Victim Survivor	*'We don't just want GP referring to us who don't know what they are doing. Everyone's navigating, everyone is referring.'* DFVSS *'Being in human services, including GPs - it's really really hard and very traumatic at times.'* DFVSS *'Women were returning from GP appointments ether traumatised or not treated.'* DFVSS *'So I think education and awareness for DFV for any psychologist or GP is really important, but not easy.'* DFVSS *'The health system needs to stop telling people that they don't comply when in fact it's a result of their trauma.'* DFVSS	*'The training has helped to me more proactive because I have a better understanding. I can then normalise my questioning – I am working on that.'* GP *'Before the training I did not see DFV as such a big problem or something I could do something about.'* GP *'Many GP's want to respond and refer better, but lack the resources to do so.'* GP *'Older GPs, don't want to know about it the Younger, more open'* Practice staff person *'After I completed extra DV training I have since had a significant amount of disclosures from women experiencing DFV. The DFV problem is a hidden problem everywhere.'* GP

3

Primary Care Role

From creating the climate for disclosure to staying involved post disclosure/referral, there are practical ways primary care can support an integrated DFV response when properly supported to do so.

The Vision

There is an increasing amount of research in relation to the pervasive health impact of domestic and family violence. (Domestic and Family Violence Death Review and Advisory Board, 2017). GPs and practice staff have opportunities weekly to intervene in this insidious problem and by doing so can attempt to decrease the harm being experienced by victim survivors.

What's possible?

With the support of the DFVLL and the framework of this model medical centres can increasingly, and more often, support people to acknowledge their situation, feel safe, explore personal choice, start a process to end the violence they are experiencing and benefit from the increased quality of their primary care experience and outcomes.

What we read & heard (Literature, DFVSS & other relevant Stakeholders, GPs including practice staff)

Within this component of model the following three key themes emerged:

1. The powerful role of the GP
2. The topic of asking
3. The most effective response

In addition to these themes, there is some narrative on the unavoidable importance of:

4. Responding to Perpetrators.

Supporting evidence for these themes can be found on p32-37

What does this mean

Due to the well earned role within our communities general practice is a place of safety and care. Disclosures are occurring and GPs need to be supported to respond with a confident and united primary care conviction against DFV. Victim survivors are hoping and open to breaking their silence by being asked. Therefore, ensuring general practice has a meaningful and effective approach and response to support people in this dilemma is paramount (see diagram p.28).

What roles are required

GPs & Practice staff

Attending RRR Training and learning the basic role as *outlined on p30*

Practice 'Go-to' Person

Scheduling and coordination with DFVLL

Practice Champions

Peer to peer learning - A GP or GP staff member who champions best practice across their site and into the locality

What activities/actions are encouraged

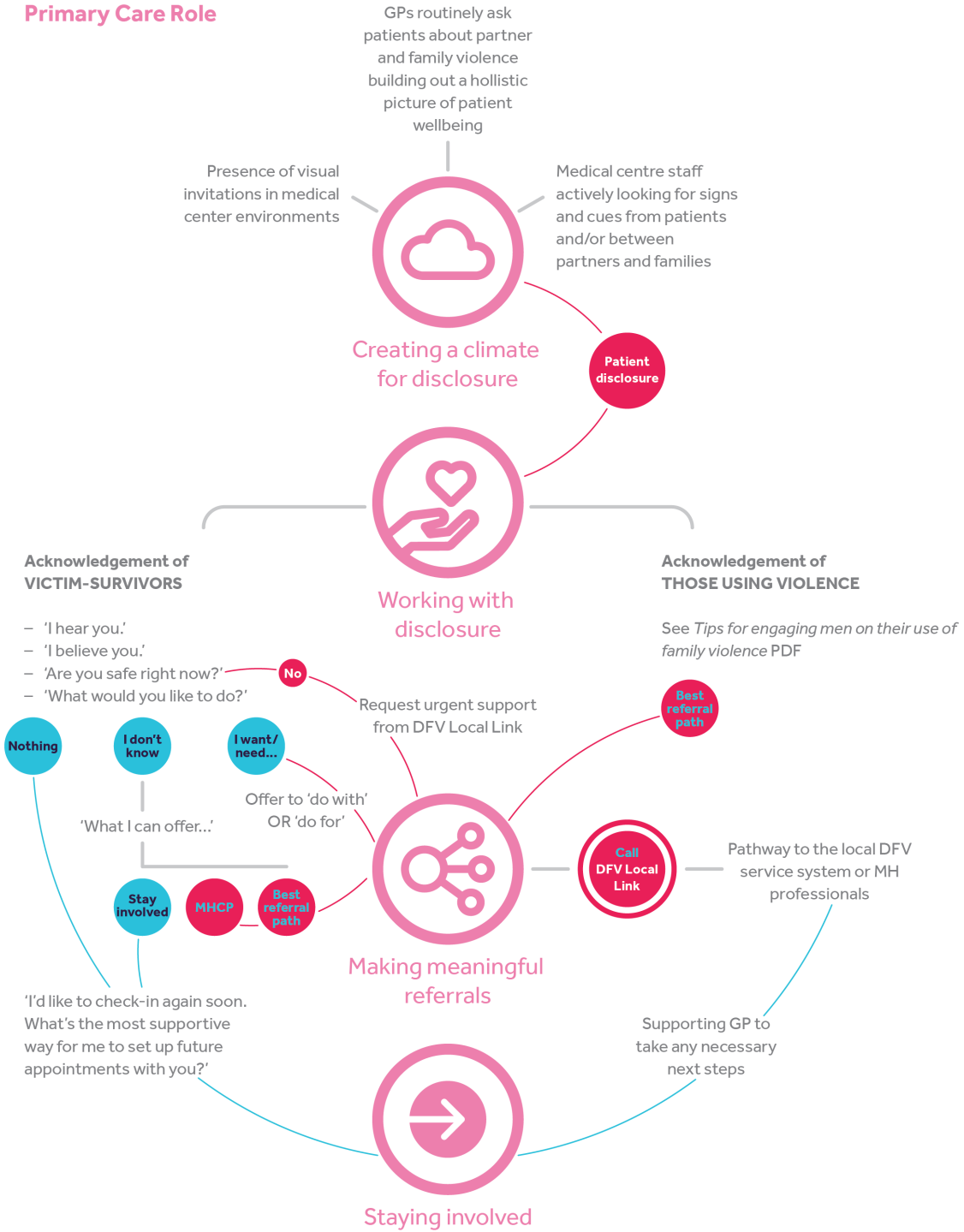
Create a climate for disclosure

- To instigate sensitive and compassionate inquiry
- Provide invitation and information
- Where possible make it routine to ask
- Where there is suspicion ask without hesitation
  - I hear you
  - I believe you
  - Are you safe right now?
  - What would you like to do?
  - DFV is not okay
- Ensure the right for a patient to see the Dr on the own

Working with disclosure (victim survivors)

- Apply trauma-aware responses
- Maintain sensitive and compassionate responses
- Ask what they would like to do
- Give options & Choice
- Validate and believe

Primary Care Role



Working with Disclosure (Perpetrators)

- Acknowledge the violence as a separate problem needing addressing whilst avoiding collusion (Domestic Violence Resource Centre Victoria, 2013)
  - Can you describe what "snapped"looks like?
  - What was that like for her?
  - Can you tell me about what was happening for you?
  - This problem at home is one thing and your health is another, both need addressing. Are you open to considering some help?

(Domestic Violence Resource Centre Victoria, 2013)

Meaningful referral

- Share relational aspects of the DFVLL (e.g. 'I've met Helen, she is really easy to talk to')
- Work in collaboration with the DFVLL

Staying Involved

- Consistently follow up with appointments
- Dual appts with DFVSS where/if appropriate

Next steps

What needs to be detailed and tested

- Priority Population considerations for a particular locality
- Perpetrator focus
- Regional Risks - few doctors (often seeing both VS & P)
- The presentation / launching of this to GP
- What's the ideal size of a locality?
- A locality with adequate resources - what does this look like?

1. The powerful role of the GP

Literature

GPs have a critical role to play with victim survivors and perpetrators, as they are often an initial and consistent point of contact for both victim survivors and perpetrators. In contrast to others in the ecosystem, they are more likely to receive disclosures and have opportunities to intervene (Domestic and Family Violence Death Review and Advisory Board, 2017).

In addition, GPs are:

- Often one of the few places women are allowed to go where power and control isn't playing a significant role even if movements are being tracked and monitored
- Often well-trusted, and seen as a safe space for disclosure
- A 'connector' to the broader support ecosystem when working well, and a significant danger (in some cases fatally) when not playing/not able to play a connecting role

Evidence points out that whilst GPs play an important role, interventions into DFV should not intend for them to replicate or replace specialist responses (Cameron, 2016). By increasing this clarity it is hoped that instances of practitioner contacts below expectations, as analysed by the recent Domestic and Family Violence Death Review and Advisory Board (2017) can be avoided such as:

- A failure to detect domestic and family violence despite overt disclosures (psychologists in four cases, GPs in five cases)

Broader evidence and guidance from the RACGP, White Book suggests that it is GPs role to provide 'first line' support, which can include:

- Identifying predisposing risk factors and noting early signs and symptoms
- Ask patients who are showing clinical indicators of intimate partner abuse about their experiences of abuse (when asking, ensuring safe to do so – e.g. that the abusive partner is not present and that they have training and systems in place)
- Being non-judgemental and supportive, and validating what the Victim survivor is saying

Victim survivors

'After disclosing to my Dr I continued to see that Dr and continued to be abused by my ex partner for another 5 years. Drs have the opportunity to do so much.'

Victim Survivor

'A few numbers is what's needed and a poster explaining a little bit more about what I can do. For people like me there was no one to talk to and I was completely unaware that there were services available.'

Victim Survivor

'I was pregnant – I told the GP everything. She could see the scratches on my arm that today have scars from. She said that was not her role and that I should seek legal advice. She did not record my conversation or refer me to anything, I felt so much shame and embarrassed.'

Victim Survivor

"My GP was not direct but he knew – he made it comfortable for me to talk about it. Knowing my partner was around he started doing things behind the scenes. He referred me to a psych who helped me to get my thoughts right.'

DFVSS & other relevant stakeholders

'Health and schools can sometimes be the only place the woman is still allowed to go.'

DFVSS

'people can be really reluctant to access mainstream services but if they do its because they feel safe there. Women more likely to access sensitive health issues in generalist practice because there are no cultural conflicts of relationships. In the generalist setting however women feel invisible, society doesn't see us'

Aboriginal & Torres Strait Islander Consideration

General Practice (GPs and practice staff)

'We are the people that are involved with people across their lives – they trust us'

GP

'good practice is about trust and the relationship – These phases (the 4 phases) are required for all health matters'

GP

'Female or male dr is not that important if you have created the conditions for the patients to be comfortable in your presence they will disclose'.

GP

'It starts in the waiting room so make it visible'

GP

'DFV as a health issue and its super common'

GP

- Providing practical care and support that responds to her concerns, but does not intrude
- Asking about her history of violence, listening carefully, but not pressuring her to talk
- Helping her to access information about resources, including legal and other services that she might think helpful assisting her to increase safety for herself and her children providing or mobilising social support (including referral to specialist DFV services)
- Working closely with specialist services, including police, to enhance safety for women and children
- Managing consequences of abuse to minimise morbidity and mortality
- Carry out preliminary risk assessment

The RACGP White Book also encourages that domestic violence posters and pamphlets should also be available in women's bathrooms within the practice or service.

LGBTIQ+ Consideration - Experiences of such violence, and the pervasive fear of assault, have a negative impact on the mental and physical health of GLBT people. It can lead to the need to conceal their sexual orientation or gender identity to reduce the risk of violence. It can also lead to non-disclosure within consultations, as the patient cannot predict the attitude of the health practitioner. (Abuse and violence: Working with our patients in general practice, 2014, p.17)

2. The Topic of Asking

Literature	Victim survivors	DFVSS & other relevant stakeholders	General Practice (GPs and practice staff)
GPs often say they do not see many patients who have experienced violence. Despite this, it has been estimated that full-time GPs are seeing up to five women per week who have experienced some form of intimate partner abuse – physical, emotional, sexual – in the past 12 months (Abuse and violence: Working with our patients in general practice, 2014, p. 10) GPs have advised that they are hesitant to inquire about abuse because of lack of time and appropriate skills, and a perception that they were unable to help abused women (Abuse and violence: Working with our patients in general practice, 2014, p 12) Victim survivors have acknowledged this lack of asking, however the majority of women have advised that they would not object to being asked. It is advised that GPs should ask patients who are showing clinical indicators of the mental and physical effects of intimate partner abuse about their experiences of abuse (Abuse and violence: Working with our patients in general practice, 2014, p. 8) **LGBTIQ+ consideration -** The result of the relative invisibility of same-sex intimate partner abuse is that GPs do not consider it, and do not ask about it. (Abuse and violence: Working with our patients in general practice, 2014, p. 17)	Victim survivors engaged in this work unanimously voiced the importance of asking about DFV: *'Act on the gut instinct – come out and say it – don't dance around it – It would have saved me so much more trauma.'* Victim Survivor *'If a Dr called it out 'Are you safe at home' - you could start a process. I would have broken down if asked and then I would have started a process'.* Victim Survivor *'I wish I had been asked - Are you safe? What else is going on? I care for your safety, I want you to be safe. You deserve to be safe and well.'* Victim Survivor Victim Survivors engaged in this work also expressed that its critical to ask about DFV when the patient is on their own: *'My abuser was with me 24/7 including Drs appts – in a pap smear he didn't want the curtain shut and was there the whole time. The doctor did not know what to do.'* Victim Survivor *'I went to a Dr with Rashes all over my body. The Dr was doing lots of tests and could not get to the bottom of the health issue so he asked asked me in front of my partner 'are you stressed?' I could not answer because my partner was there.'* It is strongly recommended that for GPs to ask people about violence ensure that it is safe to do so where possible and confirm the abusive partner is not present (Abuse and violence: Working with our patients in general practice, 2014)	*'know the conversations to have to surface it, but also when presenting with certain injuries have the confidence enough to ask more questions cause I think that sometimes they do suspect and it's still a difficult conversation to have or they don't know how to have it at all. '* DFVSS Womens health is a good lens to promote asking and screening for DFV e.g. pap smears, reproductive control and can act as the excuse to conduct conversations in private. *'Should ask, can't ask... not skilled to ask, but if you don't ask, it makes the victim feel invisible to the system becomes more of a risk.'* DFVSS	*'Does not happen here so we don't need to ask.'* GP *'My patients are mainly experiencing acute medical conditions. It rarely comes up.'* GP *'In the past there was a fear to ask people about suicide because that asking might make them suicidal which is not the case. Asking is the key – if you don't ask you have missed a golden opportunity. Invite first by prompting and if this doesn't work be more direct.'* GP *'We need to attempt to address it just as we would smoking and alcohol'* GP *'If you suspect anything keep asking. People experiencing DFV may not disclose in the first instance.'* GP *'There are times where they are expecting us to ask.'* GP *'Some patients don't know that they are even experiencing DFV so it can be about making them become aware of this by asking.'* GP *'In my 7 years of nursing, never had someone experiencing DFV.'* Practice nurse

3. The most effective response

Literature	Victim survivors	DFVSS & other relevant stakeholders	General Practice (GPs and practice staff)
Research has suggested the importance of the first response needing to be the right response; emphasising belief and validation of what has been disclosed in order to not exacerbate the feeling of shame and fear (Cameron, 2016). Unfortunately however in varied medical settings many turn a blind eye to family violence, preferring not to be involved. This has been described as a 'conspiracy of silence' resulting the problem being no-one's responsibility. (Abuse and violence: Working with our patients in general practice, 2014, p. 4) Feder et al (2006) found near unanimity among over 800 victimised women's views about the need for GPs to be empathic and non-judgemental in their care. When developing healing relationships with our patients, Scott et al (2008) 228 established that trust, hope and a sense of being known were the important things identified by patients. Health practitioners should provide first line support – listening, inquiring about needs, validating women's disclosure, enhancing safety and providing support – to women who disclose abuse (Abuse and violence: Working with our patients in general practice, 2014, p. 8) A meta-analysis of qualitative studies on the experiences of victims of intimate partner violence in primary care found, unsurprisingly, that women want their healthcare professional to be sensitive, compassionate and non- judgemental; and to have a sound understanding of the nature, complexity and long-term effects of family violence, including the social and psychological impacts. The study found that women identify the need for trust and confidentiality from their health care providers, confirmation that the violence and abuse is unacceptable and undeserved. Women want to progress at their own pace and not be pressured to disclose, to leave their partner or to make a police report (Cameron, 2006 p. 4). It is important to mention that at the point of disclosure victim survivors may not not choose referral to specialist services. It is however in the act of the GP of validating the persons experience and the expressing of the offer of support that may contribute to them being able to change their situation. These questions and responses are applicable for both male and female victims. The readiness to action model can be very helpful in understanding a patient's current position within the journey of change (Abuse and violence: Working with our patients in general practice, 2014, p.15)	*Victim survivors involved in this work spoke of instances where they felt shamed, unsupported and hopeless in interactions with GP.'* Victim Survivor *'When DV is mentioned professionals, including Drs shut down, clam up and turn to face their computer'* Victim Survivor *'I got the sense from most staff of – 'what are you doing to cause this and what are you doing to solve it'.* Victim Survivor *'My first attempt to share my story with a GP nearly prevented me from seeking help all together.'* Victim Survivor *'Consistent, empathetic checking in – over and over and there is a high chance a person may start to feel safe in that setting.'* Victim Survivor *'If you disclose you want them to say that 'I won't say anything if you don't want me to, We can speak again in a week or so.'* Victim Survivor *'Its about ensuring people are safe – if they haven't left the relationship it is still possible to make a plan.'* Victim Survivor	*'The doctors need a simple process, what do I do and where do I go... hand the risk up.'* DFVSS *'Couples counselling increases her risk. Its another another mechanism exacerbating power and control - Its saying it's both your fault.'* DFVSS *'I hear you... I have the capacity to engage you with the system.'* DFVSS *'A planned response that is timely, coordinated and appropriate.'* DFVSS **Aboriginal & Torres Strait Islander Consideration -** *'Reporting/disclosure has multiple cultural obligations for both her family and his family – there is a perception of splitting the family and then becoming isolated from her family, community and culture – plus a higher risk of children being taken into child protection system. Fear of death in custody. Fear of man being incarcerated can have heavier burden than the effects of DFV. Have to way that up. Current services responses can't support the complexity of the situation for Aboriginal women.'* The "Duluth Model" is an ever evolving way of thinking about how a community works together to end domestic violence. Informants advised a numbers of specialist services are based on this model. *https://www.theduluthmodel.org/what-is-the-duluth-model/*	*'We need a pathway so we don't have to be thinking about what can we do but rather can just follow the steps and act.'* GP *'We need to be able to advise on what happens next after disclosure'* GP *'We have to be able to say 'these are your options' We as GPs know who to contact.'* GP *'Reassure confidentiality but be aware of the GP limitations. You want to be able to point to something in order to be able to advise of resources and try and stay engaged. Does GP need a diagrammatic pathway – the thing you can point to? Yes, but it should consolidate the info that is already available because theres lots out of there its just in different places.'* GP *'I believe without doubt what my patients tell me about the harm they are experiencing.'* GP *'We need to know what to do super fast. No Dr has an hour to dedicate to a patient. We are not remunerated of recognised for doing that.'* GP

Fear of a report to Child Protection is a powerful and commonly reported disincentive for women to disclose family violence (Cameron, 2006)

Aboriginal & Torres Strait Islander Consideration - Aboriginal and Torres Strait Islander women experience domestic violence and family violence more often than other Queensland women and are more likely to be seriously injured. They are also more likely to experience family violence from a broader range of extended family relationships. The impact of past trauma is a contributing factor for violence in Aboriginal and Torres Strait Islander communities. The picture in Aboriginal and Torres Strait Islander communities is even bleaker. The Taskforce was deeply distressed by what it heard about violence in these vulnerable communities. Violence and abuse is reported as being so prevalent in some communities as to have become normalised – the people who live there consider violence to be a part of 'every day' life. The lack of support services and poor access to the justice system compound the violence and make it virtually impossible for victims, who are predominantly women and children, to escape (Cameron, 2006 p. 6).

Aboriginal & Torres Strait Islander Consideration - The evaluations of two early intervention programs with Aboriginal and Torres Strait Islander women found positive outcomes, based on a focus on culture and community. (Cameron, 2016 p. 8) Success factors:

- Culturally appropriate and informal environments
- Flexibility in design and delivery
- The positioning of women as experts in their own experiences
- Acknowledgement of the historical systemic violence and mistreatment experienced by Aboriginal and Torres Strait Islander people (Cameron, 2016 p. 9)

CALD Consideration - Avoid making assumptions about a patient's cultural beliefs. Speak to the patient as an individual while still acknowledging that their cultural background may inform their personal beliefs and expectations (Abuse and violence: Working with our patients in general practice, 2014, p. 19)

'GPs need to get the whole context before reporting to child protection as it can have can have such major ramifications . When someone is disclosing and you know they have children try and grasp a short movie version of the situation not just a photo of a snapshot. '

'I want to be asked if Im OK, I want to be tested for diseases, I want to be believed and supported. Then send me to help.'

Victim Survivor with an intellectual disability

'GP need to know who to refer to e.g. BDVS A referral to this service earlier could have saved me a lot of pain.'

Victim Survivor

Aboriginal & Torres Strait Islander Consideration -

'The power and control wheel (the duluth model)) does not speak to the Aboriginal community because of its lens of 'whiteness'

CALD Consideration -

'GP should not jump to conclusions about culture – its not always a cultural norm that female's patients need to be seen with their male partner.'

DFVSS

"Improving the climate for disclosure can be dangerous of you don't know what to do with a disclosure."

DFVSS

'We need to share the risk so it does not rely on one agency.'

DFVSS

4. Responding to Perpetrators

Literature

The Royal Australian College of General Practitioners provides GPs with guidance on how to identify and respond to men who use violence in their relationships. This includes the need to be aware of perpetrators attempts to collude with a GPs personal attitudes and beliefs, and to be wary of men minimising their responsibility, blaming the victim, and underreporting the extent of the violence (Domestic and Family Violence Death Review and Advisory Board, 2017 p. 112).

The 2017 Domestic and Family Violence Death Review and Advisory Board (p. 107) stated evidence of collusion in some cases where private practitioners failed to challenge disclosures from a perpetrator about their use of physical and coercive controlling violence.

A key concern identified by community health sector participants is the difficulties universal services will experience in responding to both victims and perpetrators (Domestic and Family Violence Death Review and Advisory Board, 2017 p. 107).

All service providers, including GPs and mental health practitioners, play a role in ensuring that both victims and perpetrators receive a consistent, standardised and culturally informed service response, wherever they come into contact with services (Domestic and Family Violence Death Review and Advisory Board, 2017 p. 12).

Documenting carefully what a patient has said about the abuse and violence in the record is important for communication with others and potentially for legal processes (Abuse and violence: Working with our patients in general practice, 2014, p. 19)

Cultural change needs to happen to stop perpetrators from using violence and coercive control in their relationships. Any integrated service response must include programs to address perpetrator behaviour and hold perpetrators to account. (Not Now Not Ever, 2015 p. 15)

Victim survivors

'Record it – in case something happens.'

Victim Survivor

'My ex partner was subpoenaing her health records. My GP became very thorough to ensure there was no grey area in my health record. She was preparing me for court and preparing herself for the Law.'

Victim Survivor

'My GP did ask me about the bruises but at the time the same Dr was being ambushed by my husband so nothing was followed through – her husband was very charming (could make friends with anyone) – he was coercing me to be his carer. The Dr was wrapped around his finger and was advocating 'your husband has a disability' therefore the Dr was encouraging the carer pathway. My situation was over looked.'

Victim Survivor

DFVSS & other relevant stakeholders

'GPs need to state; your medical situation is one thing, but the violence you have disclosed is another matter that needs addressing'.

DFVSS

'We have nothing to offer them and often they cannot take on Behavioural change programs due to English being a barrier.'

DFVSS

'You'll often find that they attend appointments with women, so that women are not in a position to disclose violence to GPs.'

DFVSS

'Don't deny service but don't buy into story. Well meaning professionals but right into it and build a huge amount of evidence about it and ultimately collude.'

DFVSS

'Within ISR there is a mens behaviour change program and in certain pockets, because of the place based focus, there are other groups forming in order to maximise the impact and share information between agencies.'

DFVSS

'The perpetrator programs are at capacity.'

DFVSS

'There is an opportunity for health to support the many cases that are not suited to mens behaviour change programs. Seeing your GP and engaging in a MHCP could be an example of this.'

DFVSS

General Practice (GPs and practice staff)

'Violence should never be an excuse for a health issues. Violence is unacceptable and both need treating.'

GP

'When seeing both the victim & Perpetrator this is difficult. When I had this I did not want to keep seeing the Perpetrator.'

GP

'No men have ever disclosed. If you are suspicious though you should ask. I would need more training in the help that's available.'

GP

'if I was faced with a perpetrator who disclosed something worse I would not know what to do.'

GP

4

Locality Response

Creating time out of business-as-usual for stakeholders to connect, name shared challenges, identify opportunities and explore alternative solutions at the locality level.

Vision

There are GPs and practice staff that want to play an effective response role. There is also evidence of emerging champions (from the GPs we spoke with). There are networks and expertise within localities that have knowledge and wisdom. There are gaps and disconnections that are obvious. With the support of the DFVLL in a locality:

- GPs and practices have an opportunity to become champions and maximize peer support across a locality
- The invitation to disclose and the points of disclosure can be backed up by a locality response that is trusted and effective
- Primary health increases its participation in and strengthens existing integrated response such as ISSR & HRT
- GPs and general practices can be a part of supporting generational change by being an official part of the response
- There can be a shared understanding that no culture, sexual orientation, race or religion is immune to DFV

What's possible?

In this context, we refer to locality as a defined geographic area, where the boundaries make sense to local residents and local services. While there is no commonly agreed definition for place-based approaches, we tend to adopt the following:

A collaborative, longterm approach responding to complex issues delivered in a defined geographic location. This approach is ideally characterised by partnering and shared design, shared stewardship, and shared accountability for outcomes and impacts.

What we read & heard (Literature, DFVSS & other relevant Stakeholders, GPs including practice staff)

Currently there is some pockets of incredible work being undertaken in the DFV sector, however simultaneously it is unclear what mechanisms exist within localities to support meaningful referrals.

> *'Healths' position in the current system is 'dependant on who you talk with'*
>
> DFVSS

What does this mean?

With a designated resource that can exist in both practice and system better coordination of what currently exists and what is genuinely needed could be improved. Primary care is formally invited across a locality to play a deliberate role, increasing it's participation and capability to be a part of stronger feedback loops across the ecosystem that would improve integration and continuity of care for those experiencing or using violence.

What roles are required

DFVLL Connector roles
maximising priority population representation when needed/possible

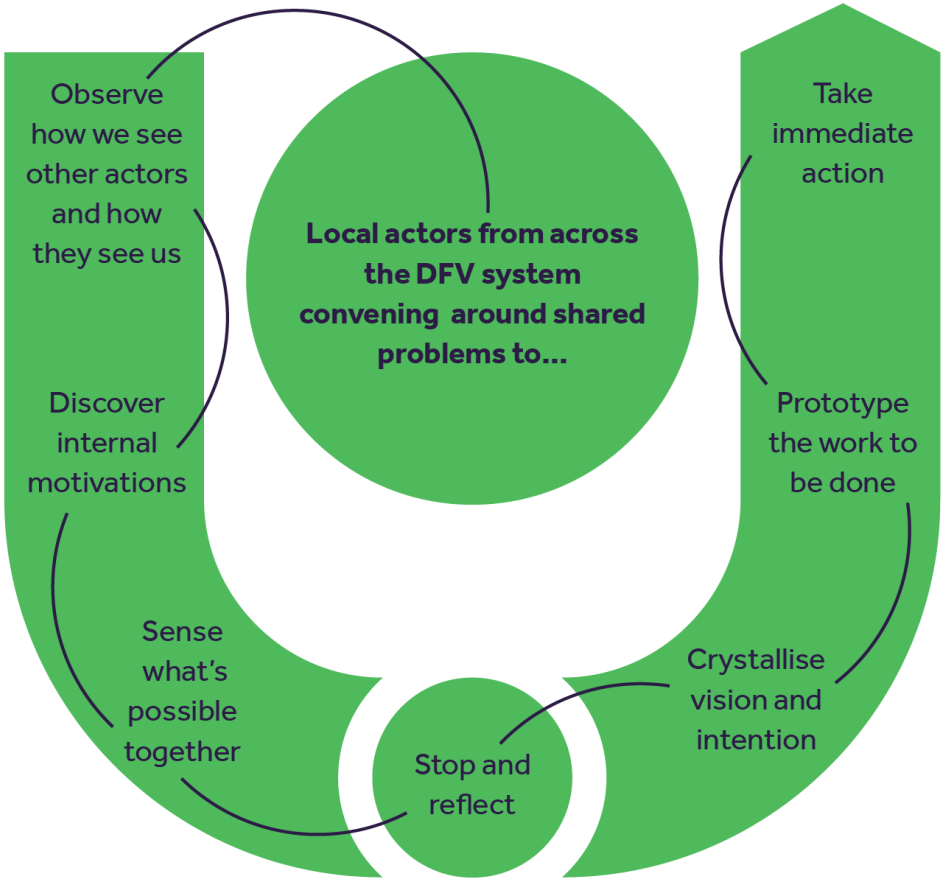
Network roles
Starting with existing HRT/ ISR/VPU

Champion GP and other Practice staff (''Go-to'' person)

What activities/actions are encouraged

- Coordinate and maintain locality specific networks of primary care and other stakeholders
- Convene primary care and DFV stakeholders from across the locality
- Bring primary care into the DFV ecosystem
- Communicate with locality network and elevate and amplify their voices into the system debate
- Identify and work to address local gaps
- Define and maintain referral pathways including those for priority populations
- Align locality network around shared problems

DFV Local Link build referral networks across the locality and 4–6 times annually convene actors from across the system.



The diagram above has been adapted for context from Theory U and is licensed by the Presencing Institute - Otto Scharmer

Next steps

What needs to be detailed and tested

- Identify the areas in which to test - where resources are or could be injected into?
- The pockets of motivation - what are they and how can they be leveraged?
- How will the locality interact with the System level?

Supporting Evidence

Literature	DFVSS & other relevant stakeholders	General Practice (GPs and practice staff)
The IRIS trial evaluated a training and support program for general practitioners, focusing on identification, support and referral in a local area (Improvement in Practice, The IRIS Case Study, 2011). An educator from a family violence specialist agency ran the training, provided advocacy for women referred by the doctors, and supported clinicians and administration staff. As part of the trial, a prompt to ask about family violence was added to the electronic medical record. This program had a significant impact. Doctors who received the training were found to be three times as likely to identify women experiencing family violence and seven times more likely to refer a woman to specialist family violence services compared to the control (Cameron, 2007, p. 7). **Aboriginal & Torres Strait Islander Consideration -** At a community level, health practitioners need to show leadership through local organisations by advocating for provision of services that meet the needs of Aboriginal and Torres Strait Islander peoples experiencing family violence (Abuse and violence: Working with our patients in general practice, 2014, p. 82) **Aboriginal & Torres Strait Islander Consideration -** An established relationship with specialist family violence services for support and stronger referral pathways Interventions with Aboriginal and Torres Strait Islander people that are community-based and community-led are essential (Abuse and violence: Working with our patients in general practice, 2014, p. 82) **LGBTIQ+ Consideration -** It is a recommendation of Not Now Not Ever (2015, p.21) (recommendation 14) that "The Queensland Government includes LGBTI specific elements in the communication strategy (Recommendation 18) to raise awareness of domestic and family violence in the LGBTI community, remove the stigmas around reporting and seeking help, and providing LGBTI victims with advice on where to go for support."	Whilst there are several established cross-sector partnerships (e.g. the HRT teams), primary care remain largely absent from the table. We recognise that bringing GPs and other relevant general practice staff to the table is challenging given their role, and the business model that drives practices. *'We are health, we dont have capacity to respond to anything else, DV is an extra'* DFVSS *'There is a lack of links and connections across the sector'* DFVSS *'I met with another provider who is doing great work with victims; Why did we not know about this; this isn't the first time something like that has happened.'* DFVSS *'There could be so much more that health could be doing such as preventing concerns and increasing generational impact to create cultural change - they are in a unique position.'* DFVSS	*"I don't know of any Psychologists who work with LGBT people around this area."* GP *"We want feedback after the referral. Patients come back and assume that you know. This can be very frustrating"* GP

5

System Response

Convening influential systems stakeholders to influence explicit structural and implicit relational conditions holding the problems of the system stuck in place.

The Vision

In this context, we refer to System as a set of things working together as parts of a mechanism or an interconnecting network. The system element of this model will support the locality network to survive and thrive and ensure that the problems that are getting in the way of progress on the ground are handed up, acknowledged and remedied.

What's possible

There are multiple opportunities to to be addressed via a systems level such as:

- Addressing broad incentives and disincentives for GP e.g. Medicare
- A focus on improving the critical intersections between primary care and the broader service system
- Addressing the system response to men using violence
- Support primary health to become an integral and invested participant in creating social change

What we read & heard (Literature, DVSSS & other relevant Stakeholders, GPs including practice staff)

Primary Care needs systems influence to acknowledge the existence of DFV. Primary Care need system support and permission to intervene. Without the support of an influential system the root cause issues such as gender and societal norms that continue to perpetuate violence or allow people in powerful positions to be silent witnesses will remain.

What does this mean

It is clear there are some significant pivots the current systems must make, to align towards better outcomes for victim survivors. Some of the pivots have already happened within parts of the system, some require intervention to emerge.

What roles are required

PHN executives

To drive and convene

Neutral Skilled Facilitator

To guide 4–6 annual convening's.

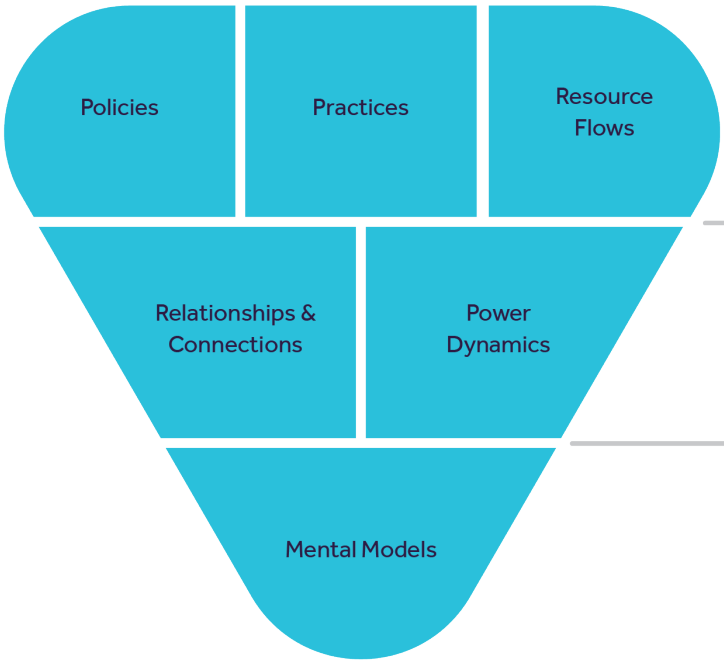
Influential federal and state government participants

Influential primary care executives (e.g. RACGP)

Influential stakeholder executives (e.g. CEO's)

What activities/actions are encouraged

- Convene influential stakeholder to act on significant systems gaps, expose, remove or decrease structural barriers that impede good practice or local progress (eg policy, lack of investment, perverse incentives)
- Share progress and effective ways of working across the state, and country - reducing duplication, sharing what works
- Commission and shepherd an evaluation process that ensures the impact and outcomes are being met & monitored
- Seek to influence and shift systemic barriers
- Promotion of a consumer centred and led model



Influencial systems stakeholders crystalising aligned actions to create...

Structural Change
Explicit 'things' that guide activity or inform distribution / allocation of assets

Relational Change
Semi-explicit differences that inform who makes decisions & in who's interest they are made

Transformative Change
Implicit dominant and often unexamined beliefs and long held ways of operating that underpin our systems

Next steps
What needs to be detailed and tested

- Identify who will lead this within the PHN?
- What are the roles the stakeholders will play?
- What are the formal and informal structures of this system network?
- What system networks can this join/leverage?

The framework depicted here draws upon the extensive literature behind systems change and systems thinking. The six conditions we mention have been articulated in various ways by a variety of academics and practitioners (see, for example, Building Ecosystems for Systems Change, Social Innovation Generation; Foster-Fishman, P.G., & Watson, E.R. The ABLe Change Framework: A Conceptual and Methodological Tool for Promoting Systems Change). Specific terminology and definitions for these conditions will vary from this article. Inspired by the well-known systems thinking "iceberg" concept and Donella Meadows' body of work—for example, Leverage Points: Places to Intervene in a System (1999)—this framework also places systems change conditions at three different levels with respect to their visibility and their ability to transform a system. Our hope is that this depiction will support foundations and other social sector institutions in developing systems change strategies by illuminating key internal and external leverage points that support sustainable progress at scale.

Supporting Evidence

Literature

The Gender Issue: It is imperative that a Queensland Domestic And Family Violence Prevention Strategy be inclusive, in terms of acknowledging that domestic and family violence is perpetrated by both genders within a range of intimate and non-intimate relationships. (Not Now Not Ever, 2015 p. 73)

Family violence and sexual violence are preventable. There is a significant role for primary prevention (Working Together to Produce Whanau Wellbeing in Waitematā, 2016)

- Promote women's social and economic autonomy to build gender equality
- Non violent social norms. Shift attitudes that condone family and sexual violence
- Strengthen safe and respectful relationships
- Strengthen cultural identities, connectedness and increase social equity
- Support healing after trauma and loss
- Celebrating diversity. People from different backgrounds feel welcome and safe. Racism, sexism and other forms of discrimination are not ok.
- Social connection. People can participate in and feel part of their community and don't feel isolated or alone.
- Helping and healing. We reach out to people in need so that they are supported to recover and heal.
- Gender equity. We treat each other with respect and our relationships demonstrate equity between all genders.

Societal factors influence whether violence is encouraged or inhibited. These include economic and social policies that maintain socioeconomic inequalities between people, the availability of weapons, and social and cultural norms such as those around male dominance over women, parental dominance over children and cultural norms that endorse violence as an acceptable method to resolve conflicts (Violence Prevention Alliance, 2019)

'Change emerges from the way the whole system behaves not from the actions of any one project or organisation. We, therefore, need to help build the fitness of the system to generate positive change' (Lankelly Chase, 2019).

DFVSS & other relevant stakeholders

'Recent health funding has gone towards improving facades of buildings when there are obvious services gaps'

DFVSS

'Interface with courts and men's behaviour is a major problem'

DFVSS

'That's a system issue, we can't do much about that'

DFVSS

General Practice (GPs and practice staff)

'If general practice was remunerated, incentivised then more Drs could/would do this work'

GP

6

Evaluation, Design and Iteration

Building measurement, evaluation, co-design and prototyping approaches into the fabric of the model will ensure that it keeps evolving and improving the lives of people affected by DFV. The purpose of this activity is to collect evidence to inform and support the on-going iteration and delivery of activities and functions across all aspects of the model.

The Vision

A model that is truly led, evaluated and improved by the consumers it is designed to support.

What's possible?

By incorporating a deliberate evaluation, design and iteration element into the model this enables changes, adaptations and improvements to be a normal and regular part of the model as a whole.

Why we recommend this as a component of the model

The Royal Commission into Family Violence (2016) suggested that policy makers and others responsible for the design, responsiveness and efficacy of the family violence system should hear directly from victims who have recent experience of the system so that improvements can be made. An evaluation process that prioritises the voices of victim survivors is an important mechanism to realise this vision. 'Rather than taking a stance of 'designing for' victim survivors, we embrace 'designing with' victim survivors, which elevates them from being the subject of reforms to partners in reform' (Voices of Hope, 2017 p. 37)

What roles are required

Neutral Skilled Facilitator

To gather feedback, invite input and co-design the evaluation, design and iteration of the model

What activities/actions are encouraged

With the support of a neutral facilitator we recommend a co-production, co-design, co-evaluation led activities that:

- Help the system stakeholders gain a multi perspective view of themselves within the system
- Building innovation capability
- Align stakeholder intentions
- Help stakeholder contextualise action for their context.
- Embed the voice of victim survivors and a focus on victim survivor experience in the everyday work and ongoing development of the model
- Inform ongoing service and practice improvement by collecting nuanced information about client experience.

Next steps

What needs to be detailed and tested

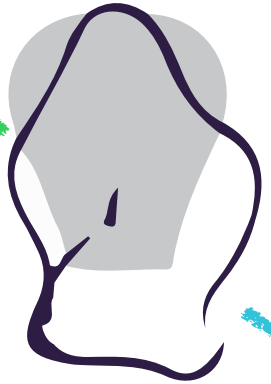
- Identify a neutral facilitator and schedule their participation
- The identification and partnering with victim survivors
- The possibility of incorporating this model into the current Brisbane South PHN Co-Production Plan
- Defining client experience and satisfaction with people with lived experience and associated indicators and measures.
- Developing a standardised framework for victim experience measurement
- Develop and implement a victim survivor / perpetrator feedback process
- Designing ways for the victim survivor / perpetrator feedback process to integrate with ongoing service and practice improvement.

Recommendations

Considerations to set the model up for success

Through testing a draft of the high-level model and exploring what's possible within the context of primary care with GPs and the service sector, we identified a suite of conditions for success. Additionally, drawing on TACSI's extensive experience in the design and implementation of alternative solutions, we're suggesting that BSPHN adopt a prototyping methodology to detail, design, test and iterate the six influencing activities from the model moving forward. This sections gives an overview of the recommended approach, sets out pre-conditions for testing and outlines the existing opportunities for further consideration.

Journey to Implementation



Research & Development

COMPLETE

- [x] RRR Training development
- [x] RRR Training implementation
- [x] Literature Review
- [x] Key informant and internal PHN stakeholder semi-structured interviews
- [x] Initial Insights
- [x] Engagement with GPs and Victim Survivors
- [x] Analysis of existing models
- [x] Draft Model
- [x] Fulfillment Criteria developed
- [x] Learning loop testing assumptions contained within the draft model with GPs and stakeholders from the DFVSS
- [x] Refined High-Level Model
- [x] Report

YOU ARE HERE

Detailing & Design

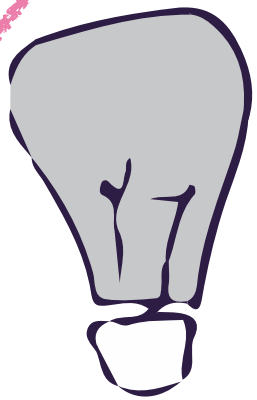
NEXT STEPS

- [ ] Define priority activities and roles for initial roll out i.e. what is the minimum viable product that will produce outcomes
- [ ] Capture potential future activities and roles for later development
- [ ] Detail and prototype named priorities for each of the six influencing activities within the model. This should include gaining clarity on the desirability (do people want it?), feasibility (can we deliver it?) and viability (do the numbers work?).
- [ ] Iterate the design of solutions based on feedback from testing with GPs and DFVSS stakeholders
- [ ] Test refined solutions with GPs and DFVSS stakeholders
- [ ] Establish relationships and internal commitment to leverage existing skills and capabilities internal to the PHN e.g. call centre capability
- [ ] Capture Detailed Model

Locality Testing & Iteration

AND THEN

- ☐ Identify testing locality (see 'Leveraging Existing Opportunities, p50) with established pre-conditions for success (see Pre-conditions, p49)
- ☐ Prototype minimum viable activities and roles at small scale e.g. to manage 2-3 medical centres within given locality
- ☐ Set testing period
- ☐ Establish prototype DFVLL and embed within locality
- ☐ Test all aspects of the Detailed Model over course of testing period
- ☐ Capture and evaluate feedback from all stakeholders taking part in the prototype across the locality
- ☐ Iterate the Detailed Model, include necessary locality adaptations
- ☐ The PHN could choose to do several loops of learning and iteration at this stage. These might include expanding the scale of the prototype and including and testing in a different locality to understand necessary adaptations for scale
- ☐ Capture Model for Commissioning



Implementation

AND EVENTUALLY

- ☐ Create implementation plan
- ☐ Use Model to commission roles and activities required to support outcomes
- ☐ Implement evaluation
- ☐ Roll out in initial localities
- ☐ Continue to evolve all aspects of the model and allow adaptation for priority populations and different localities
- ☐ Build out next phase of model development

Pre-conditions

The model in the following section names a practical role for primary care in supporting an integrated DFV response. In order for GPs and other practice staff to fulfil that role, certain conditions need to be in place to support good practice and ensure that referrals will lead to good outcomes.

In the next phase of this work, testing the model, it makes sense to identify a locality that exhibits the following pre-conditions, or is capable of building them with minimal coordination and resourcing.

Pre-condition	Looks like...
DFV Local Link is embedded in the locality	The DFV Local Link have invested quality time building relationships and networks across the locality with medical centres, GPs, DFV services, existing networks, police, hospitals, community support organisations, psychologists and counsellors. These relationships have been formalised for inclusion in a database for coordinating effective referrals.
DFV Local Link delivers robust case management	Displaying the hallmarks of successful case management and capable of delivering a person-centred service that can support responsive referrals and alternative support pathways. Deeply understand the referral criteria for each service provider.
Locality DFVSS has adequate capacity and breadth	Local DFV services have the capacity and capability to meet the needs of the community or have alternative means to support them to do so.
Locality GP, general practice staff and mental health professionals have received RRR Training	General practice staff, particularly GPs have been introduced to the mindsets and capabilities necessary to create the climate for disclosure and in turn, manage that disclosure. At least a basic understanding of the different dimensions of abuse and how to employ a trauma-aware approach. Mental health professionals including psychologists and counsellors have an appropriate level of skills to work with victim-survivors where a DFV specific service is not the right first step for a patient and a Mental Health Care Plan (MHCP) might provide an alternative solution.
Neutral Facilitator is contracted	A neutral third party is contracted on an annual basis to work with victim survivors, perpetrators and other system stakeholders to (a) gather evidence to assist with evaluation, (b) iterate and improve the model and its various elements, and, (c) facilitate convening at locality and systems levels to achieve the desired outcomes from those events.

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