



SaxInstitute 

Final Report:

Evaluation of the Improving
Health System Responses to
Family and Domestic Violence
Primary Health Network Pilots

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An evaluation conducted by the Sax Institute for the Australian Government Department of Health and Aged Care

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Glossary of acronyms used throughout this report

ACCHO	Aboriginal Community Controlled Health Organisation
AMS	Aboriginal Medical Service
ANROWS	Australia's National Research Organisation for Women's Safety
BSPHN	Brisbane South PHN
CESPHN	Central and Eastern Sydney PHN
CoP	Community of Practice
CPD	Continuing Professional Development
Health	The Commonwealth Department of Health and Aged Care
DFV	Domestic and Family Violence
FTE	Full-time Equivalent
GP	General Practitioner
GRIPS	General Practitioner Perceived Readiness to identify and respond to intimate Partner Abuse Scale
HNECCPHN	Hunter New England and Central Coast PHN
NBMPHN	Nepean Blue Mountains PHN
NWMPHN	North Western Melbourne PHN
LGBTIQA+	Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual community
LGA	Local Government Area
LL	Local Link/ Local Linker
PIP	Practice Incentives Program
PHN	Primary Health Network
RRR	Recognise, Respond, Refer
QI	Quality Improvement
SI	System Integrator (generic term used to describe the Local Linker role across all PHNs)
WVPHN	Western Victoria PHN

Executive summary

Overview of the DFV pilot

The 2019-2020 Federal budget included \$9.6 million of funding over four years for the *Improving Health System Responses to Family and Domestic Violence* measure to support the implementation of the Fourth Action Plan of the National Plan to Reduce Violence against Women and their Children (2010–2022). The measure included two streams of activity. The first stream provided funding of \$7.5 million over three years for a pilot initiative focused on improving the primary care sector’s response to domestic and family violence (DFV) (the DFV pilot). This funding expanded the Recognise, Respond, Refer (*RRR*) pilot model implemented by Brisbane South PHN (BSPHN) from 2017, and included funding for five additional Primary Health Networks (PHNs)¹: Central and Eastern Sydney (CESPHN), Hunter New England and Central Coast (HNECCPHN), Nepean Blue Mountains (NBMPHN), North Western Melbourne (NWMPHN), and Western Victoria (WVPHN) to trial new locally integrated models of family violence identification, response and referral activities to better support people experiencing domestic and family violence in those PHN regions.

The DFV pilot focused on the development and delivery of training, resources and capacity building activities for primary care staff to enhance their capacity to recognise and respond to DFV, as well as a range of system integration activities to ensure that victim-survivors receive an improved quality of support. The DFV pilot was primarily delivered by dedicated system integrator positions² that acted as conduits between primary care and DFV services – to improve integration and coordination between the primary care and DFV sectors and influence broader systems change. DFV pilot activities targeted general practice-based primary care workers, including health professionals (general practitioners (GPs), practice nurses and allied health staff) and administrative staff (practice managers, receptionists and administration).

The DFV pilot aimed to contribute to the following outcomes:

- Enhancing general practice-based primary care workers’ awareness of DFV and their capacity to identify and support DFV victim-survivors
- Enhancing relationships and collaboration between the primary care and DFV sectors to ensure coordinated responses to those affected by DFV
- Increasing primary care sector referrals to DFV support services
- Improving the support experience and outcomes for DFV victim-survivors.

A key attribute of the DFV pilot was its flexibility in model design and implementation, with each PHN developing and implementing a tailored model developed in response to their local needs and service context, building on (but not necessarily replicating) the *RRR* approach. Despite the PHN-tailored approach, three core components of the model were common across all participating PHNs: 1) training; 2) system integration; and 3) influencing the system for sustainable change.

¹ PHNs are independent organisations funded by the Australian Government to coordinate primary health care in their regions by assessing community needs and commissioning health services to enable people in their region to get coordinated health care where and when they need it.

² System integrators, the role variously referred to across PHNs as DFV local linker, connector, navigator or family violence worker.

The Sax Institute, in partnership with Australia's National Research Organisation for Women's Safety (ANROWS), was commissioned to evaluate the DFV pilot. This report provides the final implementation and outcome evaluation findings, based on data collected from July 2021 to November 2022. An interim evaluation was completed and reported in February 2022³.

Overview of the evaluation

This final evaluation of the DFV pilot had the following aims:

- 1) To describe the DFV pilot core components' implementation and stakeholder participation for each PHN during the July 2021 – November 2022 evaluation period
- 2) To understand participant perceptions of the DFV pilot activities (i.e.: training, resources, capacity building and support provided by system integrators), and the facilitators and challenges of the DFV pilot implementation
- 3) To explore the outcomes achieved at the primary care level in relation to:
 - a. Primary care workers' awareness, capacity and confidence to respond to DFV
 - b. Relationships between the primary care and DFV sectors
 - c. Primary care referrals to specialist DFV support services
 - d. The support experience and outcomes for DFV victim-survivors
- 4) To identify learnings and implications for the future.

This evaluation of the DFV pilot used a mixed methods design to gather a range of quantitative and qualitative monitoring and evaluation data for use in reviewing how well the DFV pilot met the above aims, including:

- **Quarterly progress reports** to provide context regarding the model's history, and the processes during development and implementation stages
- **Interviews and group discussions** with 36 key stakeholders (i.e., the PHN Operational Working Group, GPs, allied health practitioners, and system integrators) on their perceptions of the implementation and outcomes of the DFV pilot
- **Monitoring data** collected via custom-made tools completed by system integrators from each PHN. Data captured related to the type and frequency of GP engagement, the type and amount of training GPs and allied health practitioners and administrative staff had received, and the number of GP referrals to specialist DFV services and other support services
- **Pre-post training surveys** completed by training attendees (n=758 pre-training and 368 post-training) to assess the impact of the DFV pilot on participants' self-rated readiness to recognise and respond to DFV and to gather feedback about the training attended
- **Follow-up surveys** completed by 62 staff from general practices that had maintained ongoing engagement with the DFV pilot to explore general practice staff (health professionals and practice managers) engagement with the system integrator and other DFV pilot components (e.g., training and capacity building, quality improvement activities and resources) towards capturing a more holistic understanding of the factors influencing outcomes for primary care
- **Descriptive case studies** completed by three participating PHNs to further explore the impact of the DFV pilot among general practices most actively engaged with the system integrators.

Although individual data collection methods had their limitations (e.g., self-reported data and low survey response rates), the evaluation garnered a diversity of data from a range of key stakeholders, providing consistent views about the DFV pilot's implementation and impact, which allows confidence for the findings presented in this report to guide future implementation.

³ Knight A, Rose S, Bandara P, Redman A, Newell S, Ninnis P. Interim Report: Evaluation of the Improving Health System Responses to Family and Domestic Violence Primary Health Network Pilot. Sydney: Sax Institute 2022.

Key evaluation findings

Aim 1: Description of core components implemented in PHNs

Between July 2021 and November 2022, the six participating PHNs successfully delivered 225 DFV training sessions that were attended by over 1,700 primary care staff, including a wide range of both health professional and administrative staff. Overall, GPs were the largest attendee group, with 730 participating across all PHNs during the evaluation period, followed by 359 nurses and 311 administrative staff (including practice managers). BSPHN reported delivering fewer training sessions as a result of already having delivered most of their training prior to the evaluation period.

System integrators achieved over 3,500 meaningful engagements across almost 800 general practices (these excluded purely administrative contacts with general practices). These engagements had a heavy focus on relationship building but almost one-third involved providing general practices with DFV resources and/or general DFV advice. The DFV pilot also supported the care of DFV victim-survivors, with system integrators providing patient-specific advice on over 900 occasions, referral pathway advice on almost 700 occasions, and supporting GPs to make over 250 DFV victim-survivor referrals. System integrators also supported general practices with DFV-related quality improvement activities on almost 400 occasions. Participating PHNs were also active in a wide range of system influencing bodies and entities, including local interagency groups and various state-wide government initiatives and collaboratives.

BSPHN accounted for half of the meaningful system integrators engagements and over one-third of the engaged general practices. This is likely as a result of the strong partnerships they had already developed with general practices in their region prior to the evaluation period. While CESPHN, HNECCPHN and NBMPHN engaged with more practices, NWMPHN and WVPHN engaged with fewer practices more intensively as a result of their models requiring general practices to enrol in a complete QI training package.

Aim 2: Stakeholder perceptions of the DFV pilot

The DFV pilot (and its various activities) was overwhelmingly perceived as valued, useful, important and needed. Participating general practices provided very positive feedback about the various DFV pilot activities they had engaged with, considering them timely, of high quality, relevant for their work role and having improved their capacity and confidence to recognise and respond to DFV in a variety of ways. As in the interim report, the system integrators and the DFV-related training were considered to have had the greatest impact on enhancing the primary care sector's DFV capacity. Also as in the interim report, training participants particularly appreciated the more interactive components (e.g.: role playing, case study discussions, hearing from multiple professional perspectives) and the practical tools provided or introduced during the trainings – e.g.: action plans, referral pathways).

Stakeholder feedback indicated that the achievements of the DFV pilot were facilitated by a range of factors. The primary factor was the nature of the DFV pilot's overall approach, including:

- The Federal Department of Health and Aged Care providing funding for system integrators and DFV pilot implementation activities, although the short-term nature of this funding also raised some challenges (as discussed below)
- The DFV pilot's flexible and collaborative implementation approach, with PHNs adapting their activity delivery around the needs and preferences of their local general practices
- The partnership approach which brought the primary care and DFV sectors together to affect system change
- The focus on working with whole practices (rather than individual GPs).

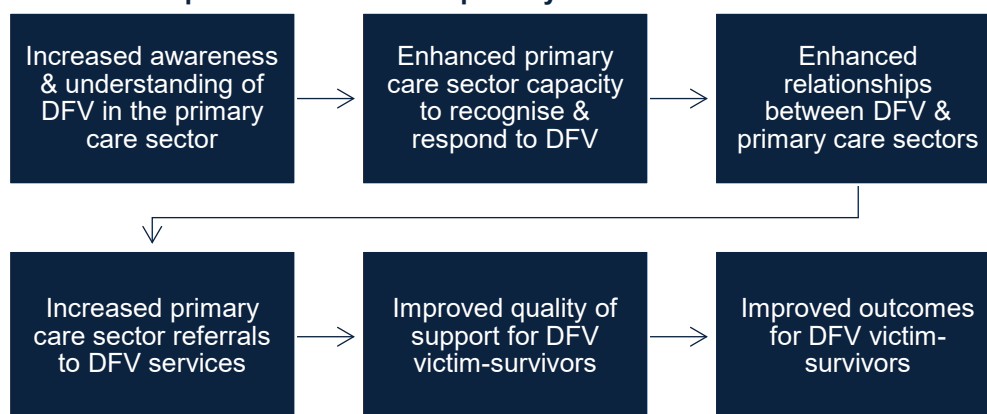
System integrators were also a key DFV pilot facilitator, with their expertise, persistence, passion and commitment to building trust and relationships with general practices frequently mentioned in stakeholder interviews. Interviewees also discussed how co-locating system integrators (in DFV services or general practices) enabled more integrated and collaborative care for DFV victim-survivors and how the PHNs' involvement helped substantially with giving the DFV pilot credibility and engaging GPs.

DFV pilot implementation was hampered by pre-existing primary care attitudes towards DFV and the time-poor nature of modern general practice (which was exacerbated by the COVID-19 pandemic and other natural disasters), issues of staff recruitment and retention, and by the relatively short implementation timeframe of the DFV pilot. Some PHNs reported a reluctance to encourage system integrators to take a more direct or involved role with practices due to concerns they would be unable to continue funding such a role when the pilot concluded. The latter challenge has now been overcome by the announcement that the DFV pilot has received additional funding for another four years, during which its reach and scope will be expanded.

Aim 3: Outcomes at the primary care level

As summarised in Figure 1, this report presents evidence that the DFV pilot is contributing towards an improved support experience and outcomes for DFV victim-survivors by: generating primary care sector awareness and understanding about DFV; enhancing the primary care sector's DFV capacity, processes and confidence; establishing and embedding trust between GPs and DFV services; and increasing the number and quality of DFV referrals from the primary care sector.

Figure 1: Overview of DFV pilot outcomes at the primary care level



The improved DFV capacity was evident in respondents' pre-post training survey responses, with both the GRIPS⁴ (for health professionals) and a broad range of PHN-nominated DFV capacity indicators (for both health professionals and administrative staff) indicating statistically significant improvements across all indicators. Follow-up survey respondents considered the DFV pilot was the main contributor to their improved DFV-related capacity, with the system integrators and the DFV-related trainings considered to have had the greatest impact.

Interviews with key stakeholders similarly identified many changes arising from the DFV pilot, most frequently in relation to building primary care sector DFV capacity and confidence and improving support quality (and referral numbers) for DFV victim-survivors but also in relation to enhancing relationships between primary care and DFV sectors, raising the profile of DFV in the primary care sector and improving outcomes for DFV victim-survivors. However, interviewees also raised a need for improved feedback loops from DFV services to GPs about the outcomes of referrals made to them.

⁴ GRIPS = General Practitioner Perceived Readiness to identify and respond to intimate Partner Abuse Scale.

Aim 4: Learnings and recommendations

The findings presented throughout this report demonstrate that the DFV pilot has made steady progress towards achieving its aims of improving primary care DFV awareness and capacity, enhancing relationships and collaboration between the primary care and DFV sectors, increasing primary care sector referrals to DFV support services and improving the support experience and outcomes for DFV victim-survivors.

This progress has been achieved through varying approaches and activity combinations across the six participating PHNs, in response to local contexts, needs and primary care sector capacity and preferences. At this stage, there is insufficient evidence to understand whether the different PHN models (or components of them) are more or less effective than each other. However, the tailored place-based approach is considered a key factor in the DFV pilot's success to date and the following components have emerged as particularly valuable across multiple PHNs:

- Funding the system integrator role to work towards building relationships and actively engaging general practices
- Engaging DFV services to deliver the system integrator roles as a first step towards enhancing relationships and collaboration between the primary care and DFV sectors
- Delivering DFV-related training to whole practices (including administrative and allied health staff), rather than to individual GPs
- Providing relevant complementary resources and practical tools as these helped solidify training outcomes and facilitate primary care sector practice changes
- Regular face-to-face contact with general practices (possibly through co-location of system integrators) to reinforce training outcomes and keep DFV on general practices' radar
- Providing some form of incentive (financial and/or continuing professional development (CPD) points) to encourage general practices to engage with DFV pilot activities.

Based on these key learnings and the detailed findings presented throughout this report, we make the following recommendations to enhance the ongoing implementation of the DFV initiative:

Key learnings	Detailed findings
1. Maintain the flexible implementation approach but consider establishing a common branding and key messages/ components for the ongoing DFV initiative	Learnings from the DFV pilot provide a solid foundation that can inform future implementation activities for the ongoing DFV initiative, which would benefit from a common branding and key messages or components across all participating PHNs. This would enable more consistent promotion and evaluation of the future implementation. However, there will still be an ongoing need for flexibility, collaboration and co-design (especially in new sites) to ensure they remain relevant to diverse communities.
2. Maintain the system integrator role and PHN involvement	The system integrators were critical in the general practice engagement and wide-ranging outcomes achieved by the DFV pilot and should remain a core element in the ongoing DFV initiative – to maintain already-established relationships and foster new ones. The PHN involvement was also important given their pre-existing relationships with GPs and their role in supporting general practice. PHNs and system integrators should consider forging relationships with peak bodies to get onto conference agendas to promote the DFV initiative and messages to a broader audience.

3. Prioritise face-to-face engagement with general practices	<p>The increased use of face-to-face contact with general practices in this phase of the DFV pilot (compared to the reliance on other methods during the COVID-19 pandemic) facilitated relationship building and increased engagement with DFV pilot activities, including training, resources and system integrators. PHNs could consider co-locating their system integrators within DFV services and/or general practices as this was found beneficial in the PHNs trying it during the DFV pilot.</p>
4. Continue to provide DFV training and explore additional training avenues	<p>The DFV pilot has achieved considerably improved capacity among participating general practices but there are still many more practices to be engaged and upskilled, especially in relation to awareness of DFV as a health issue. Already-trained practices could also benefit from additional and/or refresher trainings in the future. PHNs and Health could also consider advocating for the inclusion of DFV training in RACGP professional development and relevant undergraduate and/or postgraduate health professional courses. Ideally, there should be coordination between the various government departments and other entities providing DFV-related training (e.g., Monash University’s pilot course on recognising and responding to sexual violence).</p>
5. Explore options for incentivising general practice engagement	<p>Given the primary challenge faced in implementation was engaging general practices, Health and PHNs should continue to explore options for incentivising and encouraging engagement. For example, three PHNs (HNECCPHN, NWMPHN and WVPHN) have used behavioural contracting techniques through the Practice Incentives Program (PIP) Quality Improvement (QI) Incentive to support general practice engagement with the DFV pilot.</p>
6. Increase the focus on diverse community groups experiencing DFV	<p>In response to stakeholder feedback in the interim report, some PHNs continued to tailor their approaches to meet the needs of priority population groups, such as Aboriginal and Torres Strait Islander, CALD, LGBTIQ+ and children. However, in a reflective workshop in late 2022, all PHNs identified a need for an increased focus on this going forward⁵. PHNs and Health should consider options that enable the model to support these diverse groups. This might include PHN collaboration on the evidence base and shared training, resources and support (learning from the work already undertaken in some PHNs). Health could also consider supporting training packages that take diversity and intersectionality into account. Where possible, Health should align these activities with <i>The National Plan to End Violence against Women and Children 2022-2032</i>.</p>
7. Continue evaluating the DFV pilot and explore options for facilitating improvements in data systems and collection	<p>The data challenges identified in the interim evaluation report remain, that is regarding collecting and accessing consistent and secure primary care administrative data that demonstrate the role they play in supporting DFV victim-survivors and the outcomes achieved in relation to integration with the DFV sector. Health should explore options for facilitating improvements in data systems and collection, to support the development of secure, integrated reporting systems that are embedded within primary care and specialist DFV services, and allow transparent access to de-identified information such as primary care referrals to specialist DFV services. The evaluator of the next phase should also refine the tools and processes developed for this evaluation to reduce the burden on PHNs and DFV services and facilitate access to real-time reporting.</p>

⁵ Outcomes and Next Steps - PHN DFV Trial Workshop 13-14 Oct 2022.

Introduction

As part of the 2019-20 Budget, the Australian Government announced funding totalling \$9.6 million (over four years) for the Improving Health System Response to Family and Domestic Violence measure, to support the implementation of the Fourth Action Plan of the National Plan to Reduce Violence against Women and their Children (2010–2022). This funding included \$7.5 million for an expansion of the Recognise, Respond, Refer (*RRR*) model implemented by Brisbane South Primary Health Network (BSPHN) from 2017, and for piloting locally integrated models of DFV recognition, response and referral in five additional Primary Health Networks (PHNs): Central and Eastern Sydney (CESPHN), Hunter New England and Central Coast (HNECCPHN), Nepean Blue Mountains (NBMPHN), North Western Melbourne (NWMPHN) and Western Victoria (WVPHN).

For the DFV pilot, each PHN developed and implemented an integrated model tailored to respond to their local needs and service context, building on (but not necessarily replicating) the *RRR* approach. DFV pilot activities targeted general practice-based primary care workers, including health professionals (GPs, practice nurses and allied health staff) and administrative staff (practice managers, receptionists and administration).

The DFV pilot aimed to contribute to the following outcomes:

- Enhancing general practice-based primary care workers' awareness of DFV and their capacity to identify and support DFV victim-survivors
- Enhancing relationships and collaboration between the primary care and DFV sectors to ensure coordinated responses to those affected by DFV
- Increasing primary care sector referrals to specialist DFV support services
- Improving the support experience and outcomes for DFV victim-survivors.

A key feature of each PHN's model was the creation of dedicated 'system integrator' positions that focused on enabling better integration across the primary care and DFV sectors. The system integrators were variously referred to as the DFV Local Links (BSPHN and HNECCPHN), DFV Navigator (CESPHN), DFV Linker (NBMPHN), the Family Violence Worker (NWMPHN) and the Family Violence Connector (WVPHN).

Table 1 provides an overview of the demographic and geographical context of each PHN (sourced from Australian Bureau of Statistics and PHN websites), highlighting the diversity of each region. For example, geographical spread was by far the largest in HNECCPHN, while CESPHN had the smallest, most densely populated area with the greatest number of general practices. BSPHN, CESPHN and NWMPHN had higher cultural diversity, while HNECCPHN had the highest representation of First Nations people. This diversity influenced PHNs' priority groups and delivery approaches, which are discussed further in Appendix G.

Table 1. Demographics and region geography by PHN

	BSPHN	CESPHN	HNECCPHN	NBMPHN	NWMPHN	WVPHN
Population	1,200,000	1,500,000	1,200,000	360,000	1,900,000	714,000
First Nations population	2.8%	1.05%	6.4%	3.7%	0.5%	1.5%
Population born overseas	31%	40%	18%	24%	33%	13%
Geographical size	3,770 km ²	626 km ²	130,000 km ²	9,186 km ²	9,186 km ²	79,834 km ²
N general practices	340	611	387	138	561	214
N GPs	1,388	2,142	1,325	463	2,475	703
N practice nurses	695	613	628	202	1,064	645

Evaluation approach

Overarching program logic

A key innovation of the DFV pilot was its flexible model design and implementation in response to the different needs and circumstances of each PHN region. Given this, an overarching program logic was developed in collaboration with representatives from Health and PHNs, to guide the design and implementation of the evaluation (see Figure 2 on the next page). The program logic allowed for the flexible and tailored nature of the DFV pilot by including common components and consistent outcomes across the PHNs.

The three common core components of the DFV pilot were: 1) training; 2) system integration; and 3) influencing the system for sustainable change. The *training* component included activities aimed at increasing the capacity and capability of general-practice-based primary care workers to support DFV victim-survivors. The *system integration* component involved PHNs appointing system integrators⁶ to deliver activities aimed at improving the primary care sector's ability to integrate with the broader DFV service sector. The *influencing the system for sustainable change* component included activities aimed at strengthening parts of the system (e.g., primary care or DFV sectors) or the system as a whole (e.g., an integrated primary care – DFV service system).

The program logic (see Figure 2 on the next page) shows how the DFV pilot intended to influence outcomes at three levels of the primary care-DFV service system: 1) primary care; 2) specialist DFV services; and 3) victim-survivors. While there was some variation between PHNs' DFV pilot models, there was consistency in the core problems (listed in the "Situation" column) the DFV pilot models were trying to resolve and the outcomes they were seeking to influence ("Outcomes" column).

Evaluation aims

This final evaluation of the DFV pilot had the following aims:

- 1) To describe the DFV pilot core components' implementation and stakeholder participation for each PHN during the July 2021 – November 2022 evaluation period, specifically the:
 - a. Training activities (core component 1, Figure 2)
 - b. System integration activities (core component 2, Figure 2)
 - c. System influencing activities for sustainable change (core component 3, Figure 2)
- 2) To understand participant perceptions of the DFV pilot activities (i.e.: training, resources, capacity building and support provided by system integrators), and the facilitators and challenges of the DFV pilot implementation
- 3) To explore the outcomes achieved at the primary care level in relation to:
 - a. Primary care workers' awareness, capacity and confidence to respond to DFV
 - b. Relationships between the primary care and DFV sectors
 - c. Primary care referrals to specialist DFV support services
 - d. The support experience and outcomes for DFV victim-survivors
- 4) To identify learnings and implications for the future.

⁶ System integrators, the role variously referred to across PHNs as DFV local linker, connector, navigator or family violence worker.

Figure 2: Program logic for the DFV pilot

	Situation	Intervention Core components and example activities	Outcomes
<p>Primary Care</p>	<p>Primary care staff (including GPs, practice nurses and administrative staff):</p> <ul style="list-style-type: none"> Have not been trained to recognise and respond appropriately to DFV There is a level of discomfort asking patients about DFV (i.e. uncertainties about legal implications of disclosure, how to respond or who to refer to) GPs do not feel comfortable/supported to care for victim-survivors GPs are not reporting DFV consistently and are not aware of the specialist support services available for victim-survivors, or how to navigate women to these services GPs have low levels of trust in the ability of these services to affect change/support victim-survivors Primary care staff do not understand the role of specialist DFV services in supporting victim-survivors and do not receive feedback from them on the outcomes of their referrals GPs encounter emotional, legal and financial barriers to improving their DFV response during a consult. 	<p>Core component 1: Training Example activities:</p> <ul style="list-style-type: none"> Delivery of formal DFV training for general practitioners, primary care nurses, Aboriginal Health Workers and Practitioners, and other primary health care workers Delivery of informal DFV education/training for general practitioners, primary care nurses, Aboriginal Health Workers and Practitioners, and other primary health care workers Development of guides and educational materials for general practitioners, primary care nurses, Aboriginal Health Workers and Practitioners, and other primary health care workers. <p>Core component 2: System integration Example activities:</p> <ul style="list-style-type: none"> Creation of a Local Linker function that acts as a conduit between primary care and locally relevant specialist DFV services to: <ul style="list-style-type: none"> Provide ongoing training, support and advice to primary care on DFV Provide a single referral point to local specialist DFV services for primary care Provide training, support and advice for specialist DFV services on the role of primary care in DFV Support specialist DFV services to close the referral loop with primary care Improve collaboration between specialist DFV services and primary care to ensure coordinated responses for victim-survivors Advocate for primary care and the role it plays in supporting victim-survivors to specialist DFV services. Development of guidance documents, policies and referral pathways into specialist support services for primary care. 	<p>Primary care staff have:</p> <ul style="list-style-type: none"> Improved readiness to address DFV <ul style="list-style-type: none"> GRIP scale which measures knowledge, confidence recognising, asking about and referring for DFV, self-efficacy, motivational and emotional readiness (Leung et al., 2017) Other practice staff measured using bespoke measure Improved understanding of the role of specialist DFV services in supporting victim-survivors An increased number of GPs recognising DFV An increased number of GP referrals to local specialist DFV services.
<p>Specialist DFV Services</p>	<p>Specialist DFV Services working with victim-survivors of DFV:</p> <ul style="list-style-type: none"> Are under-resourced and often at- or over-capacity Do not understand the role of GPs in supporting victim-survivors Do not always receive referrals from GPs Inconsistent closing of the 'referral loop' with GPs to inform them of care plan/actions taken. 	<p>Core component 3: Influencing the system for sustainable change Example activities</p> <ul style="list-style-type: none"> PHN advocacy for increased, consistent funding of the specialist DFV sector Co-locating the Linker/Connector role across primary care and specialist DFV services Interdisciplinary Communities of Practice and networking events between primary care and the specialist DFV sector Advocating for better integration between primary care and specialist DFV sector Mentoring provided by BSPHN. 	<p>Specialist DFV services have:</p> <ul style="list-style-type: none"> Improved understanding of the role of primary care in supporting victim-survivors An increased number of victim-survivors attending their services as a result of GP referrals Increased the number of 'closed referrals'.
<p>Victim-survivors</p>	<p>Victim-survivors of DFV:</p> <ul style="list-style-type: none"> Are not aware of DFV support services available or how to navigate them Are not aware of services that are culturally safe Even if they are aware of supports, they are not always comfortable disclosing to GPs ...this contributes to: Poor mental health (depression and anxiety) Poor quality of life Reduced feelings of personal safety Poorer physical health (e.g. increased levels of chronic disease). 	<p>Core component 3: Influencing the system for sustainable change Example activities</p> <ul style="list-style-type: none"> PHN advocacy for increased, consistent funding of the specialist DFV sector Co-locating the Linker/Connector role across primary care and specialist DFV services Interdisciplinary Communities of Practice and networking events between primary care and the specialist DFV sector Advocating for better integration between primary care and specialist DFV sector Mentoring provided by BSPHN. 	<p>Victim-survivors have:</p> <ul style="list-style-type: none"> Increased awareness of support services available and how to navigate them Increased comfort to discuss partner abuse with GP Increased access to DFV services/supports.

Improvements in the **physical health** (i.e. reductions in chronic disease), **mental health** (i.e. reductions in depression and anxiety), **quality of life** and perceptions of **personal safety** for victim-survivors.

Data collection and analyses

This evaluation used a mixed methods design to gather a range of quantitative and qualitative monitoring and evaluation data for use in reviewing how well the DFV pilot delivered in relation to the above aims. The data collection tools and methods are described in the following sections, including indications of which DFV pilot aim(s) each method contributed towards assessing and how the data were analysed.

Monitoring data tools

To describe DFV pilot implementation activities, monitoring data were collected and reported quarterly by either PHN operational staff or the system integrator in each PHN between July 2021 and November 2022 using the following tools (see Appendix A) developed specifically for this evaluation:

- **The General Practice Training Tracker** (aim 1a) – This tool captured data related to the type and amount of training general-practice-based health professionals and administrative staff received. It also captured information on the date, practice name and code, local government area (LGA), the type of practice (multi-GP or sole operator), the training type (clinician, whole practice, informal), training date, delivery mode (face-to-face, online, hybrid), and the number and roles of staff who completed the training.
- **The GP Engagement Tracker** (aim 1b) – This tool captured data related to the type and frequency of GP engagement with the system integrators over the course of the monitoring period. It captured information on date of engagement, practice name and code, LGA, the type of practice (multi-GP or sole operator), main contact, engagement mode (phone, email, face-to-face), the outcome of each engagement, and general comments about the experience. In consultation with PHN operational staff and system integrators, this tracker was revised following the interim report to capture greater detail regarding the types of engagement, with a focus on key interactions between the system integrator and general practices. The updated GP Engagement Tracker was used from April 2021 (see Appendix B for the updated tracker guide).
- **The Referral Tracker** (aim 3c) – This tool captured data related to the number of GP referrals to specialist DFV services. It also captured the GP name and code, DFV service name and code, whether the system integrator role sat within the service or PHN, and the number of referrals per reporting period. In consultation with PHN operational staff and system integrators, this tracker was revised following the interim report to capture greater detail regarding the range and types of referral – that is either by the GP, by the system integrator (if applicable for the PHN) or if a referral recommendation was made. The intent was to provide greater context for the PHNs whose system integrators did not participate in client-facing engagements or accept direct referrals. This tracker was also revised to capture greater detail regarding the types of support within the DFV services that victim-survivors were being given. The updated Referral Tracker was used from April 2021 (see Appendix B for the updated tracker guide).

In addition to the above data trackers, each PHN submitted quarterly progress reports to provide additional information about each PHN's contextual and programmatic implementation information (aim 1). This tool captured information about planned activities for each component, such as the type and purpose of each activity, as well as highlights and challenges for the reporting period (see Appendix C).

Data from the three tracker tools and the PHN progress reports were reviewed and aggregated, and are presented as counts and percentages (i.e., prevalence), overall and by PHN. These analyses were supplemented by information sourced through the stakeholder interviews.

Evaluation data tools

To explore the potential outcomes achieved by the DFV pilot, two separate surveys were administered online via Qualtrics: 1) Pre-post training surveys (see Appendix D); and 2) A follow-up survey (see Appendix E). Electronic survey links were sent to practice managers and/or GPs by system integrators or PHN operational staff. Practice managers, or other responsible staff members, then distributed the survey links to their participating colleagues.

Pre-post training surveys (aim 3a)

Participating health professionals and administrative staff were asked to complete surveys at two time points, to explore change in outcomes as a result of the DFV training component. The first (pre-training) survey was completed prior to the participants attending training. Between June 2021 and February 2022, the second (post-training) survey was completed 8-weeks post-training to allow participants an opportunity to engage with their local system integrator. However, following the interim report and in consultation with PHN operational staff and system integrators, timing of this second survey was altered to be immediately following their training (February – November 2022). This was a strategy to improve the post-training survey response rates for the final evaluation. The second survey was also shortened with items pertaining to system integrator interactions moved to the follow-up survey. Where possible, data from the former and current iterations of the post-training survey have been merged for analysis.

The pre-post training survey questions asked about respondents' demographics, profession and experience; any previous DFV training; feedback about the training attended; any perceived improvement in their ability to recognise and respond to DFV; and any intended practice changes. These surveys also included a series of questions to assess respondents' self-rated DFV capacity, tailored to their roles within the general practice, as a health professional or administrative staff. Health professionals completed a validated measure, the GRIPS (General Practitioners' Perceived Readiness to identify and respond to Intimate Partner Abuse Scale)⁷, which assesses three domains (self-efficacy, motivational readiness and emotional readiness). Administrative staff completed a shorter set of readiness⁸ and confidence items.

As shown in Table 2, between July 2021 and 13 November 2022 (the cut-off date for inclusion in this evaluation report), 758 pre-surveys and 368 post-surveys were completed, representing overall response rates of 44% and 22% of all 1708 training attendees, despite bringing forward the post-training surveys. The response rates were likely impacted by the demands of the COVID-19 pandemic on general practice capacity and motivation to complete a voluntary survey. Although the low response rate means that outcome data should be interpreted with caution, the numbers of surveys collected provide reasonable coverage from all key stakeholder groups.

WVPHN, CESP HN and HNECCPHN achieved above average response rates for the pre-training survey, while NWMPHN achieved above average post-training survey response rates. In relation to professional type, response rates were above average for administrative staff and allied health practitioners and below average for GPs.

⁷ Leung, T.P.-Y., et al., GPs' perceived readiness to identify and respond to intimate partner abuse: development and preliminary validation of a multidimensional scale. *Australian and New Zealand Journal of Public Health*, 2017. 41(5): p. 512-517.

⁸ As the GRIPS has not been validated for non-health professionals, a brief version was administered.

Table 2: Pre-post training survey response numbers and rates by PHN and professional role

		Number training attendees	Pre-survey N (%)	Post-survey N (%)
Overall		1708	758 (44%)	368 (22%)
By PHN	BSPHN ⁹	135	9 (7%)	0
	CESPHN	520	261 (50%)	94 (18%)
	HNECCPHN	426	207 (49%)	95 (22%)
	NBMPHN	176	80 (45%)	32 (18%)
	NWMPHN	306	114 (37%)	110 (36%)
	WVPHN	145	87 (60%)	36 (25%)
By professional role	GP	730	210 (29%)	104 (14%)
	Nurse	359	149 (42%)	74 (21%)
	Administrative	311	196 (63%)	92 (30%)
	Allied Health	239	143 (60%)	64 (27%)
	Other	136	70 (51%)	33 (24%)

Table 3 further describes the demographic characteristics of the survey respondents, with most being female, aged under 50 years, having no previous DFV training and, for health professionals, having over ten years' experience. Respondent characteristics were similar in both the pre-training and post-training surveys.

Table 3: Pre-post training survey respondent characteristics

Characteristics		Pre-survey (n=758) N (%)	Post-survey (n=368) N (%)
Gender (95 did not answer)	Female	639 (85%)	237 (84%)
	Male	108 (14%)	44 (16%)
	Non-binary	2 (<1%)	2 (<1%)
Age (years) (95 did not answer)	Under 30	174 (23%)	58 (20%)
	30s	175 (23%)	59 (21%)
	40s	176 (24%)	85 (30%)
	50s	142 (19%)	57 (20%)
	60+ years	81 (11%)	24 (8%)
Years of experience as a health professional (n = 517 & 257 for pre and post respectively) (7 did not answer)	5 years or less	155 (30%)	66 (26%)
	6-10 years	87 (17%)	41 (16%)
	11-20 years	113 (22%)	75 (29%)
	>20 years	157 (31%)	73 (29%)
Any previous DFV training? (200 did not answer)	Yes	184 (25%)	38 (22%)
	No	522 (69%)	127 (73%)
	Unsure	46 (6%)	9 (5%)

The pre-post training surveys were analysed using Stata 16 statistical software with descriptive counts and proportions presented for all question variables, overall (i.e.: aggregated across all 6 PHN sites) and, where relevant, by PHN. Open-ended survey questions were analysed thematically and aggregated across the six PHNs. Mean scores and 95% confidence intervals (CIs) were generated for rating scales (and their sub-domains) and independent t-tests were performed to assess any differences in means between the overall

⁹ Due to their briefer and opportunistic training approach and completing separate RACGP follow-up surveys, BSPHN found it impractical to seek attendees' participation in the pre-post training surveys.

pre-training and post-training survey data. In addition, where both pre-training and post-training survey data could be matched for individuals, paired t-tests were conducted to assess differences in means.

Follow-up survey (aims 1, 2 & 3)

As discussed above, from February 2022, the follow-up survey was administered separately to the pre-post training survey, about 3-6 months post-initial engagement with the DFV pilot (this timing was guided by each PHN based on their activities and model). The follow-up survey aimed to explore general practice staff (health professionals and practice managers) engagement with the system integrator and other DFV pilot components (e.g., training and capacity building, quality improvement activities and resources) to capture a more holistic understanding of the factors influencing outcomes. Core items were included to allow comparisons across PHNs, along with additional questions tailored for how each PHN was implementing the DFV pilot.

The follow-up survey included the following items:

- Demographics and professional background/experience
- Exposure or engagement with the DFV pilot activities (incl. frequency and type):
 - The system integrator
 - Training and capacity building activities
 - Quality improvement activities
 - Resources
- Ratings and satisfaction regarding the DFV pilot activities
- Intended practice changes.

Participants were a convenience sample. The system integrators were asked to identify and invite participants from general practices that had maintained ongoing engagement with the DFV pilot. While recognising the potential bias of this approach, it was considered the most suitable for providing additional rich data on the influence of the system integrators (acknowledging that the wider cohort may not have been exposed to this component). This approach also addressed the issue of low response rates that occurred in the first round of data collection for the interim evaluation. As shown in Table 4, between 1st August and 23rd November 2022 of 335 participants invited, 62 completed the survey (response rate of 18.5%).

Table 4. Follow-up survey response numbers and rates by PHN and professional type

	BSPHN	CESPHN	HNECCPHN	NBMPHN	NWMPHN	WVPHN	TOTAL
Practice managers	5 (38%)	2 (15%)	---	---	2 (15%)	4 (31%)	13
Health professionals	13 (33%)	6 (15%)	4 (10%)	9 (23%)	10 (26%)	7 (18%)	49
TOTAL	18 (29%)	8 (13%)	4 (6%)	9 (15%)	12 (19%)	11 (18%)	62

As shown in Table 5, follow-up survey respondents were mostly English-speaking female health professionals (mostly GPs) aged 40 years or over working in general practices, with a fairly even split between those who had been practising for up to 10 years and for over 10 years.

Table 5: Characteristics of follow-up survey respondents

Characteristics		Follow-up survey (N=62)
		n (%)
Gender (13 did not answer)	Female	40 (82%)
	Male	9 (18%)
Age (years) (13 did not answer)	Under 30	2 (4%)
	30s	13 (27%)
	40s	17 (35%)
	50s	14 (29%)
	60+ years	3 (6%)
Speak a language other than English at home? (13 did not answer)	No	34 (69%)
	Yes	15 (31%)
Professional role	GP	30 (48%)
	Practice manager	13 (21%)
	Allied health ¹⁰	12 (19%)
	Nurse	7 (11%)
Workplace (2 did not answer)	Solo GP	8 (13%)
	Small multi-GP practice (2-5 GPs)	6 (10%)
	Medium multi-GP practice (6-10 GPs)	21 (35%)
	Large multi-GP practice (11+ GPs)	9 (15%)
	Allied health service	10 (17%)
	Other ¹¹	6 (10%)
Years of experience as a health practitioner (n = 49 ¹²)	5 years or less	15 (31%)
	6-10 years	8 (16%)
	11-20 years	16 (33%)
	>20 years	10 (20%)

The follow-up surveys were analysed using Excel with descriptive counts and proportions presented for all question variables, overall (i.e., aggregated across all 6 PHN sites) and, where relevant, by PHN.

¹⁰ Allied health professionals included OTs, speech pathologists, physiotherapists, social workers, chiropractors & psychologists.

¹¹ The other workplaces included: mental health service (n=3), primary health services targeting CALD and/or refugee populations (n=2) and an ACCHO (n=1).

¹² This question was not asked of the 13 practice manager respondents.

Stakeholder interviews (aims 1, 2 & 3)

As shown in Table 6, 24 semi-structured interviews were conducted (between October and November 2022) with a total of 36 key stakeholders involved in delivering the DFV pilot to explore their views on its implementation and impact (intended or unintended)¹³. Interview guides were developed by the evaluation team, tailored around the roles of the various stakeholder groups (see Appendix F). All interviews were conducted via Microsoft Teams, recorded (with participants' consent) and transcribed verbatim by an independent service.

Table 6: Qualitative interviews participation summary by PHN

Stakeholder group	BSPHN	CESPHN	HNECCPHN	NBMPHN	NWMPHN	WVPHN	Total
PHN Operational Staff	1	1	1	1	1	1	6
System Integrators	7	-	5	2	2	2	18
DFV Service Staff	3	-	1	3	-	2	9
Other Key Stakeholders ¹⁴	2	-	1	-	-	-	3
Total	13	1	8	6	3	5	36

The transcribed stakeholder interviews were systematically analysed in NVivo software, using a coding framework developed by the evaluation team, guided by the interview questions. Two research officers independently coded a sample of transcripts to identify and refine the emerging themes and sub-themes in relation to the evaluation questions.

Case studies (aim 3)

Case studies were compiled to highlight examples of what the DFV pilot achieved when general practices actively engaged with the DFV pilot. A convenience sample of potential examples was identified through quarterly progress reports, stakeholder interviews or PHN operational staff or system integrators nominating potential participants, who were then invited to complete descriptive case study templates detailing what happened, what changed and how it contributed towards achieving the DFV pilot's aims. While recognising the potential bias of this approach, it was considered the most suitable for providing additional data on the influence of the DFV pilot. Case studies were gathered from three PHNs¹⁵ and are presented as snapshots in relevant sections of this report.

Ethics

Ethics approval for this project was granted on 29 October 2021 by the University of New South Wales Human Research Ethics Committee (HC210694), with subsequent variations to the data collection tools also reviewed and approved by the committee.

¹³ The interim evaluation also included data from interviews with 8 GPs.

¹⁴ Includes GP advisors and LE advisor.

¹⁵ All six PHNs were invited to submit case studies but only three did so.

Methodological limitations

A limitation of the monitoring data is that they are collected and entered by the system integrators. It is likely that some service interactions are not captured, resulting in a potential underestimation of the level of activity undertaken during the DFV pilot. Similarly, system integrators could not always be aware of relevant referrals made by GPs, particularly in PHNs where system integrators were not co-located in a DFV service. Therefore, referral data collected through the Engagement Tracker or Referral Tracker are likely to underestimate the actual number of GP referrals to DFV services.

It is also likely that each system integrator entered the monitoring data in a slightly different way, since they were encouraged to tailor the monitoring tools to ensure they were fit-for-purpose. This means there is likely variation in, for example, the number of interactions recorded in each PHN if they employed different definitions of 'interaction'.

Another limitation is the less than optimal response rates, especially for the post-training and follow-up surveys (about 20%). All response rates were likely impacted by the COVID-19 pandemic and the consequent demands placed on GPs and practice staff, inhibiting their availability and/or motivation to complete voluntary surveys.

There may be some selection bias in relation to the qualitative interviews with those responding to the invitation being more likely to have a positive perception of the DFV pilot.

Despite the limitations described above, the evaluation garnered a diversity of data from a range of key stakeholders, providing consistent views about the DFV pilot's implementation and impact, which allows confidence for the findings presented in this report to guide future implementation.

Findings

This report provides the final implementation and outcome evaluation findings, based on data collected from July 2021 to November 2022. An interim evaluation was completed and reported in February 2022¹⁶.

Aim 1: Description of core components implemented in PHNs

Component 1: Training and capacity building activities

Description of activities

Table 7 provides an overview of the training and capacity building activities provided by each PHN (see Appendix H for more detailed information), highlighting the diversity of approaches, which is explored following the table and in subsequent sections of the report findings. In summary, the training and capacity building activities included formal DFV training, communities of practice (CoP) and, for several PHNs, optional complementary workshops that aimed to provide a deeper understanding of the complex issues associated with DFV.

Table 7: Overview of PHNs' approaches to training and capacity building

PHN	Training	Delivery mode	Audience	Length & RACGP CPD points (where relevant)
BSPHN	Recognise, Respond, Refer Foundational training	Face-to-face	All general practice staff including Allied Health that work from the practice Whole of practice encouraged	1-2hrs 2-4 CPD points
	Recognise, Respond, Refer Foundational training	Online	Individual general practice staff including Allied Health that work in a practice	2hrs 4 CPD points
	Foundational training follow-up – case studies and Q&A	Face-to-face	All general practice staff including Allied Health that work from the practice Whole of practice encouraged	1-2hrs 2-4 CPD points
	Responding to DFV in the context of culture and identity	Online	All general practice staff including Allied Health that work from the practice	4 x 2hr sessions 40 CPD points
	Coercive control	Face-to-face	All general practice staff including Allied Health that work from the practice	1hr 2 CPD points
	GP Community of Practice (CoP)	Face-to-face, online	GPs with a special interest in DFV	1.5hrs x 5 (1/month) + reflective activities 40 CPD points
CESPHN	Responding to DFV in Primary Care	Face-to-face, online	All primary care providers	1-3 hours
	Non-Fatal Strangulation in the context of DFV	Online	GPs, practice nurses	1 hour
	Supporting CALD patients experiencing DFV	Online	GPs, practice nurses, allied health, admin staff	1 hour

¹⁶ Knight A, Rose S, Bandara P, Redman A, Newell S, Ninnes P. Interim Report: Evaluation of the Improving Health System Responses to Family and Domestic Violence Primary Health Network Pilot. Sydney: Sax Institute 2022.

PHN	Training	Delivery mode	Audience	Length & RACGP CPD points (where relevant)
HNECC PHN	Phase 1: The Readiness Program: Safer Families	Face-to-face, online	All General Practice Staff	3 hours
	Phase 1 & 2: Starting the Conversation: Practice Nurse DFV Training	Online	Practice Nurses	1.5 hours
	Phase 1 & 2: Presentations at Primary Care conferences where appropriate / the opportunity arises	Face-to-face, online	Primary Care	As appropriate
	Phase 2: Customised training. Any DFV training requested by General Practice will be delivered by a GP for peer-to-peer learning	Face-to-face, online	Primary Care	1-3 hours
	Phase 2: Non-Fatal Strangulation in the context of DFV	Online	Primary Care	1 hour
NBMPHN	Recognise Respond Refer: Introduction to DFV	Face-to-face, online	All General practice staff. Whole of practice are encouraged to attend	1-2 hours 3 CPD points
	Online Event for Allied Health Professionals	Face-to-face, online	All Allied Health providers	1-2 hours
	Recognise, Respond & Refer – Introduction to DFV (Students)	Face-to-face, online	Medicine in Context Uni students Australian Medical Students Association	1-2 hours
	Your Practice Portal-Webinars A suite of 7 short webinars pertaining to DFV within vulnerable groups: (CALD; Children/ Young People; Disability; First Nation; Older People; Male Victims; LGBTIQ+.	Online	Developed by Agpal for NBMPHN	15-20 minutes each Certificate of attendance
NWMPHN	Primary Care Pathways to Safety: The Readiness Program	Online	GPs, practice nurses, admin staff and open to all practice staff	8 hours (3 hours contact online) CPD accredited 2 x 1.5hr virtual sessions delivered by GP facilitator & FV support worker
	RACGP online GP learning module	Online	GPs	
WVPHN	Phase 2: A-Lives	Face-to-face, online	Whole of Practice approach	45 mins non-clinical staff 2-hour clinical staff 4 practice visits
NSW PHNs Joint trainings	"Should I? Shouldn't I?" When to report and share information about children and adults at risk from DFV	Panel webinar	GPs, practice nurses, allied health, admin staff	1.5 hours
	"Too Little, Too Much" Recording domestic and family violence disclosures in general practice	Panel webinar	GPs, practice nurses, allied health, admin staff	1.5 hours

Each PHN started delivering their training at different points in time: BSPHN in 2018, NWMPHN in January 2020, and CESPHN, HNECCPHN, NBMPHN and WVPHN in July 2021. In terms of their overarching training approach, HNECCPHN, NWMPHN and WVPHN initially used the *Primary Care Pathways to Safety* DFV training. This training package was developed, managed and delivered externally by Safer Families (University of Melbourne), consisting of two 90-minute sessions – the first targeted towards the whole-of-practice, and the second specifically for GPs. The training content includes practical components such as appropriate engagement with patients, self-reflection exercises and the opportunity to review current clinical protocols. While PHNs indicated some benefits of commissioning Safer Families to deliver the training component (e.g., the convenience of readily accessible, evidence-based content), they also found the sessions came with a high commissioning cost and were somewhat rigid with limited opportunity to adapt the content to their local context. Therefore, from July 2022, HNECCPHN and WVPHN discontinued the Safer Families training package, opting to deliver locally-developed training sessions for this reason.

The time commitment that Safer Families required was a minimum of three hours spaced over two one-and-a-half-hour sessions, and a lot of general practices said to us we just can't give you that time... Another reason was that we weren't able to localise it or tweak it or change it in response to what our local patch was telling us that they needed. (PHN operational staff)

BSPHN used the original *RRR* training package. The training is a single 2-hour session targeting whole practices and provides an introductory overview of DFV in the primary care setting. NBMPHN used a modified version of the *RRR* training which involved a single 1-hour online session, available for whole practices and allied health practitioners. Whereas BSPHN delivered *RRR* training in partnership between the PHN and local DFV services, NBMPHN's training was delivered by a dedicated PHN-employed program development officer.

CESHPN delivered the *Responding to Family and Domestic Abuse and Violence in Primary Care* training, a single 90-minute session targeted towards whole practices but was also accessible for allied health practitioners separately. The training focused on skills to identify signs of DFV in patients, as well as providing care via risk and assessment planning and engaging support from DFV services. CESPHN employed a dedicated DFV Navigator to manage and deliver training.

BSPHN, CESPHN and NBMPHN tailored their training to ensure the content and delivery mode suited the needs of each training group. For example, the timing (e.g., lunch sessions or after hours), length and number of sessions were not prescribed so that each session could be adapted to accommodate the participants needs and availability.

I generally customise to the practice, so they might ask for one hour, for an hour and a half or two hours ... also it's customised in terms of the content, like if it's an allied health provider, we have a separate training that we do for physios, so really trying to make it relevant to the audience's experience. (PHN lead)

Most PHNs implemented opportunities for forums or mentoring support in the form of Communities of Practice (CoPs), although the purpose and management of the CoP varied in each PHN. For instance, in BSPHN, the CoP started in November 2020 and was available only to GPs. In HNECCPHN and WVPHN, the CoP was facilitated by Safer Families focused on pre-defined topics and was open to whole practices. NWMPHN ran a series of *Multidisciplinary Regional Family Violence* CoP sessions which was open to broader stakeholders (e.g., health service and DFV service staff) as well as general practice staff.

In addition to their primary training packages, PHNs delivered several complementary activities. HNECCPHN provided practice nurse-specific DFV training and a training package developed to improve practitioner understanding of the developmental speech issues in children impacted by DFV. Furthermore, HNECCPHN developed training packages targeting diverse or minority populations, including LGBTIQ+ and the Ezidi

community (Armidale only). NBMPHN offered additional capacity building activities for diverse populations, including a suite of brief online videos that address the impact of DFV in groups such as LGBTIQ+, older people, young people, Aboriginal and Torres Strait Islander peoples, members of culturally and linguistically diverse (CALD) communities, males and people with disabilities. NBMPHN also developed a training package specifically for Aboriginal and Torres Strait Islander populations and delivered training to university medical students. WVPHN offered family violence ECHO sessions: these combine didactic learning (based on the modules developed by Safer Families) and case-based learning, delivered over a series of online workshops.

A notable difference reported across PHNs was the use of Practice Incentive Programs (PIP) payments by HNECCPHN, NWMPHN and WVPHN to encourage general practice participation in the DFV pilot. Here, practices received payments on completion of key milestones (e.g., training, quality improvement activities).

A key challenge, experienced by all PHNs to different degrees, was the COVID-19 pandemic. This significantly limited their ability to deliver training face-to-face, as originally intended, due to social distancing restrictions, and resulted in predominantly online training delivery via videoconferencing programs (e.g., Zoom). This particularly impacted the Victorian-based and NSW-based PHNs.

So delivering the training, we did that via Zoom and we had support from the PHN, we had tech support, we had our PowerPoints, and we were able to pivot at the last minute to be presenting the training. But as far as travelling and doing it person to person and providing that in-house support at clinics, that was sort of restricted because of travel. (System integrator)

Our local link trainers weren't able to get into practices when they were delivering those trainings, so it was done online, so there's not that time to ask a question or for that informal relationship building that happens ... so that was something that has definitely hindered our ability to build relationships and elicit the referrals and secondary consultations this pilot was really hoping to achieve (PHN lead)

The biggest challenge would be COVID. Our organisation is very conservative when it comes to their COVID policy, which has meant I haven't been able to get out face to face and actually start a conversation with people who are already just under pressure. (System integrator)

Participation in DFV training activities

As detailed in Table 8, PHN tracker data indicated a total of 225 training sessions delivered during the evaluation period, reaching over 1,700 participants across all six PHNs. The number and type of training sessions and the number of attendees varied across PHNs. BSPHN reported delivering fewer training sessions as a result of already having delivered most of their training prior to the evaluation period (118 sessions attended by 803 participants between February 2018 and June 2021)¹⁷.

Table 8: Number of training sessions and attendees by PHN, July 2021 – November 2022¹⁸

PHN	Training	N sessions	N attendees
BSPHN	RRR training	29	88
	Diverse groups	5	27
	Other training/support	3	20
CESPHN	Responding to DFV in Primary Care	58	446
	Managing the challenges of clinical therapeutic interventions in the context of domestic violence	1	22
	Other training/support	4	52
HNECCPHN	Primary Care Pathways to Safety	19	154
	Other training/support	19	272
NBMPHN	RRR training	14	95
	Introduction to DFV-Foundational training	12	37
	Other training/support	17	44
NWMPHN	Primary Care Pathways to Safety	26	306
WVPHN	Primary Care Pathways to Safety	18	145
Total		225	1,708

As shown in Table 9, most training sessions were delivered online, with NWMPHN and WVPHN, who were impacted the greatest by lockdown restrictions, delivering their training exclusively online. By contrast BSPHN, who were least impacted by lockdown restrictions, delivered their training mostly face-to-face.

Table 9. Delivery mode of training by PHN, July 2021 – November 2022

	BSPHN	CESPHN	HNECCPHN	NBMPHN	NWMPHN	WVPHN	Total*
Online	9 (24%)	39 (62%)	22 (63%)	30 (77%)	26 (100%)	18 (100%)	144 (66%)
Face-to-face	26 (70%)	24 (38%)	10 (29%)	8 (20.5%)	0	0	68 (32%)
Online and face-to-face	2 (5%)	0	3 (9%)	1 (2.5%)	0	0	6 (3%)

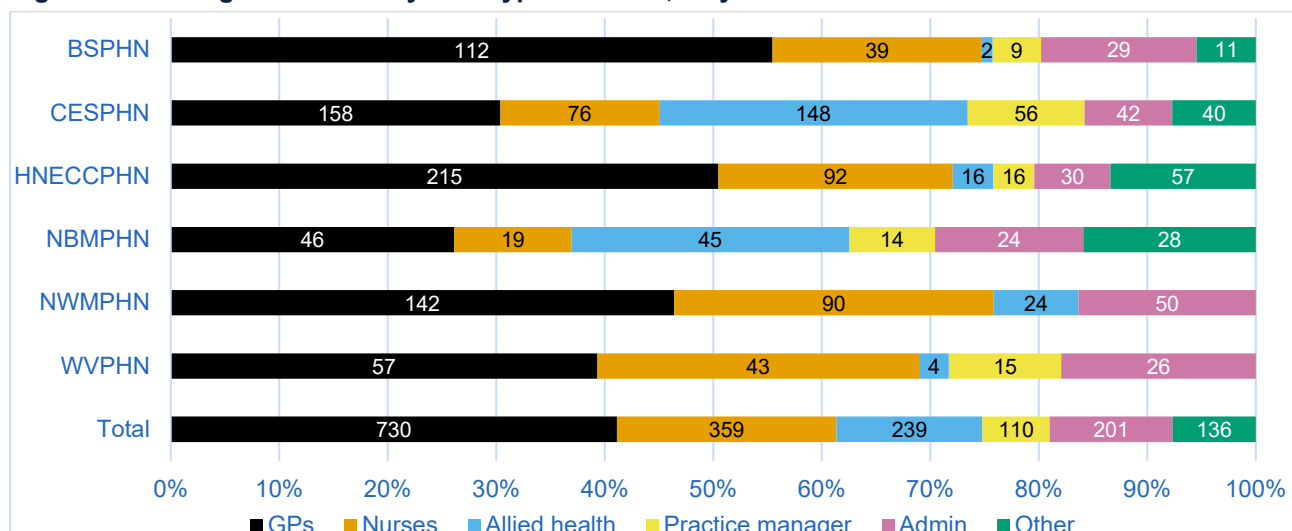
* Missing, n=7

¹⁷ BSPHN, Achievements of Brisbane South PHN implementation of the Recognise, Respond, Refer program. 2021: Brisbane.

¹⁸ Participation data were only collected for training activities (e.g. Pathways to Readiness training), and not other capacity building activities such as the Communities of Practice. For the purposes of analysis, the training participation data for different types of training in each PHN were grouped together.

PHN tracker data indicated that a wide range of professional roles engaged with the DFV pilot training, which was usually delivered to multiple staff within general practices (see Figure 3). Overall, GPs were the largest attendee group, with 730 participating across all PHNs during the evaluation period, followed by 359 nurses and 311 administrative staff (including practice managers).

Figure 3: Training attendance by staff type and PHN, July 2021 – November 2022



Component 2: System integration activities

The main system integration activity implemented by PHNs for component 2 was the creation of dedicated system integrator positions that focused on enabling better integration across the primary care and DFV systems. The system integrators were variously referred to as the DFV Local Links (BSPHN and HNECCPHN), DFV Navigator (CESPHN), DFV Linker (NBMPHN), the Family Violence Worker (NWMPHN) and the Family Violence Connector (WVPHN).

Description of system integrator roles

Table 10 provides an overview of how the system integrator roles were operationalised in each PHN, highlighting the diversity of approaches in relation to the roles, providers and staff numbers, largely dependent on the needs and structure of their local service settings (this diversity is explored further following Table 10). In summary, system integrators were responsible for developing systems and processes for working with primary care staff to support appropriate DFV practice responses, and for facilitating safe and timely referral pathways into specialist DFV and other services.

Table 10. Overview of how system integrator roles were operationalised within each PHN

PHN	Name and Full-time Equivalent (FTE)	Provider	Role description
BS PHN	<i>DFV Local Link</i> (4.2 FTE): <ul style="list-style-type: none"> 2.0 FTE in Brisbane South 2.0 FTE for Redlands & Logan 0.2 FTE for Beaudesert 	Three local DFV services: <ul style="list-style-type: none"> Brisbane Domestic Violence Service Centre for Women & Co. YFS Beaudesert 	<ul style="list-style-type: none"> Single referral point for patients affected by DFV Advice & support to help general practice staff better recognise & respond to DFV Secondary consults for GPs concerned about a specific patient Connect patients to appropriate DFV supports & services Connect general practice staff to support for debriefing & compassion fatigue
CES PHN	<i>Primary Care DFV Navigator</i> (0.6 FTE)	PHN, moving to commissioning DFV service by February 2023	<ul style="list-style-type: none"> Referral assistance Secondary consults for GPs concerned about a specific patient Advice & support to help general practice staff better recognise & respond to DFV

PHN	Name and Full-time Equivalent (FTE)	Provider	Role description
HNECC PHN	<i>Phase 1: DFV Local Link</i> (3 FTE):	Three local DFV services:	<ul style="list-style-type: none"> • DFV training in co-facilitation with a GP • Referral assistance to the state-based Safer Pathway initiative • Secondary consults for GPs concerned about a specific patient
	<ul style="list-style-type: none"> • 1 FTE for Armidale • 1 FTE for Central Coast • 1 FTE for Tamworth 	<ul style="list-style-type: none"> • Armidale Women's Shelter • Relationships Australia • Tamworth Family Support Services 	
	<i>Phase 2: DFV Local Link</i> (3.6 FTE):	Women's Domestic Family Violence Court Advocacy Service (WDVCAS)/NSW Safer Pathway	<ul style="list-style-type: none"> • Single referral point for patients affected by DFV • Advice and support to enable primary care staff to Spot the Signs, Start the Conversation and LINK for support • Connect patients to appropriate DFV supports and services
	<ul style="list-style-type: none"> • 0.6 FTE for Mid Coast • 0.6 FTE for Oxley • 0.6 FTE for Tamworth • 0.6 FTE for New England • 0.6 FTE for Newcastle • 0.6 FTE for Central Coast 		
NBM PHN	<i>DFV Linkers</i> (3 FTE to Nov 2022):	Three local DFV services:	<ul style="list-style-type: none"> • Provide patients with over the phone, or face-to-face, support regarding DFV including appropriate referral pathways • Advice & support to help general practice staff better recognise & respond to DFV • Provide feedback to referrers regarding patient outcomes • Provide First Nations support to primary care for staff and patients
	<ul style="list-style-type: none"> • 1 FTE for Blue Mountains / Lithgow • 1 FTE for Hawkesbury / Nepean • 1 FTE Aboriginal Linker for whole region 	<ul style="list-style-type: none"> • DV West • Relationships Australia • Nepean Community Neighbourhood Services 	
NWM PHN	<i>Family Violence Worker</i> (1 FTE to June 2022):	Two local DFV services:	<ul style="list-style-type: none"> • Co-design & facilitate education and training • Consult & follow up with DFV specialist services • Support development of links between primary care & DFV services • Secondary consults for GPs concerned about a specific patient around culture, language & diversity • Support clinical & non-clinical staff
	<ul style="list-style-type: none"> • 0.5 FTE for Northern region • 0.5 FTE for Western region 	<ul style="list-style-type: none"> • Berry St • GenWest 	
WV PHN	<i>Family Violence Connectors</i> (3.4 FTE):	Three local DFV services:	<ul style="list-style-type: none"> • <i>Phase 1:</i> Support general practices with training program, including relationship building, and facilitating QI activities. • Developing cross-sector protocols to assist local community groups and Aboriginal & Torres Strait Islander people
	<ul style="list-style-type: none"> • 1.6 FTE for Northern Grampians • 0.8 FTE for Central Goldfields • 1 FTE for Warrnambool 	<ul style="list-style-type: none"> • Grampians Community Health • Centre for Non-Violence • South Western Centre for Sexual Assault 	<ul style="list-style-type: none"> • <i>Phase 2:</i> Deliver A-LIVES training to whole general practices • Conduct 4 general practice visits over 2-month period to develop localised resources, review & assist with policies and procedures. • Secondary consults for GPs concerned about a specific patient • Attend Orange door meetings across the region

With the system integrator role already well established in BSPHN, they were naturally less focused on fostering relationships with general practices or targeted communities compared to other PHNs. The geographical size of PHNs also influenced the number of system integrators required to fulfil the role, with more recruited to service HNECCPHN and WVPHN, given the geographical range of their region, compared to CESPHN and NWMPHN which were smaller in size. HNECCPHN and NBMPHN had Aboriginal-identified positions, as both PHNs had a focus on establishing ties with Aboriginal communities and promoting cultural awareness.

The responsibilities and function of the system integrators also varied considerably across PHNs. Some system integrators were client-facing, while others supported GPs in their interactions with patients. For example, for BSPHN and NBMPHN, the system integrators were involved in referrals and secondary consults with general practices. For the remaining PHNs, the system integrator was primarily responsible for training

and/or developing key resources to support system integration or influencing activities. The latter approach was taken by some PHNs because their system integrators were funded by the pilot, and they were reluctant to introduce an important service to primary care that could not be guaranteed long-term. Since the extension of the DFV pilot, CESP HN, HNECCPHN, and WVPHN have re-assessed the function of their system integrator in their next phases of implementation to include client-facing or referral-based responsibilities.

As with the training delivery, there was also considerable variation in when system integrator roles began operating in each PHN. BSPHN was the first to establish system integrator roles, from late-2019, while HNECCPHN, NWMPHN and WVPHN recruited their system integrators in early 2021, and CESP HN and NBMPHN in mid-2021. A number of PHNs reported challenges with recruiting and/or retaining their system integrator roles, with CESP HN and NWMPHN struggling to recruit and WVPHN experiencing high staff turnover. For CESP HN, the system integrator role has been fulfilled internally by PHN staff instead of being commissioned and co-located in a local DFV service as originally planned (and will be achieved in February 2023).

Number and characteristics of meaningful engagements between system integrators and primary care

As shown in Table 11, PHN tracker data recorded over 3,600 meaningful interactions¹⁹ between system integrators and primary care staff across 781 general practices during the DFV pilot evaluation period, with considerable variation across PHNs. BSPHN accounted for half of these meaningful engagements and over one-third of the engaged general practices. This is likely as a result of the strong partnerships they had already developed with general practices in their region prior to the evaluation period.

While CESP HN, HNECCPHN and NBMPHN engaged with more practices, NWMPHN and WVPHN engaged with fewer practices more intensively as a result of their models requiring general practices to enrol in a complete QI training package. For CESP HN and NBMPHN, this reflects their flexible and opportunistic approach to engaging general practices, while for HNECCPHN, it reflects their expansion to a whole region approach (as opposed to their early focus on specific communities).

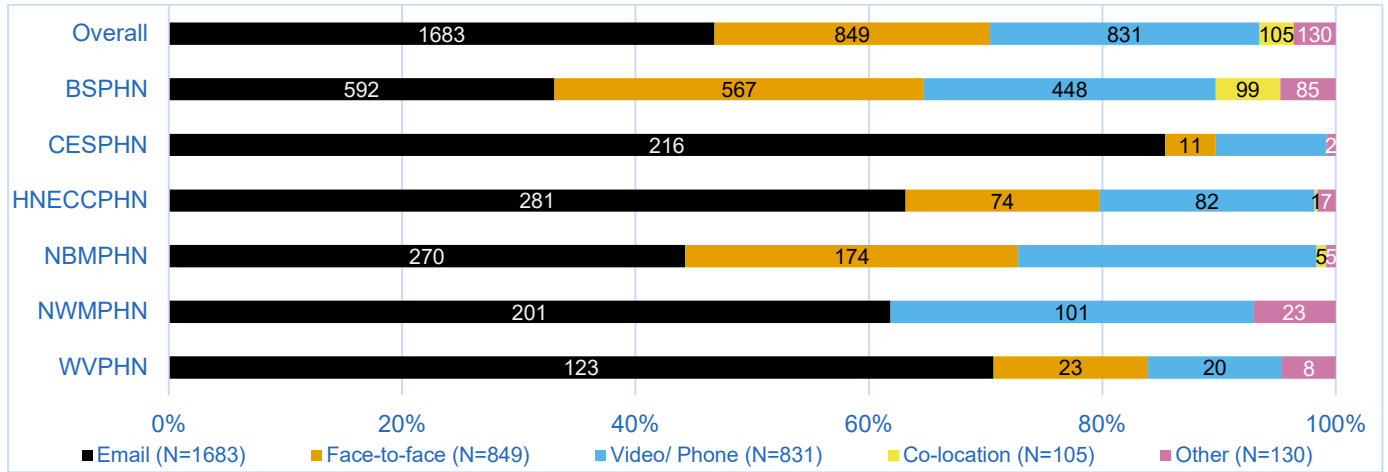
Table 11. Distribution of meaningful engagements with system integrators and primary care staff by PHN, July 2021 – November 2022

	BSPHN	CESPHN	HNECCPHN	NBMPHN	NWMPHN	WVPHN	Total
No. of engagements between system integrator and practice	1,793 (50%)	253 (7%)	446 (12%)	611 (17%)	330 (9%)	174 (5%)	3,607
Practices engaged with							
Total number of practices	302 (39%)	127 (16%)	159 (20%)	145 (19%)	26 (3%)	22 (3%)	781
Min-Max engagements per practice	1-78	1-9	1-11	1-24	3-28	1-32	
Mean±SD engagements per practice	5.8±7.9	1.7±1.5	1.5±2.0	4.0±3.8	12.6±6.8	7.5±8.6	

¹⁹ See Appendix B for further details of the meaningful interaction types (which excluded purely administrative contacts with general practices).

As shown in Figure 4, PHN tracker data indicated that email was the predominant engagement modality for most PHNs, although BSPHN and NBMPHN both reported almost one-third of their engagements being face-to-face. This is not surprising for BSPHN, given QLD experienced less severe COVID-19 social distancing restrictions. While NSW also experienced strict lockdown measures, NBMPHN prioritised face-to-face connections once these restrictions eased in an effort to enhance relationships with the primary care sector.

Figure 4: Modality of meaningful engagements with system integrators, July 2021 – November 2022

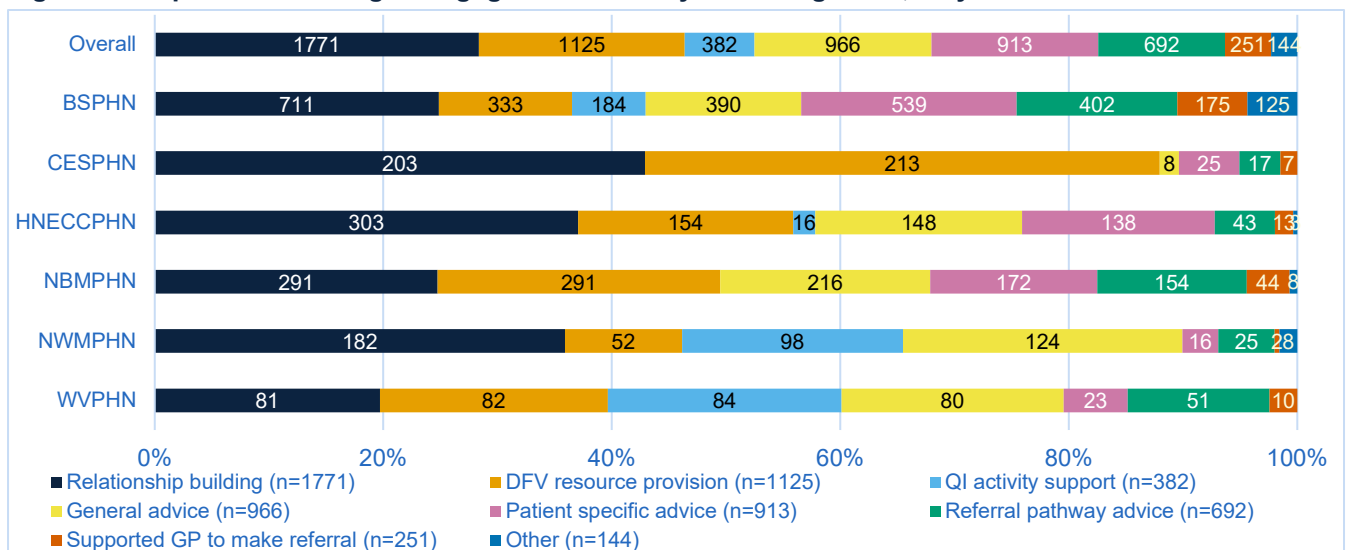


Note: Missing (total), n=8.

As shown in Figure 5, relationship building was the most common purpose of system integrator engagements, featuring in over a quarter across the six PHNs. This reflects the efforts required to forge and establish connections with general practices and to sustain their awareness of the DFV pilot and associated activities. Relationship building included introducing system integrators to practice staff, regular catchups and communications with general practices. As one system integrator described it, the process of initiating relationships required substantial effort and was akin to selling a service to primary care:

It involved a lot of cold calling and marketing components, and the fact we kind of had to sell the program to general practices to get them engaged, to get them on board with us... it involves a lot of small talk, a lot of relationship building, more extensive contacts, because you've got to constantly develop that relationship and build trust. (System integrator)

Figure 5: Purpose of meaningful engagements with system integrators, July 2021 – November 2022



Note: Multiple options could be selected, see Table 11 for total N meaningful engagements overall and by PHN).

Providing DFV resources was also a common purpose of engagement, including providing general DFV-related materials, brochures, posters and flyers (see Appendix I for more information about the resources distributed by each PHN).

PHNs with client-facing system integrators (BSPHN, NBMPHN and, later, HNECCPHN) reported providing more patient-specific and referral pathway advice. WVPHN reported similar figures likely due to the state-wide roll out of the Orange Door Network (a Victorian government initiated DFV service) in 2022. Engagements that provided support for GPs to make a referral were consistently low across PHNs, likely due to the early stage of implementation for most PHNs and the impacts of limited face-to-face interaction with GPs due to COVID-19. NWMPHN and WVPHN had high rates of engagement relating to quality improvement (QI) activity support, which was a key component of their models.

Component 3: System influencing activities for sustainable change

As shown in Table 12, PHN tracker data indicated that PHNs were active in a wide range of system influencing bodies and entities, including local interagency groups and various state-wide government initiatives and collaboratives (see Appendix J for further details).

Table 12. Local and /or State-based system influencing activities.

PHN	System Influencing Entity/ Activity	Lead	
BSPHN	Integrated Service Response and High-Risk Teams	DFV service providers	
	Local Level Alliance and Regional Child & Family Committees	DFV service providers	
	QLD State Government Partnerships	BSPHN	
	QLD PHN DFV Collaborative	BSPHN	
	Metro South Hospital and Health Service partnership	BSPHN	
	RRR Network	BSPHN	
CESPHN	CESPHN DFV Assist Advisory Committee	CESPHN	
	Regional Domestic Violence Networks and Interagency Groups	Various organisations in CESPHN region	
	General Practices Conference and Education (GPCE) Australian Primary Health Care Nurses Association (APNA)	Consortium between CES, HNE & NBM PHNs	
HNECC PHN	NSW Safer Pathways Initiative	HNECCPHN	
	Local Level Alliance and Regional Child & Family Committees	DFV Local Links	
	NSW Ministry of Health	HNECC, CESPHN and NBM PHNs	
	General Practices Conference and Education (GPCE) Australian Primary Health Care Nurses Association (APNA)	Consortium between CES, HNE & NBM PHNs	
	NBMPHN	PHN General Practice Clinical Council, Allied Health Clinical Council, Primary Care Advisory Committee and Community Advisory Committee	NBMPHN
		RRR Steering Committee	NBMPHN
NSW PHN Collaborative (DFV Pilot sites)		All PHNs	
Safety Action Meetings		Local DFV Services	
Nepean DV Network		Penrith City Council	
Hawkesbury Action Network Against Domestic Violence		Women's Cottage (Local DFV Service)	
Lithgow Cares		Linc (Local DFV service)	
Coalition Against Violence & Abuse		Blue Mountains Women's Health Centre	
General Practices Conference and Education (GPCE) Australian Primary Health Care Nurses Association (APNA)		Consortium between CES, HNE & NBM PHNs	
NWMPHN		Engagement with state-wide central intake referral services- Orange Door & Safer Families Centre	NWMPHN

PHN	System Influencing Entity/ Activity	Lead
WVPHN	Co-design	WVPHN
	Co-design	First Nations Consultant
	Family Violence/Child Wellbeing Systems forum	Orange Door
	Service System Navigator meetings	WVPHN
	LAPG Meetings – Local Area Planning Group	Wimmera Family Violence Local Area Planning Group

Aim 2: Stakeholder perceptions of the DFV pilot

Overall perceptions and value of the DFV pilot

As in the interim report, interviewees provided very positive feedback about the pilot. They talked about its value, importance, and its potential to save lives. Common themes emerged in relation to the impact it was having on building: relationships and trust between the primary care and DFV sectors; primary care sector understanding and insights about DFV; DFV capacity in primary care; and to improving the quality and quantity of referrals from primary care to DFV support services.

It's been so rewarding, and the family violence workers that I've worked with in this program have all been 100 percent committed, driven, specialist. We've learnt as much from each other as we've taught to other people. (System integrator)

I think it's one of the most valuable projects I've ever worked on. I see that there is such a need for it into the future, it just needs to be sustained, and then built upon. (System integrator)

The DFV pilot has the potential to save lives. It could possibly have already done that, we've gotten people out of unsafe situations more than a couple of times. (System integrator)

They (DFV Services) also were really keen to do some of that systems work. And so I think that that's worked really well and I think, like as soon as we approach them they were like, "Oh my God, we're dying to like get in with GPs", so there just wasn't any hesitation. (PHN lead)

Only 15 (27%) follow-up survey respondents offered any suggestions in response to a question about how the DFV Initiative could be improved or any other additional supports that may be needed, with most of these relating to the need for continuation of the system integrator role (8 comments) and a desire for continued involvement and learning opportunities, including for general practices not already reached by the DFV pilot (6 comments).

I hope the Initiative continues going as it was very supportive of me and my clients' needs. (Allied health practitioner)

The local link role needs to have ongoing funding so that a steady career path for social workers who choose to do this work is established. As a GP I need the certainty that this way to refer will become part of the landscape of support for me and my DFV survivor patients. If there was a similar service for sexual assault or child maltreatment - and even schooling issues I would be thrilled as I think early intervention and community support can make such a big difference to long term health outcomes. (GP)

One system integrator interviewee also suggested engaging more and diverse audiences in the design of training to accommodate emerging issues and reflect community diversity.

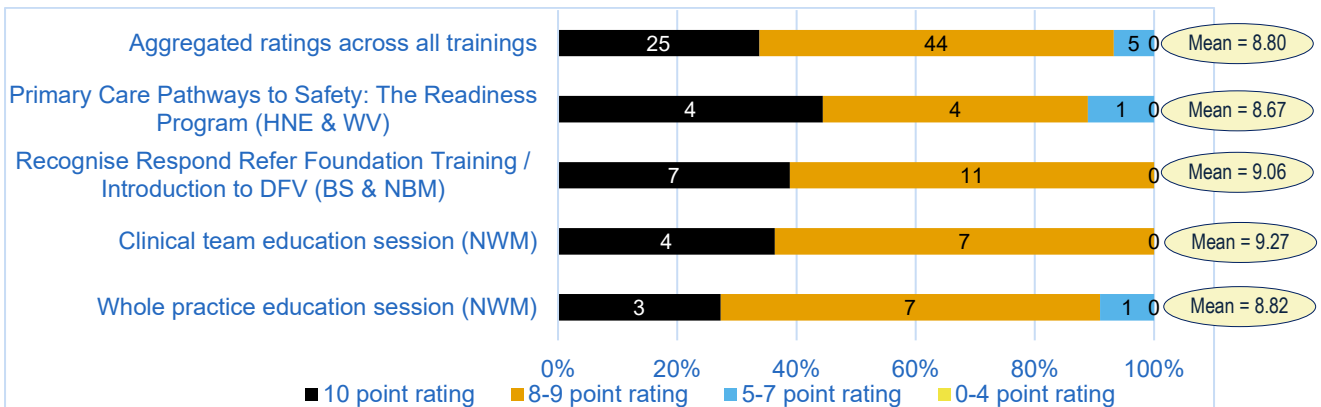
If you're tailoring the response to just white women you're missing out on a lot of people ... trans women, women of colour, women with disabilities, Aboriginal and Torres Strait Islander victim-survivors ... there's particular things that would influence practice in different community groups, so I think it would be great to be able to really delve into that stuff, because some of the clinics were really interested, particularly if they were specialised in a certain community. (System integrator)

Feedback about DFV pilot activities

Feedback about the DFV training

In the follow-up survey (completed 3-4 months after training), 57 (92%) respondents reported having attended at least one of the DFV-related trainings nominated by PHNs for inclusion in the survey: 36 attended one, 18 attended two and 3 attended three trainings. The most commonly attended trainings were RRR (20 respondents), NWMPHN Education sessions 1 and 2 (12 and 11 respondents respectively) and Pathways to Safety (9 respondents). Figure 6 shows that follow-up survey respondents rated the quality of all the trainings very highly, with over one-third of all ratings at the top of the 0-10 point scale ranging from “Terrible” to “Excellent” and an overall mean rating of 8.8 points (N=62, sd=1.15) across all the trainings delivered. The post-training survey (completed 1-8 weeks after training) provided similar feedback, with an overall mean quality rating of 8.6 (N=230, sd=1.28). Figure 6 includes specific ratings for the most attended trainings, showing higher mean ratings for NWMPHN’s clinical team education sessions and the RRR training.

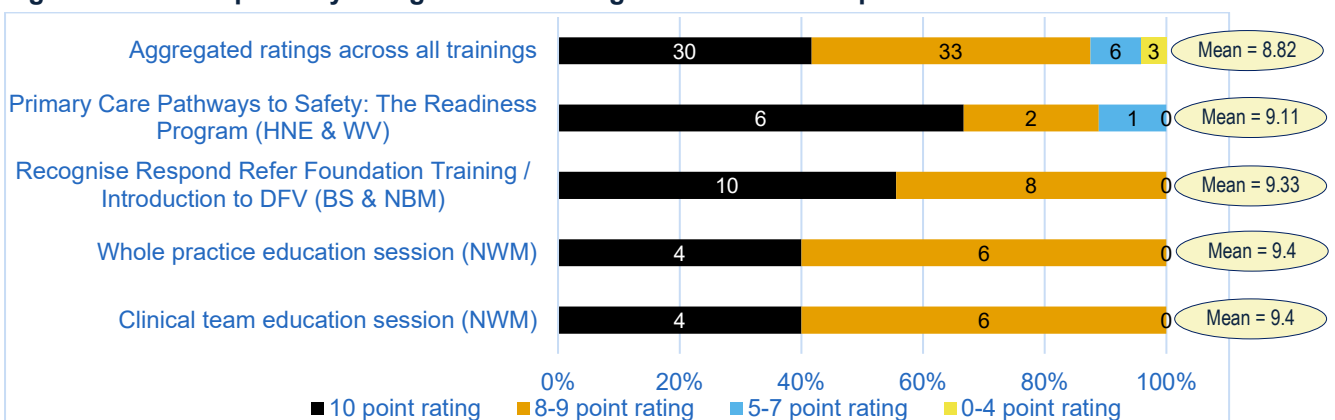
Figure 6: Follow-up survey ratings of the quality of training received through the DFV pilot



Note: Ratings were about “How would you rate the quality of the DFV training?”, 0 = Terrible, 5 = OK, 10 = Excellent.

Figure 7 shows that follow-up survey respondents also considered the training as very relevant to their work, with over one-third of all ratings at the top of the 0-10 point scale ranging from “Terrible” to “Excellent” and an overall mean rating of 8.8 points (N=62, sd=1.56) across all the trainings delivered. The post-training survey provided similar feedback, with an overall mean relevance rating of 8.5 (N=230, sd=1.67). Figure 7 also includes specific ratings for the most attended trainings, showing that very high mean ratings for all of them.

Figure 7: Follow-up survey ratings of the training’s relevance to respondents’ work



Note: Ratings were about “How would you rate the relevance of the DFV training for your role?”, 0 = Terrible, 5 = OK, 10 = Excellent.

While training relevance was rated very highly on average in both the post-training and follow-up surveys, there were some statistically significant differences between respondents with different work roles, with:

- Practitioners rating the training as more relevant for their work than administrative staff
 - **Post-training survey:** means = 8.76 (n=144, sd=1.4387) and 7.98 (n=86, sd=1.8972) respectively, giving an independent t-test value of 3.3196 (p<0.005)
 - **Follow-up survey:** means = 9.04 (n=53, sd=1.4272) and 8.18 (n=17, sd=1.8109) respectively, giving an independent t-test value of 2.0245 (p<0.05)
- Practice managers rating the training as more relevant for their work than other administrative staff
 - **Post-training survey:** means = 8.82 (n=34, sd=1.19277) and 7.42 (n=52, sd=2.0708) respectively, giving an independent t-test value of 3.9722 (p<0.0005).

In the post-training surveys, almost all eligible respondents (272 of 276, 99%) responded to an open-ended question about what they found most useful about their recent training. The nominated highlights were thematically coded into the following key themes, with many respondents nominating more than one theme:

- Positive feedback about the training generally – re: presentation, usefulness, relevance, etc (n=80, 29%)
- How the training had improved their understanding about DFV – re: signs, prevalence, etc (n=76, 28%)
- How the training had improved their understanding about and/or access to relevant resources/ referral options/ system integrators (n=72, 26%)
- How the training had improved their understanding and/or confidence to ask about and discuss DFV with their patients (n=52, 19%)
- The more interactive components of the trainings – e.g.: role playing, case study discussions, hearing from multiple professional perspectives (n=43, 16%)
- The practical tools provided or introduced during the trainings – e.g.: action plans, referral pathways (n=27, 10%)
- How the training had improved their understanding and/or confidence to support and manage patients experiencing DFV (n=26, 9%)
- The opportunity to reflect on their own practice, especially when whole practices were involved (n=9, 3%).

Knowing the different types of DFV and understanding how to talk to them about it. That there are some very subtle signs that there could be a DFV situation. That there are more services out there now to help & that there is more being done to help those that need it. (Practice manager)

Improving my confidence in identifying and asking about DV – how to broach the subject with patients. Understanding the pathway for referring a patient who is experiencing DFV and how they are connected to services. (GP)

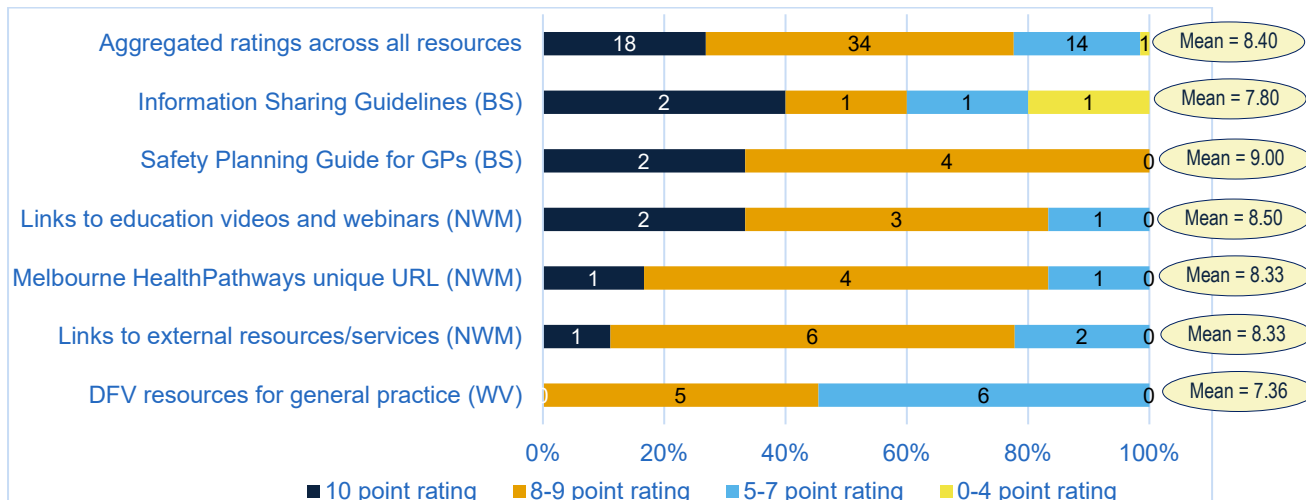
Extremely useful. It brought us together as a practice and gave valuable knowledge and information for us to use practically. I think it has changed all of our practice. (GP)

Feedback about the DFV resources

In the follow-up survey, 47 (76%) respondents reported having used at least one of the DFV-related resources nominated by PHNs for inclusion in the survey: 31 had used one, 9 had used two, 5 had used three and 2 had used four resources. The most commonly used resources were WVPHN's *DFV Resources for General Practice* (11 respondents), NWMPHN's *Links to External Resources and Services* (9 respondents) and BSPHN's *Safety Planning Guide for GPs* (6 respondents). Figure 8 shows that respondents found the DFV resources very useful, with over a quarter of all ratings at the top of the 0-10 point scale ranging from "Not at all useful" to "Extremely useful" and an overall mean rating of 8.4 points across all the resources accessed. The figure also includes specific ratings for the most accessed resources, showing some variations in

perceived usefulness although these variations need to be interpreted cautiously due to the small numbers of respondents accessing each of them.

Figure 8: Follow-up survey ratings of the usefulness of the resources accessed through the DFV pilot

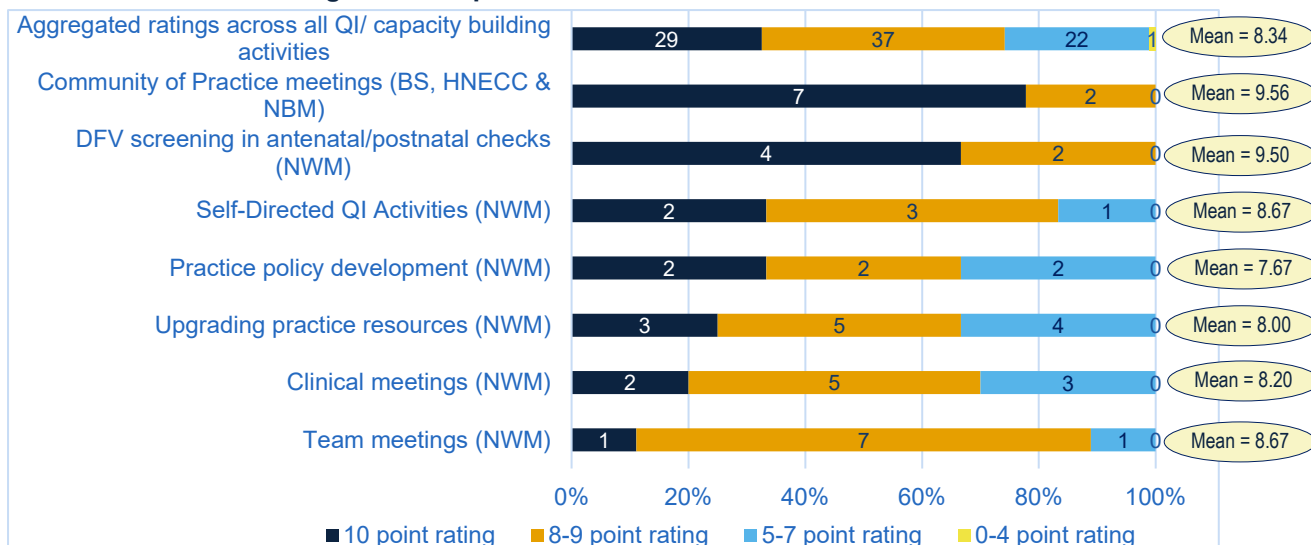


Note: Ratings were about “How useful have you found the resource in your work?”, 0 = Not at all, 5 = Somewhat, 10 = Extremely.

Feedback about quality improvement and capacity building activities

In the follow-up survey, 35 (56%) respondents reported having participated in at least one of the quality improvement or capacity building activities nominated by PHNs for inclusion in the survey: 19 had participated in one, 4 in two, 1 in three, 2 in four, 4 in five and 5 in six activities. The most commonly attended activities were the CoPs and clinical meetings (10 respondents each) and team meetings (9 respondents). Figure 9 shows that respondents found the quality improvement and capacity building activities very useful, with over one-third of all ratings at the top of the 0-10 point scale ranging from “Not at all useful” to “Extremely useful” and an overall mean rating of 8.5 points across all the activities respondents participated in. The figure also includes specific ratings for the most accessed activities, showing the CoP and Antenatal/ Postnatal check as being particularly useful.

Figure 9: Follow-up survey ratings of the usefulness of the quality improvement and capacity building activities accessed through the DFV pilot



Note: Ratings were about “How useful have these activities been in your work?”, 0 = Not at all, 5 = Somewhat, 10 = Extremely.

Feedback about the system integrator support

As shown in Figure 10, 51 (82%) follow-up survey respondents reported having engaged with their local system integrator, usually in a variety of ways, with a mean of 5.9 types of engagement per respondent. While the more general forms of system integrator advice and support were accessed by more respondents, the more individual patient-specific forms of support were accessed more frequently by those using them.

Figure 10: Follow-up survey respondents’ frequency of seeking support from the system integrators

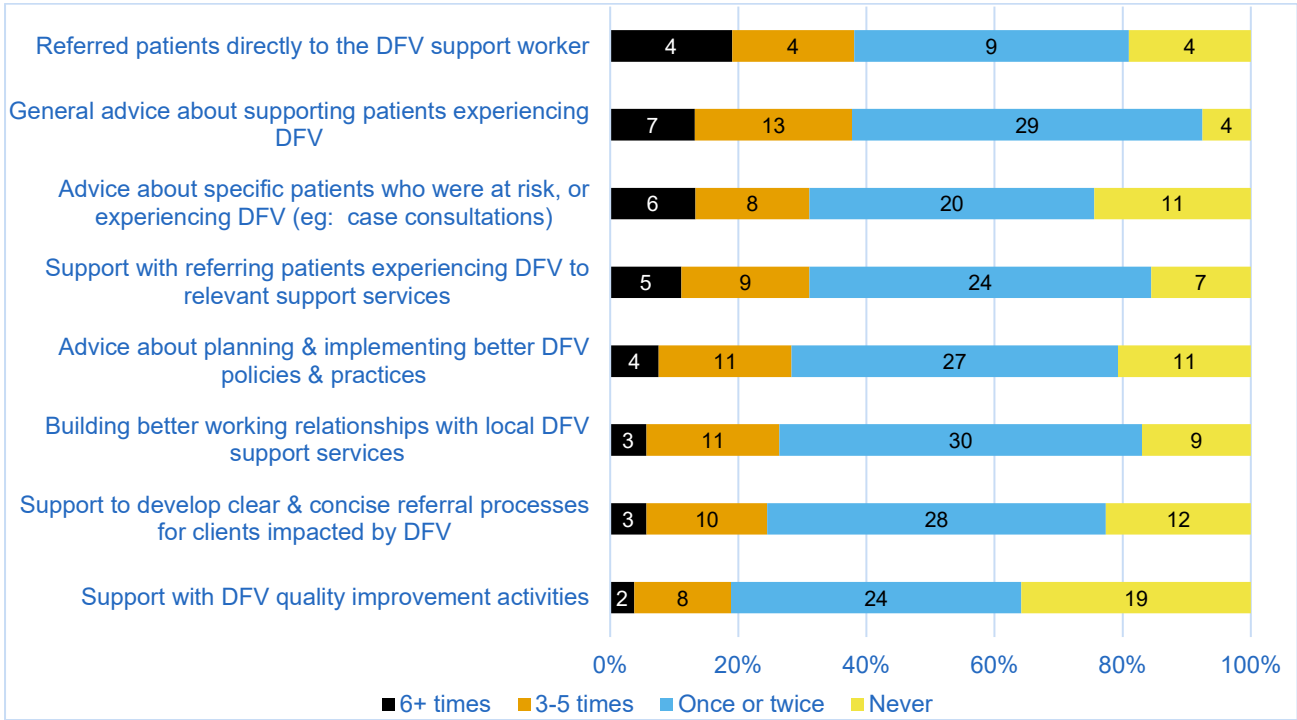
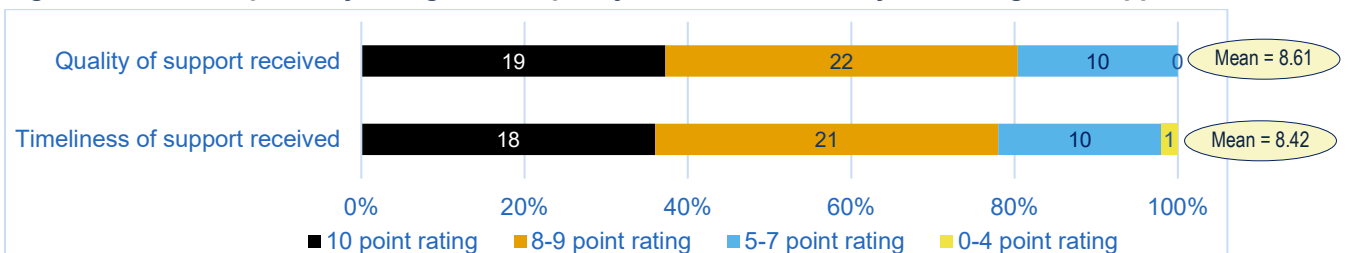


Figure 11 shows a high level of satisfaction with the quality and timeliness of support provided by the system integrators, with over one-third of all ratings at the top of the 0-10 point scale ranging from “Terrible” to “Excellent”, and overall mean ratings of 8.6 and 8.4 points respectively.

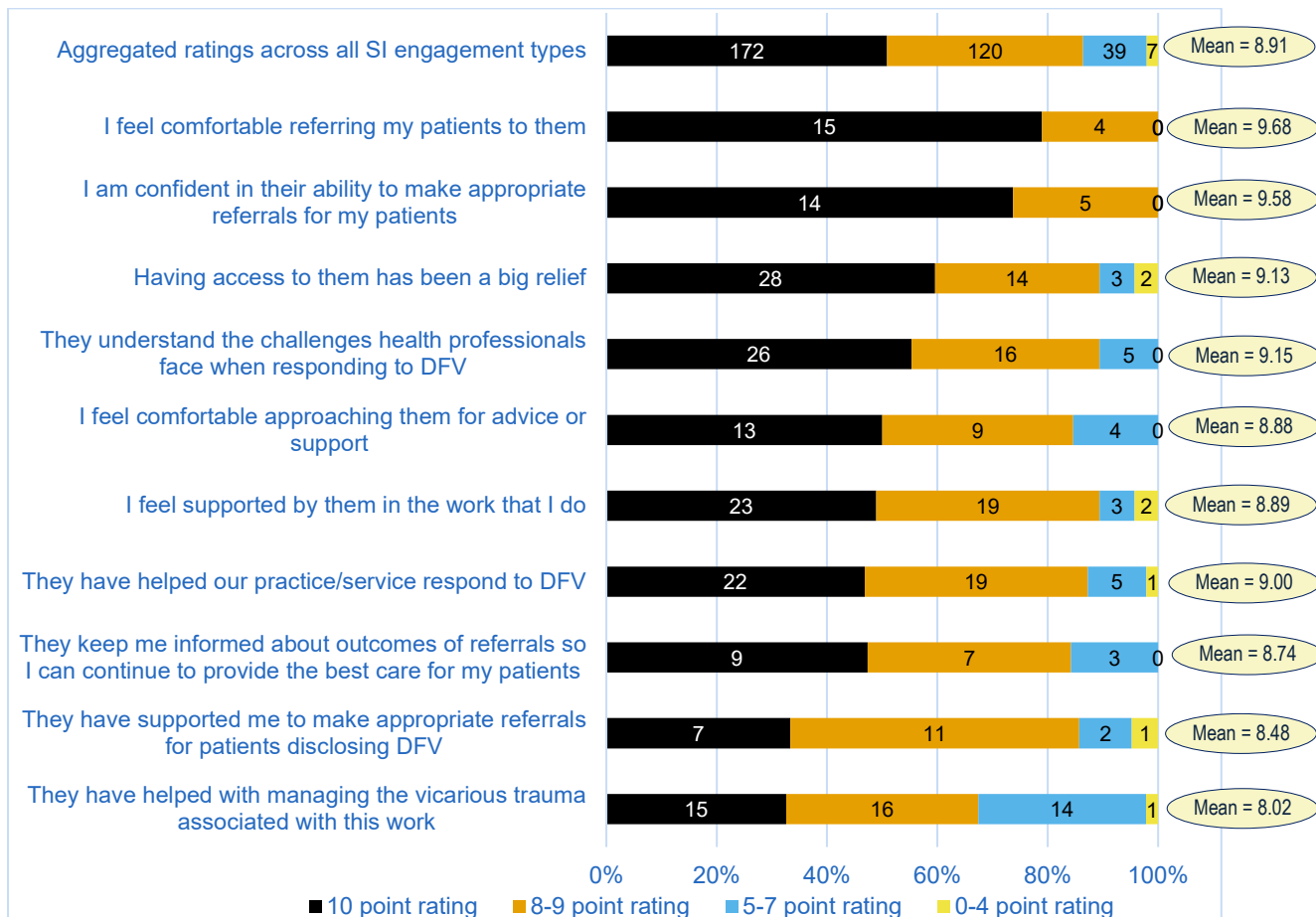
Figure 11: Follow-up survey ratings of the quality and timeliness of system integrator support



Note: Ratings were about “How would you rate your local DFV support worker in relation to...?”, 0 = Terrible, 5 = OK, 10 = Excellent.

Figure 12 shows high levels of respondent satisfaction with the system integrators, with over half of all ratings at the top of the 0-10 point scale ranging from “Not at all useful” to “Very much so”, and an overall mean rating of 8.9 points across all the support ratings. Respondents were most satisfied with the system integrators as a referral point for patients experiencing DFV and with their ability to make additional appropriate referrals.

Figure 12: Follow-up survey feedback about the system integrators



Note: Ratings were about “How much do you agree with the following statements about your local DFV support worker?”, 0 = Not at all, 5 = Somewhat, 10 = Very much so.

Figure 13 presents a case study of how the system integrators are valued and appreciated by general practices.

Figure 13: Case study demonstrating primary care sector appreciation of the system integrators

Case Study shared by a NBMPHN practice nurse – SYSTEM INTEGRATOR APPRECIATION

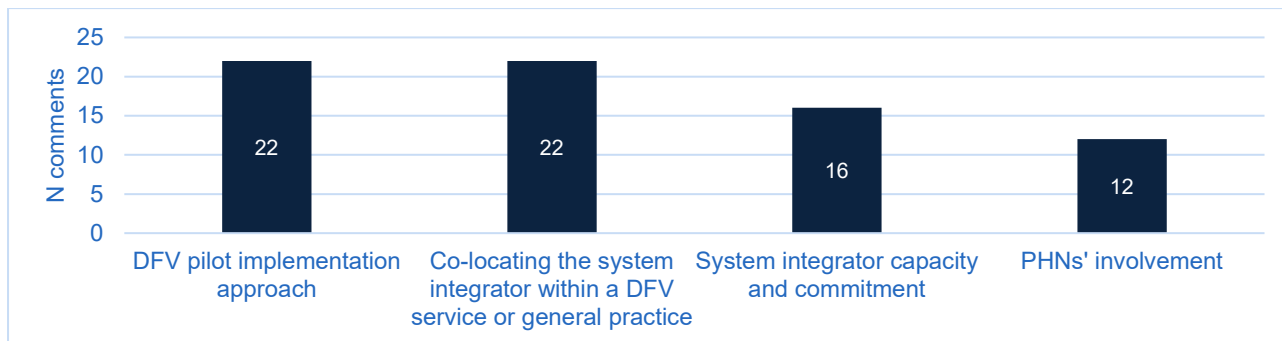
What happened: Our practice engaged with the DFV pilot initially via the training and then became aware of the system integrator and expressed interest in engaging with them for DFV support – initially via email/telephone for case consultations and general information seeking. The engagement has been ongoing and the system integrator now co-locates at our practice on a regular basis (once a fortnight).

The outcome: The engagement with the DFV pilot and the system integrator has provided opportunities for a coordinated and collaborative approach to support victim-survivors, especially since the co-location. She has enabled DFV to be forefront of the practice and her co-location has supported the confidence of GPs to assist victim-survivors and ask the question.

Facilitators of the DFV pilot implementation

Figure 14 summarises interviewees' responses when asked what factors had facilitated their implementation of the DFV pilot, with the nature of the DFV pilot implementation approach and system integrator co-location the most commonly nominated. The following sections provide an overview of the feedback received in relation to the four perceived facilitator themes from the stakeholder interviews.

Figure 14: Themes of interviewee-perceived facilitators of the DFV pilot implementation



DFV pilot implementation approach

One of the most commonly nominated DFV pilot facilitators was the nature of the DFV pilot's overall approach, including:

- Health providing funding for system integrators and implementation activities, although the short-term nature of this funding also raised some challenges (as discussed below)
- The DFV pilot's flexible and collaborative implementation approach, with PHNs adapting their activity delivery around the needs and preferences of their local general practices
- The partnership approach which brought the primary care and DFV sectors together to affect system change
- The focus on working with whole practices (rather than individual GPs).

[The PHN is] very flexible so we can build a really clear rationale as to how it's going to support us as specialists, but also support the team and the team's goals which is almost completely unique. I've yet to come across another funding body who is so clearly happy to sit in the back seat and let the people in the field drive the program. (System integrator)

It's really been a close partnership and I know that they really value that we listen. Like from when they say this isn't working and then we'll pivot and vice versa. (PHN lead)

Without them having those relationships, you know, we wouldn't feel comfortable referring. We wouldn't feel comfortable even asking, "hey, who do you think is a good person for XY&Z?" (DFV service)

We tried to be as flexible as possible with the training ... doing some after hours, some as lunchtime sessions, sometimes trying to squeeze them in a shorter time. (System integrator)

The whole practice approach was important because it's a very complex issue and it can't be delivered by just one person or a couple of people at a practice – it needs to be everyone's job ... that was also the feedback from practices – how important it is to share that kind of load. (PHN lead)

The other great thing was seeing how a whole practice can work together as a team ... seeing them talk to each other and how they can really glue together to attack this problem. (Key stakeholder)

Co-locating the system integrator within a DFV service

System integrators co-located within DFV services felt welcome and considered it a positive experience that enabled more integrated and collaborative care for DFV victim-survivors – a view reinforced by a practice nurse in one of the PHN case studies.

I don't really find there's pushback [from DFV services]. I find that it's really welcomed me ... and I'm really clear about what my role is and people say "thank you, that's great, yeah, I'll do that, you can do that, that's fabulous". (System integrator)

As a new practice, having [system integrator] co-locate has set a precedence in recognising and responding to DFV, e.g., introducing policies to support practice staff in relation to abusive clients and displaying signage for patients to inform the practice is DFV-informed ... staff have also valued her as a resource enabling DFV to be forefront of the practice ... her co-location has supported the confidence of GPs to assist victim-survivors and ask the question. (Practice nurse)

Some system integrator interviewees also commented on the increased engagement achieved when they were able to operate face-to-face (which was heavily restricted throughout most of the COVID-19 pandemic), especially when this was through being co-located at general practices. System integrators reported finding this “super valuable” for building relationships, trust and engagement with the primary care sector.

When you get in front of them face to face and have a bit of a laugh they tend to become a bit more open. (System integrator)

Having those case consultation conversations face to face is so nice and they can also let me know about any troubleshooting stuff that they're having with secure messaging and I can take that back to the PHN ... and once they know how to do it in terms of sending their referral, they know how to send it to anybody, so it's a win-win. (System integrator)

Having regular co-location is super, super valuable in that modelling that we can do. (System Integrator)

System integrator capacity and commitment

The system integrators were another commonly nominated facilitator for the DFV pilot, with many interviewees commenting on the value of having access to their expertise, their persistence, and their personal attributes and passion.

The program has to be heavily influenced by the system integrator and the specialist knowledge that we bring to this, anybody can throw together quite an academic training or package, but family violence is so much more complex and nuanced than anything that you read in the literature, and it's that perspective on the ground that we're bringing a really unique family violence lens. (System integrator)

They're in front of people saying we're the subject expert matters, come to us, we're here to support you, don't do this on your own. (PHN operational staff)

Their commitment to building trust and relationships with GPs was seen as a key facilitator of the DFV pilot. This was achieved by keeping GPs informed, feeding back patient outcomes (where consent was given by patient), and following through with actions. GPs could see first-hand what the DFV service sector could do for patients, which meant they felt validated and could demonstrate their worth and value through examples.

It's that sort of trust thing, it's about doing what you say you're going to do, and that only happens through proof of doing it. (System integrator)

I think stories are effective, they're really effective. So it's less about I can do A, B, and C, and more about here's an example of how something relatively small can actually make a difference. (System integrator)

PHN involvement

Interviewees also valued the involvement of the PHNs and their pre-existing relationships with GPs. This was especially true for system integrators based in DFV services, who felt working with PHN general practice support officers helped with engaging general practices by adding validity to their role and presenting a united approach. PHNs also contributed to the DFV pilot by raising awareness of it through networking and speaking engagements, supporting place-based implementation approaches (rather than a homogenous model) and offering ongoing support to their system integrators.

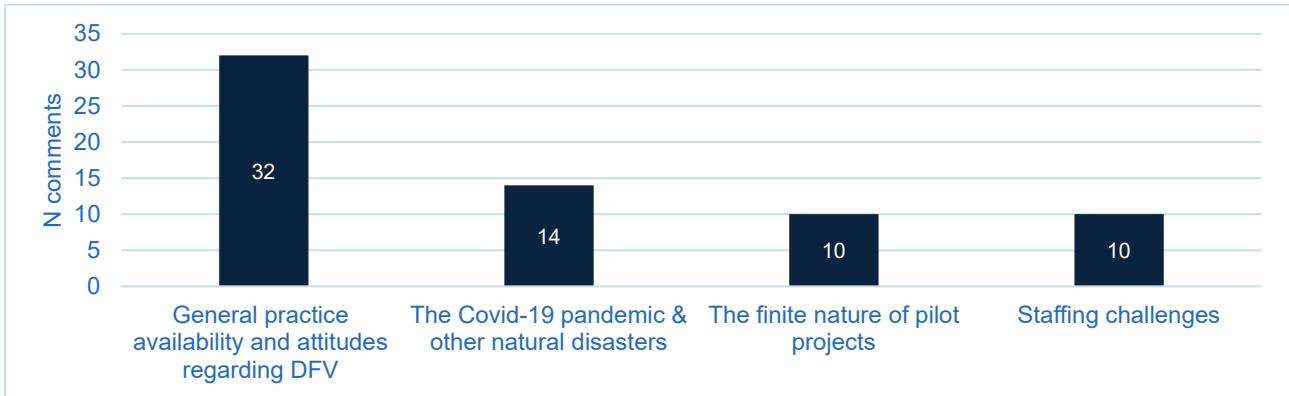
When you've got a Relationships Australia ID tag on ... but then you turn up with their General Practice Support Officer and [GPs are] like “okay, they actually really are linked in with the PHN”. It's just this big, united front that we're all doing this together and we're here to support you no matter what you need, so that has been great. (System integrator)

I would say my role is also definitely supporting the linkers ... we work quite closely together – we meet formally every fortnight but also communicate informally throughout those two weeks. (PHN lead)

Challenges with the DFV pilot implementation

Figure 15 summarises interviewees' responses when asked what challenges they encountered with the DFV pilot implementation, with general practice availability and attitudes regarding DFV, and the COVID-19 pandemic the most commonly nominated. The following sections provide an overview of interviewee feedback in relation to the four perceived challenge themes. Where relevant, other data from the pre-post training and the follow-up surveys has also been incorporated.

Figure 15: Themes of interviewee-perceived challenges with the DFV pilot implementation



General practice availability and attitudes regarding DFV

Many interviewees raised concerns about some GPs' attitudes towards DFV, with some GPs questioning whether DFV was an issue in their community or appropriate to raise in a general practice setting.

I feel a little bit disappointed in that we have to sell it because the need for it is really clear to me ... we have identified there is this gap in servicing that we are here to fill it, to support doctors and their patients and the general practice staff. (System integrator)

I think the system integrators face a lot of resistance because it is a bit of an old-boys' club. (DFV service)

I didn't realise that DV was not spoken about in GP world. Their lack of knowledge and education around that side of things was quite shocking ... they're like "DV doesn't exist in my area" and they're very adamant on that. (System Integrator)

The time constraints of primary care were recognised by all stakeholder groups. However, it was also perceived that some GPs saw the DFV pilot as another thing they had to take responsibility for, rather than seeking support from their local system integrator.

They're very short on time. Everything's gotta be quick and sharp, and so I guess being flexible around that. But it is a challenging one and it just means that it's a really long game. (PHN operational staff)

I think the workload for them, that's pretty significant. (System integrator)

I got a sense from some practices that it was too overwhelming, they didn't know where to start, and they thought they had to do it all, and it didn't matter how many times we said no, we're here to help you with that, it sort of never got across. (System integrator)

Interviewees also commented about the critical nature of their relationship with practice managers and administrative staff in the larger practices, recognising that they played a gatekeeper role and could have considerable influence on the extent to which GPs and other health professionals engaged with the DFV pilot.

The practices all have their gatekeepers and if you can't get past that person, you've got no chance. (PHN operational staff)

As long as you get either the nurse, the practice manager or a GP on board, then the whole practice is on board. So. it's just about finding the person and their preferred method of contact. (System integrator)

Other interviewees reported experiencing push-back from GPs who did not view the DFV service sector as their equal counterpart in supporting victim-survivors, with varying levels of trust in the DFV sector prior to the DFV pilot. Interviewees also raised concerns about a lack of feedback from DFV services to GPs having referred patients to them, which was something the DFV pilot sought to address.

I think there's also sometimes, some that think they know more than they actually do, and that's a really interesting one, the power dynamic there with the medical professionals, and really getting questioned over their credentials and their expertise. (PHN operational staff)

We heard a lot from general practices that they didn't have a lot of trust in the DFV sector ... if they had engaged with the sector at all, which a lot hadn't, they just hadn't had a good experience ... they would send a referral and never hear anything back. (PHN lead)

One of the things GPs hate is when they refer a patient and never know what happens ... did she get there? did they offer her anything? ... so we've made sure that we close that feedback loop by making sure that every GP is contacted and the services that are offered to their patient have been explained to them. (Key Stakeholder)

The COVID-19 pandemic & other natural disasters

All stakeholder group interviewees nominated the COVID-19 pandemic as a significant hinderance for the DFV pilot. Specifically, they reported that restrictions on face-to-face contact made it difficult to establish productive relationships with general practices.

COVID was like the nightmare... for the DV linker not being able to even physically go out to the centres, I mean everything about it was just impossible for them. (DFV service)

One of the biggest challenges was COVID, that we weren't able to go to the clinics face to face, because I think we would have got a far better engagement, far better uptake, we would have built those relationships and those connections, and like you can only do so much online, it's so tricky to connect with people. (System integrator)

Interviewees also commented that competing priorities for general practices (e.g. COVID vaccination programs and supporting affected patients) reduced their availability to engage with the DFV pilot.

Being in the heart of COVID was quite challenging because general practice were very focused on the COVID response and then the vaccine rollout. (PHN lead)

GPs were just so busy because they were dealing with COVID. (System integrator)

Other interviewees considered that COVID-related burnout and trauma impacted staff energy levels and willingness to engage in the DFV pilot. Other natural disasters, such as the floods in NBMPHN, also similarly hindered the DFV pilot implementation.

My role was difficult during COVID to try and bring the DFV pilot to life when we had an incredibly stretched and tired workforce. (PHN operational staff)

it's had a massive impact, the effects of COVID ... even now we're out and about and we're maskless, I think the PTSD, the trauma that sort of left these practices is having a massive impact. (PHN lead)

The finite nature of pilot projects

The nature of pilots being implemented for finite periods was also raised as a challenge. Interviewees highlighted that building relationships with stakeholders and creating significant change in such complex issues require time.

I do sometimes have to remind myself that this is a marathon and we're at the very beginning, and that behaviour change does take a long time. We know it doesn't happen overnight. (PHN operational staff)

There's been some really great movement, it's been really wonderful to actually see those changes, even if they're very slow at being drawn out. (System integrator)

Other interviewees talked about the “pressure to be doing a little more at this point in time” to ensure the success and continued funding of activities beyond the DFV pilot’s initial funding period, with concerns raised about promoting a service or resource to primary care that was potentially not guaranteed for the long-term.

Come the 31st of January, the DFV pilot may not be a thing anymore ... and I don’t feel that I should be promoting something we won’t have access to in a couple of months. We’re coming up to the busiest time of the year, so I’m doing what’s in the best interests of women, not what’s in the best interests of the PHN.
(System integrator)

A lot of GPs say “yeah, we see people like you come and go, why would I invest my time where we’re funding based and especially around the DV sector you’re in, you dangle the carrot, you give us a leaflet, and then by the time I remember to call you, your funding has expired”. (PHN lead)

Staffing challenges

System integrator recruitment and retention was challenging for some PHNs, especially during the peak of the COVID-19 pandemic. This impacted the DFV pilot’s momentum with the need for re-establishing relationships when key staff left their positions.

When staff move I think it can change how the partnership works and everything. (System Integrator)

We just didn’t have the staffing, we lost a lot of staff during the pandemic – people were just going “I’m trying to home-school and the job’s too stressful” or people moved out of the city as well ... I don’t know where they all went, because we still can’t recruit that well. (System integrator)

We had so much trouble recruiting in the first place, I think it started with the pandemic and then workers became really hard to recruit ... we finally had someone come in to run the program but they left, so I just stepped and ran it. (System integrator)

Some interviewees talked about the potential for system integrator burn-out, particularly in the time required to foster and maintain relationships with primary care but also as a result of trauma associated with the COVID-19 pandemic.

I’m really careful now with booking the calendar, because at first I was just like “right, they’ve got a time, just agree to it”, just to get people to come. I accidentally did that one week when we were actually at a two-day conference and had to run the two-hour training after a full day at the conference ... it was like lesson learnt. (System integrator)

Other interviewees experienced challenges with turnover of staff in the general practices they had engaged with, requiring additional time and effort to build new relationships and upskill new staff.

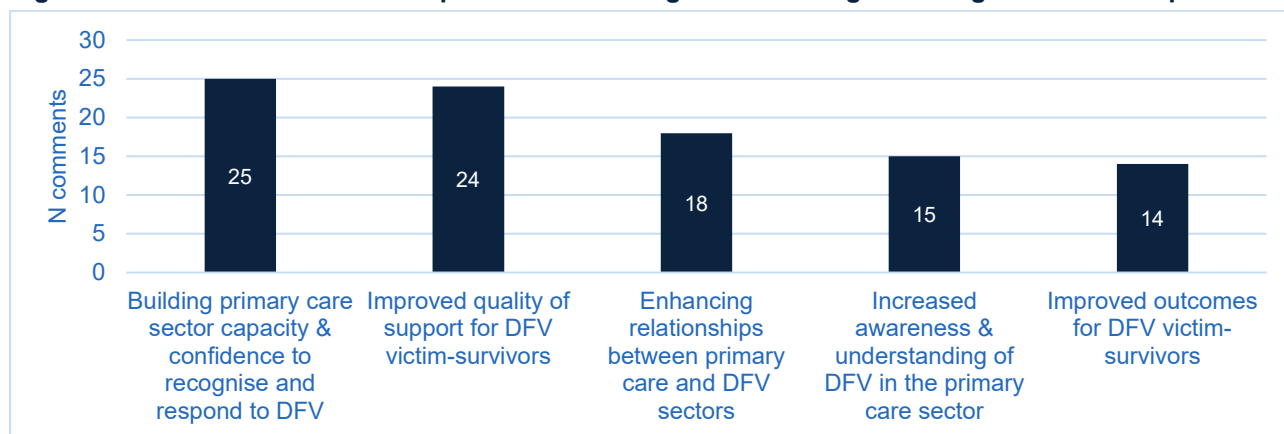
I think the relationships between GPs and DFV services will hopefully continue. I guess the difficulty with that is the turnover of staff as GPs can go to different surgeries and or could just be there short-term.
(DFV service)

We delivered to a group of practices that then closed and then there was a high turnover of staff ... so that lack of consistent person for us to contact and new staff weren’t aware of what we were doing ... so it became really disjointed and it was hard to maintain engagement. (System integrator)

Aim 3: Outcomes at the primary care level

Figure 16 summarises interviewees’ responses when asked what they considered the most significant changes arising from the DFV pilot, with building primary care sector capacity and confidence and improved support quality for DFV victim-survivors most commonly nominated. The following sections provide an overview of interviewee feedback in relation to the five perceived impact themes. Where relevant, other data from the pre-post training and the follow-up surveys has also been incorporated.

Figure 16: Themes of interviewee-perceived most significant changes arising from the DFV pilot



Increased awareness and understanding of DFV in the primary care sector

A critical initial outcome of the DFV pilot was raising the profile of DFV in the primary care sector, which was among the most significant change themes nominated by interviewees. This increased profile was seen as an important step to engaging general practices to play a more pivotal role in recognising and responding to DFV among their patients.

I think it's getting GPs to kind of broaden their horizons around social health altogether ... we've been able to have these conversations and linking domestic violence to mental health and substance use, and getting them to kind of relook at how they view those as social issues, rather than focusing on only that biomedical model. (System integrator)

We're opening up that knowledge base of DV and that has the potential to save lives. (System integrator)

Enhanced primary care sector capacity and confidence to recognise and respond to DFV

Another critical outcome of the DFV pilot was building primary care capacity in relation to DFV (via the various training sessions, CoPs and, in some PHNs, QI activities), which was interviewees’ most commonly-nominated significant change arising from the DFV pilot. Interviewees frequently commented on how the DFV pilot had enhanced attendees’ DFV knowledge and confidence to recognise and respond to situations with their patients when they occur.

Internal capacity was built in general practice ... we had about 50 disclosures, there were two cases that were escalated and the Police were called. So I think that that shows that the program is working... doctors are confident enough to ask those questions. (PHN operational staff)

Sometimes there's been a GP that has been seeing a patient for years and they just never asked the question. And then once they did the training, or had contact with the local link and they asked the question and all of a sudden they're like, "Oh my God, like I just had no idea this was going on". (PHN operational staff)

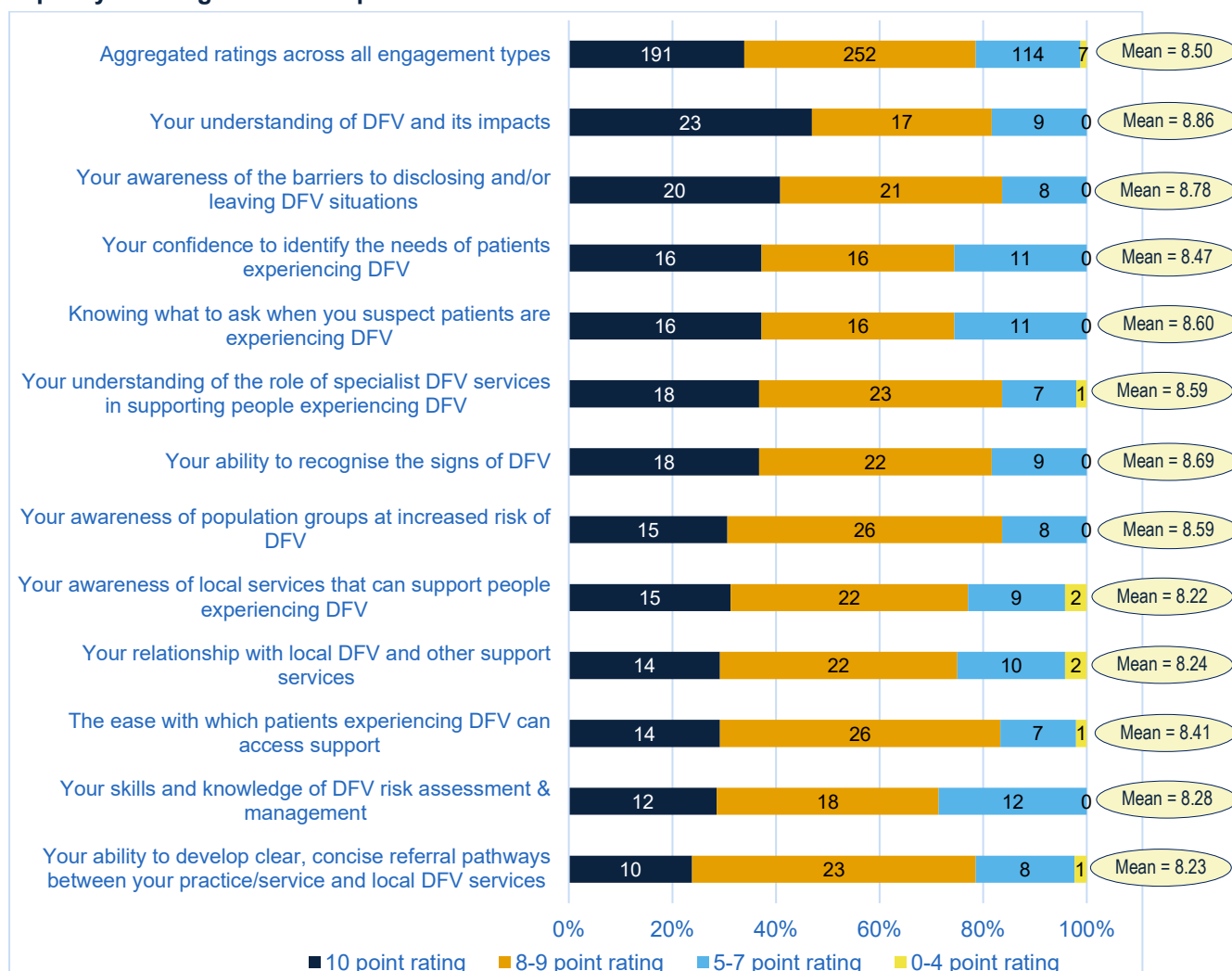
Interviewees also spoke about positive experiences where they had general practices regularly engage with them, who had genuine care and interest to build their knowledge and skillsets in DFV. Here, system integrators praised the practice staff for welcoming and interacting with the DFV pilot.

We've watched [the GP's] skillset grow and develop so much, which has been fantastic... there's quite a few GPs that have really embraced the program. (System integrator)

Then there's some, particularly registered nurses, I have to give them credit for this, who see us as their backup when it comes to domestic and family violence, they see us as a really active resource, they want to get ideas from us, they want to get better at responding and recognising domestic and family violence, but they're also really interested in that service response, so they'll ask things about what could I do different, what could I do better, what is available for my patients, and really try and be a connector, an active role in that space. (System integrator)

Figure 17 shows follow-up survey respondents perceived the DFV pilot had substantially enhanced their capacity to recognise and respond appropriately to patients experiencing DFV. Over one-third of all ratings were at the top of the 0-10 point scale ranging from “Not at all useful” to “Very much so”, with an overall mean rating of 8.5 points across all the potential impacts. Respondents perceived the biggest improvements were in their understanding of DFV and its impacts and in their awareness of the barriers to disclosing and/or leaving DFV situations.

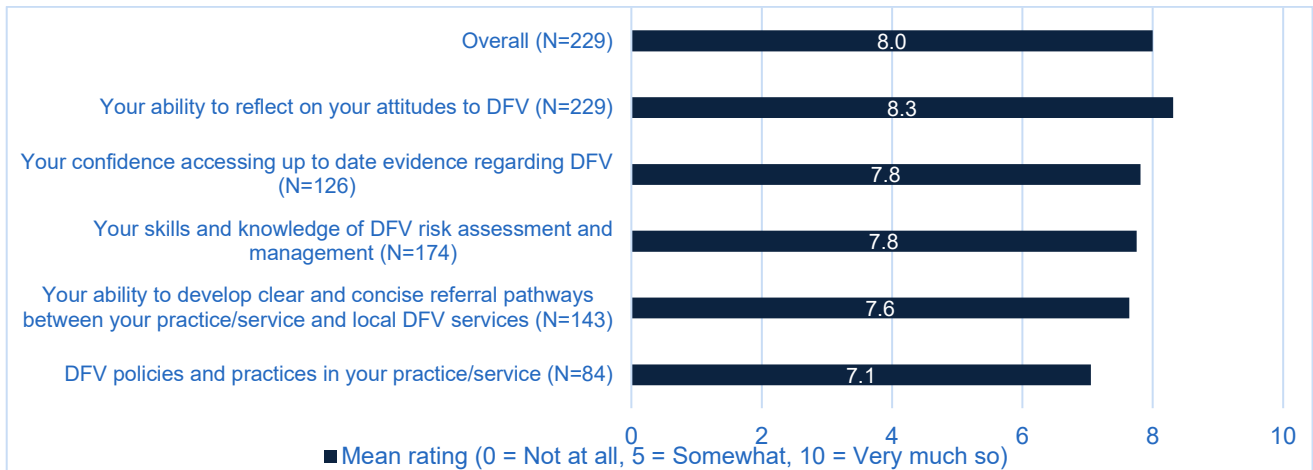
Figure 17: Follow-up survey perceptions of the impact of the overall DFV pilot on respondents' capacity to recognise and respond to DFV



Note: Ratings were about “To what extent do you think the DFV Initiative has helped with improving the following?”, 0 = Not at all, 5 = Somewhat, 10 = Very much so.

As shown in Figure 18, post-training survey respondents provided similarly positive perceptions about the extent to which the training they received had improved various aspects of their DFV capacity, especially their ability to reflect on their attitudes to DFV.

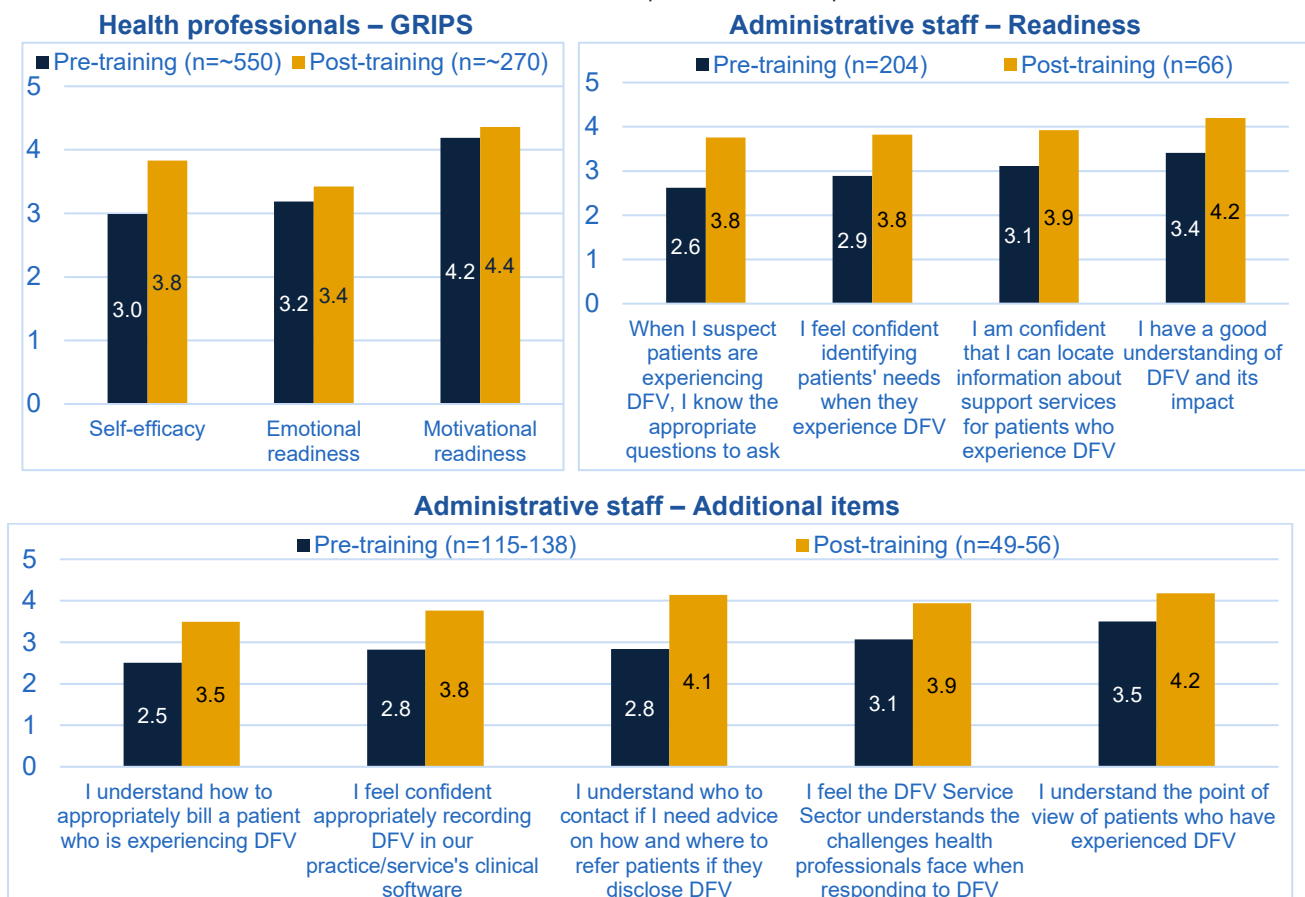
Figure 18: Post-training survey perceptions of the extent to which training attended helped improve respondents' capacity to recognise and respond to DFV



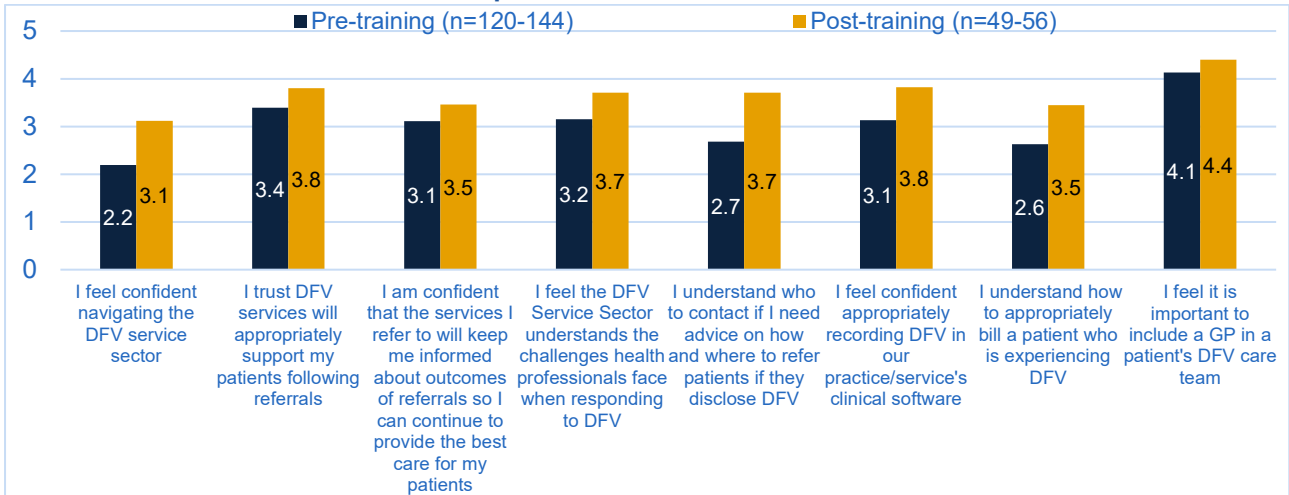
As shown in Figure 19, these perceptions were reinforced by very statistically significant pre-post training increases ($p < 0.0001$) on all three GRIPS domains (for health professionals), the four bespoke readiness items asked of administrative staff and additional capacity-related questions nominated by the PHNs for both health professionals and administrative staff (see Appendix K for the detailed t-test results).

Figure 19: Pre-post training survey changes in respondents' self-reported DFV capacity

Note: Response options were 1 = Strongly disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly agree. Ns indicate the number of respondents for each question set.



Health professionals – Additional items



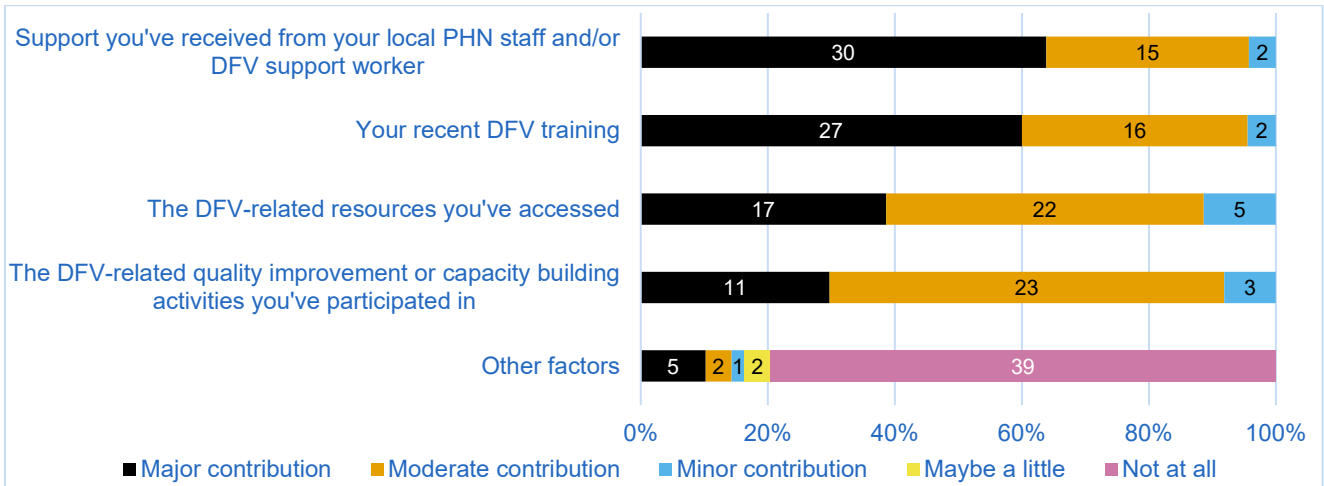
As shown in Figure 20, follow-up survey respondents considered the DFV pilot was the main contributor to their improved DFV-related capacity, with the system integrators and the DFV-related trainings considered to have had the greatest impact. These two components were also the most frequently nominated in response to a question about which activity or resource had the biggest impact on respondents' DFV-related capacity (training with 15 nominations and the system integrator with 12 nominations).

Continual engagement with DV Linker, initial RRR training; and being involved in a warm referral²⁰ of a client to DV Linker and witnessing how they work. (Allied health practitioner)

Relationships with the local link team and the other GPs in the community of practice have increased my confidence in my work and me feeling of being able to do this work because I am supported. (GP)

Working as a complete team has helped us all improve in this area and support one another. Has been fantastic to have access and training from such a wonderful team. (GP)

Figure 20: Follow-up survey perceptions of the relative contributions of the DFV pilot components



²⁰ Warm referrals involve service providers supporting clients' initial contact with other services – this could mean calling on the client's behalf or meeting with the client and the service together.

Figure 21 presents a case study of how the DFV pilot has comprehensively changed a general practice's understanding, capacity and practice in relation to recognising and responding to DFV.

Figure 21: Case study demonstrating improved primary care DFV awareness and capacity

Case Study shared by a NWMPHN practice manager – CAPACITY BUILDING

What happened: As part of the DFV pilot, the practice completed QI activities to support staff in recognising and responding to DFV. These included:

- Playing a family violence awareness video in the practice waiting room (obtained and with permission from Services Australia for Tonic Media Network).
- Displaying/ providing 1800RESPECT lanyards, pens and note pads in each consultation room to remind GPs of the project, and to promote the service to patients
- Developing a screening question for GPs and nurses to ask at mental health plans/reviews, antenatal appointments, cervical screening and refugee health assessments
- Secondary consult support and supervision provided by the Local Family Violence Worker at clinic meetings.

The outcome: Overall, practice staff have benefited greatly from participating in the QI activities, reporting increased awareness of family violence prevalence, knowledge of the different types of family violence and how it impacts patients. Staff also feel better equipped, more empowered and ready to screen and respond to people experiencing family violence. Dedicating time for case discussions in clinical meetings has offered opportunities for staff to share many impactful stories which all have learnt from to better their screening and care for patients experiencing family violence. Staff feel the QI activities have facilitated a culture of 'family violence awareness and open discussion' within the practice. Another outcome was improved efficiency in the practice by having a streamlined process and information on hand.

Enhanced relationships between primary care and DFV sectors

Another significant change or key achievement of the DFV pilot identified by participants was the enhanced sense of integrated support being developed between the primary care and DFV sectors. Some interviewees discussed the level of trust that was being established between the sectors, and the perception of being viewed as equals or allies in supporting victim-survivors.

It's quite ground breaking, building these bridges and bringing these sectors together for the first time ... it's a culture shift, so the different sectors not seeing each other as the enemy anymore. (Key stakeholder)

[Primary care are] seeing the DV local links as really strong partners and someone they can lean on for support, that they can work with to provide care jointly. (PHN operational staff)

It seems like the primary care and the local links really view each other as counterparts, and there's that level of trust there when the engagement is facilitated. (DFV service)

I don't think I've ever been in a program that's engaging so well with its external partners ... it's very much an example of everybody really coming together for the same goal and everybody really believing in the program, which has been great. (DFV service)

Traditionally, the DFV service sector and primary care are worlds apart, they may as well be two different planets, and part of this pilot was to start to build bridges between those two worlds, bringing them into a physical room together ... that was really helpful to get these two sectors that previously didn't have a lot of connection talking to each other. (PHN lead)

There was also improved understanding and empathy among those in the DFV sector of the primary care context, and newfound awareness of the role GPs can play.

On our side of the fence in the DV sector, we've gained a better understanding of the role that GPs can play in women's lives (DFV service)

I've learnt so much about the medical setting... it can be passed to other patients to build our knowledge and awareness around it and connect people in. (System integrator)

Increased primary care sector referrals to DFV services

The primary care sector's enhanced DFV awareness, capacity and relationships resulted in increased primary care sector referrals to DFV services. Three of the participating PHNs (BSPHN, HNECCPHN and NBMPHN) accepted direct referrals from GPs²¹, with a total of 139 referrals reported in the PHN data trackers between April and November 2022. As shown in Table 13, the people referred were predominantly non-Aboriginal, non-CALD females of varying ages and without a disability. However, in BSPHN almost one-third of referrals were Aboriginal and over one-third were CALD, and in HNECCPHN one-fifth had a disability. Almost all referrals were accepted in BSPHN and NBMPHN but only two-thirds were accepted in HNECCPHN, mostly due to the system integrator's inability to make contact with those referred. It is important to note that system integrators would not always have been aware of GP referrals to DFV services, particularly where they were not co-located in a DFV service. Therefore, the referral data reported here are likely an underestimation of the actual number of GP referrals to DFV services in the monitoring period. This gap in data highlights the need for the implementation of secure, integrated reporting systems that are embedded within primary care and specialist DFV services, that allow transparent, yet de-identified, access to information such as primary care referrals to specialist DFV services.

Table 13. Characteristics of cases directly referred to system integrators, April – November 2022

		BSPHN (n=53)	HNECCPHN (n=44)	NBMPHN (n=42)	Total (n=139)
Age (years) (12 unknown)	Under 30	16 (33%)	7 (18%)	11 (28%)	34 (27%)
	30s	19 (40%)	5 (13%)	8 (20%)	32 (25%)
	40s	8 (17%)	11 (28%)	12 (30%)	31 (24%)
	50s	5 (10%)	13 (33%)	6 (15%)	24 (19%)
	60+	---	3 (8%)	3 (7%)	6 (5%)
Gender (1 unknown)	Female	53 (100%)	43 (98%)	38 (93%)	134 (97%)
	Male	---	1 (2%)	3 (7%)	4 (3%)
Aboriginality (12 unknown)	Aboriginal	13 (25%)	3 (8%)	1 (3%)	17 (13%)
	Torres Strait Islander	---	---	---	---
	Both	3 (6%)	4 (10%)	2 (6%)	9 (7%)
	Neither	37 (70%)	32 (82%)	32 (91%)	101 (80%)
Culturally & Linguistically Diverse (10 unknown)	Yes	20 (38%)	4 (10%)	3 (8%)	27 (21%)
	No	33 (62%)	35 (90%)	34 (92%)	102 (79%)
Have a disability? (21 unknown)	Yes	4 (8%)	6 (21%)	1 (3%)	11 (9%)
	No	49 (92%)	22 (79%)	36 (97%)	107 (91%)
Referral outcome	Accepted	52 (98%)	28 (64%)	41 (98%)	121 (87%)
	Declined	---	1 (2%)	1 (2%)	2 (1%)
	Unable to contact	1 (2%)	15 (34%)	---	16 (12%)

Note: Cells may not add to 100% due to rounding.

- As shown in

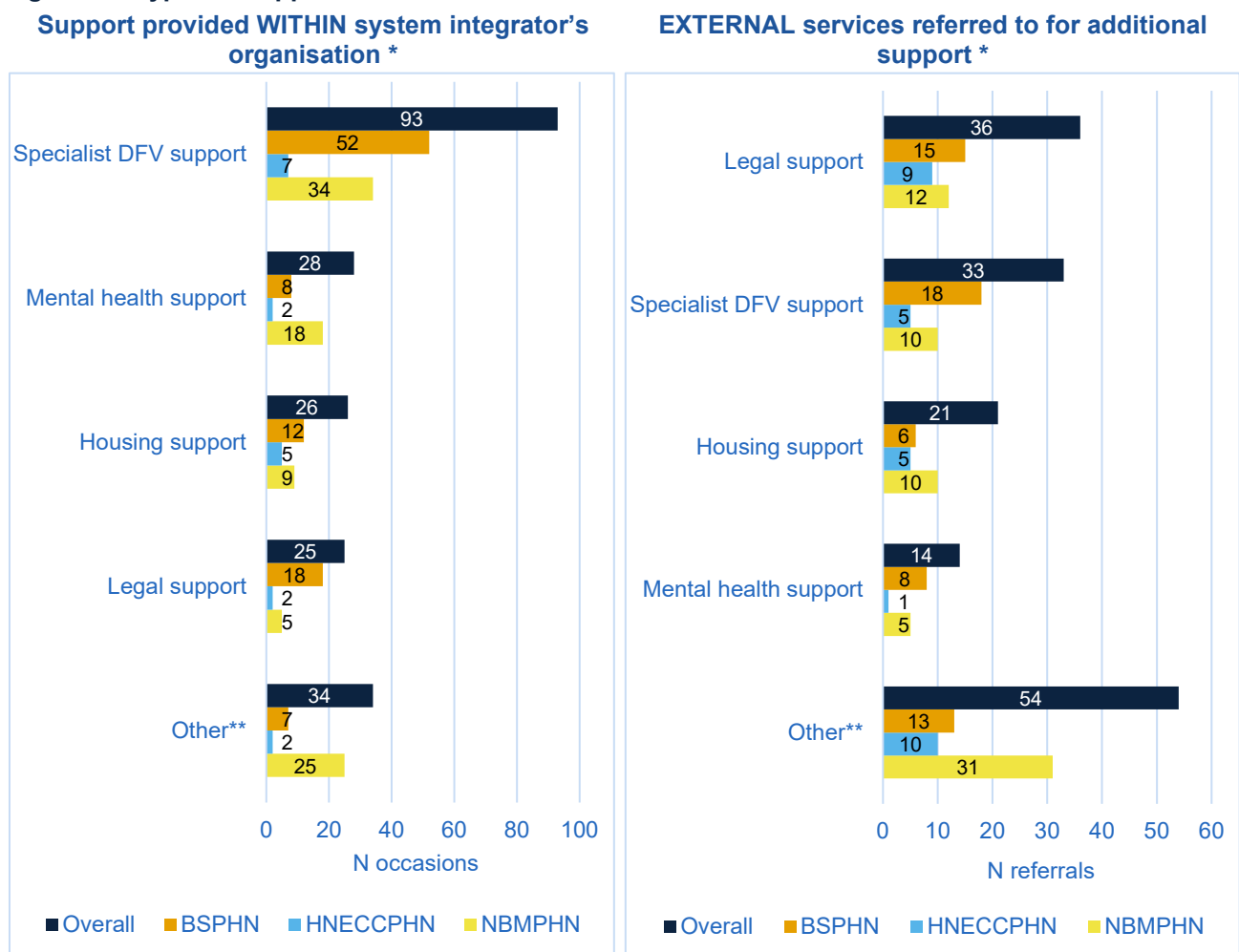
²¹ The other three PHNs were reluctant to accept direct referrals due to the short-term nature of the DFV pilot's funding.

Figure 22, referred clients received mostly specialist DFV support within system integrators' organisations, with some internal mental health, housing and legal support. Some DFV pilot referred clients were also referred on to other organisations, most often for legal and additional DFV support.

The support and onward referrals received by accepted clients varied considerably across the three PHNs:

- In BSPHN, all clients received specialist DFV support, about one-third received legal support and a quarter received housing support with specialist DFV and legal support also the most common onward referrals
- In HNECCPHN, a quarter of clients received specialist DFV support and about one-fifth received housing support with other support and legal support the most common onward referrals
- In NBMPHN, four-fifths of clients received specialist DFV support, over half other support and two-fifths received mental health support with other support and legal support the most common onward referrals.

Figure 22: Types of support offered to direct referrals



* Multiple referral options could be selected ** Other included (but not limited to): financial, employment and medical supports

Some system integrator and DFV service staff interviewees also commented about how the numbers of referrals received from GPs had increased since their exposure to the DFV pilot. For example, a system integrator talked about having increased reach to victim-survivors via general practices, having “access to people who typically wouldn't have come into contact with a regional DV service”.

Definitely [an increase in referrals], because we never got these DV referrals from doctors, and so whatever the statistics are that is definitely an increase. (System integrator)

Figure 23 presents a case study of how the DFV pilot is increasing DFV referrals from primary care, through improving relationships between the primary care and DFV sectors.

Figure 23: Case study demonstrating how the DFV pilot helped increase DFV referrals from primary care

Case Study shared by a HNECCPHN system integrator – PRIMARY CARE DFV REFERRALS

What happened: In August 2022, HNECCPHN commissioned Legal Aid NSW to take over its system integrator roles for the DFV pilot, through their existing Women’s Domestic Violence Court Advocacy Services (WDVCASs), with the aim of increasing primary care referrals into Safer Pathway, a NSW government initiative that supports victim-survivors of DFV. Currently, 98% of referrals to Safer Pathways come from NSW Police, with almost no referrals being made by GPs, who don’t have a working knowledge of the DFV sector in NSW and lack confidence in making referrals and navigating conversations with patients experiencing DFV.

The outcome: The system integrators have developed and fostered relationships with the primary care sector, having the time, capacity and specialist DFV knowledge required to support GPs in navigating the DFV sector through de-briefings or secondary consultations, as well as increasing their confidence and awareness of DFV in primary care setting. Between September and November 2022, there have been 15 referrals from GPs into Safer Pathways within the PHN catchment area, broadening the reach of the program and enabling improved continuity of care for DFV victim-survivors.

Improved quality of support for DFV victim-survivors

The integrated approach between the primary care and DFV sectors was seen as ultimately benefiting victim-survivors by improving the support they receive. Here, interviewees discussed how this allowed for trauma-informed care as well as warm (or facilitated) referrals for victim-survivors.

The patient will have a far better experience because the workers that are now working with us are experienced in trauma-informed care, making sure that that woman doesn’t need to keep repeating her story every time. (DFV service)

The health practitioners are more aware of DV services, DV services are more aware of health practitioners, and then you’ve got the clientele in the middle that are aware that they feel supported between those two areas. (DFV service)

I’ve now got a list of GPs who are DV-informed and trauma-informed who I’ve worked with and all the case workers across our service have that. (System integrator)

We’re making sure that the woman is at the centre of the safety planning, that it’s about her needs, almost like a one-stop shop, so it’s a smoother, more client-centred and friendly approach to that whole process of referrals. (DFV service)

In the post-training surveys, about three-quarters of eligible respondents (178 of 232, 77%) indicated that they planned to or had already changed their practice as a result of their training, with 118 providing examples that could be grouped the following themes:

- Asking more patients about their home situations (if concerned &/or as part of routine screenings) (n=45)
- Being more aware of DFV/ alert to indicators of DFV (n=42)
- Having more resources and promotional items in the waiting room, toilets &/or consultation rooms (n=25)
- Providing patients experiencing DFV with resources and/or referrals (n=22)
- Better supporting/ managing/ documenting patients experiencing DFV (n=18)
- Engaging with local DFV support services/ seeking additional training (n=3).

I know what questions to ask and what language to use if I suspect DFV and then I know who to contact/what's available out there for clients dealing with DFV so that I can more confidently direct them (where they are ready for intervention). (GP)

The following changes have been implemented: 1) The supply of reading material for patients on the recognition of domestic violence; 2) Routinely screening all patients through questions on possible exposure to violence; 3) Offering patients support and referral services to those patients requiring these services; 4) Providing follow up services to patients exposed to violence; 5) Assess and treat co-morbidities (mental health complications etc). (Practice manager)

Of 21 follow-up survey respondents asked whether they had had an opportunity to apply their learnings from their DFV-related training, 19 (90%) indicated that they had: 34 once or twice, 9 a few times, and 6 many times. The most commonly mentioned applications were:

- Advising / connecting patients to support services (n=9)
- Identifying patients experiencing DFV (n=6)
- Providing support/ ongoing management for patients affected (n=6)
- Implemented routine screening for DFV (n=4)
- Displaying promotional DFV materials (n=3).

I had a patient who was the survivor of severe DFV and who was already in safe housing with some victim support but did not have a DFV specialist caring for her ... I was able to call the Local Link to find out how to get her more support, how to access legal help, and it made a massive difference to the patient, and to my sense that I could help her. (GP)

I have been able to audit and then implement improvement activities in our practice to increase patient and clinician awareness /knowledge about DFV. We have brochures and pamphlets about DFV in our waiting room and a family violence awareness video is played on our TV. We have 1800 respect cards in all our consult rooms as well as posters. Our team have participated in training and feel more confident in identifying and responding to someone who has disclosed DFV. We have developed a screening question for clinicians to ask patients to screen for DFV. (GP)

Figure 24 presents two case studies of how the DFV pilot has helped improve the support DFV victim-survivors receive – one through primary care and another through a DFV service-based system integrator.

Figure 24: Case studies demonstrating improved support quality for DFV victim-survivors

Case Study shared by a NBMPHN system integrator – DFV SUPPORT QUALITY

What happened: After attending training, one of their larger regional general practice (9 GPs, 4 practice nurses & 6 reception staff) began regularly contacting the system integrator by phone and email (during the Covid-19 restrictions) for case consultations and general information seeking. When restrictions eased, the system integrator began co-locating at the practice on a fortnightly basis.

The outcome: The GPs and practice staff are making a really positive impact in supporting patients who are experiencing DFV – from better equipping their practice to support DFV disclosures, to providing a safe space for patients and linking them in with the appropriate supports, their DV-informed practice approach is something to be congratulated. I am also able to relay information back to local DV services and networks to facilitate a better working relationship between them and GPs, which has seen this particular practice provide DV-specific medical services (Bulk Billing, DV informed/sensitive GPs etc).

Case Study shared by a HNECCPHN system integrator – DFV SUPPORT QUALITY

What happened: A system integrator received a referral from a GP in their catchment area following a practice visit. The referral was for a client with complex and immediate safety needs, having fled her home in the middle of the night, leaving her young children behind. The client had no access to money, and no protection from the perpetrator who she believed was tracking, following and stalking her.

The outcome: The system integrator made contact with the client and completed a threat assessment with her using the DVSAT. The client was assessed as 'at serious threat', and referred to an upcoming Safety Action Meeting. Due to the complex needs of the client, she was also assigned a Women's Domestic Violence Court Advocacy Services (WDVCAS) caseworker who assisted her in securing accommodation, financial assistance, a safe phone and security cameras. The case worker also assisted the client with making a report to police, resulting in an application for an Apprehended Domestic Violence Order (ADVO) for the client's protection. As the WDVCAS also provides support for victim-survivors attending court, the WDVCAS caseworker was also able to provide court support for the client through the ADVO process.

Improved outcomes for DFV victim-survivors

Although it is still relatively early in the implementation of the DFV pilot, some interviewees discussed how they felt it was already improving outcomes for victim-survivors, giving a number of examples where the DFV pilot had positively supported victim-survivors and the powerful impact it had had on their lives.

For individuals, I think there have been really positive outcomes, because they've got the support that they need... it's huge in that person's life. That's what I see regularly, the difference that it makes to individuals. (DFV service)

One GP called me and her patient had come in for cracked heels with her mother-in-law but the GP just felt like something wasn't right... it turned out this woman was being very, very badly abused by the whole family, including the mother-in-law that was attending her appointments. So I spoke to her and we talked about all the different options available and where she could be referred to ... so the GP was able to help her make a referral and she did leave the relationship, actually. (PHN operational staff)

It's really making a difference to people who experience violence. (PHN lead)

Figure 25 presents a case study of how the DFV pilot has helped a victim-survivor and her partner.

Figure 25: Case study demonstrating improved outcomes for DFV victim-survivors

Case Study shared by a NWMPHN GP – VICTIM-SURVIVOR OUTCOMES

What happened: A patient presented extremely agitated and distressed, wanting a referral for a psychologist and to discuss some medications for anxiety. On further questioning, she disclosed that she was in a physically abusive relationship and that her partner had severe alcohol abuse problems. I listened to her concerns, and she stated that she had already reported the physical abuse to police and was safe and had family support. However, she also was very worried about her partner and wanting to support him from a distance. She said she would like to see if he would like an appointment to discuss any options open to himself. She was referred to a psychologist and internally to the alcohol and other drugs support counsellors for support as an affected family member. Her partner saw me separately (he was specifically offered to see someone else to avoid any conflict of treating both, but was firm he wanted to see me).

The outcome: He has done very well, is now taking medication for his mood, has been linked in with his own psychologist, has alcohol and other drug counselling and is taking medication to treat his addiction. There have been no further cases of violence or abuse towards his partner, and whilst they are not living together, she feels supported and her anxiety is now well under control. His mood is much improved, he has stopped drinking and is reconnecting with his family and slowly with his partner in a way she feels safe.

Aim 4: Learnings and recommendations

Key learnings

The findings presented throughout this report demonstrate that the DFV pilot has made steady progress towards achieving its aims of improving primary care DFV awareness and capacity, enhancing relationships and collaboration between the primary care and DFV sectors, increasing primary care sector referrals to DFV support services and improving the support experience and outcomes for DFV victim-survivors.

Despite the challenges of the COVID-19 pandemic (and other natural disasters), between July 2021 and November 2022, the six participating PHNs successfully delivered 225 DFV training sessions that were attended by over 1,700 primary care staff, including a wide range of both health professional and administrative staff. Overall, GPs were the largest attendee group, with 730 participating across all PHNs during the evaluation period, followed by 359 nurses and 311 administrative staff (including practice managers). In addition, system integrators achieved over 3,500 meaningful engagements across almost 800 general practices. These engagements had a heavy focus on relationship building but almost one-third involved providing general practices with DFV resources and/or general DFV advice.

There was also evidence of the DFV pilot supporting the care of DFV victim-survivors, with system integrators providing patient-specific advice on over 900 occasions, referral pathway advice on almost 700 occasions, and supporting GPs to make over 250 DFV victim-survivor referrals. System integrators also supported general practices with DFV-related quality improvement activities on almost 400 occasions. Participating PHNs were also active in a wide range of system influencing activities, including local interagency groups and various state-wide government initiatives and collaboratives.

The DFV pilot (and its various activities) was overwhelmingly perceived as valued, useful, important and needed, with evidence it is contributing towards an improved support experience and outcomes for DFV victim-survivors by: generating DFV awareness, understanding and insight; building DFV capacity, processes and confidence; establishing and embedding trust between GPs and DFV services; and increasing the number and quality of DFV referrals. Participating general practices provided very positive feedback about the various DFV pilot activities they had engaged with, considering them timely, of high quality, relevant for their work role and having improved their capacity and confidence to recognise and respond to DFV in a variety of ways. As in the interim report, the system integrators and the DFV-related training were considered to have had the greatest impact on enhancing the primary care sector's DFV capacity. Also in keeping with the interim report, training participants particularly appreciated the more interactive components (e.g.: role playing, case study discussions, hearing from multiple professional perspectives) and the practical tools provided or introduced during the trainings – e.g.: action plans, referral pathways).

The improved primary care sector DFV capacity was evident in respondents' pre-post training survey responses, with both the GRIPS (for health professionals) and a broad range of PHN-nominated DFV capacity indicators (for both health professionals and administrative staff) indicating statistically significant improvements across all indicators. Follow-up survey respondents considered the DFV pilot to be the main contributor to their improved DFV-related capacity, with the system integrators and the DFV-related trainings considered to have had the greatest impact.

Interviews with key stakeholders similarly identified many changes arising from the DFV pilot, most frequently in relation to building primary care sector DFV capacity and confidence and improving support quality (and referral numbers) for DFV victim-survivors but also in relation to enhancing relationships between primary care and DFV sectors, raising the profile of DFV in the primary care sector and improving outcomes for DFV

victim-survivors. However, interviewees also raised a need for improved feedback loops from DFV services to GPs about the outcomes of referrals made to them.

Stakeholder feedback indicated that the achievements of the DFV pilot were facilitated by a range of factors.

The primary factor was the nature of the DFV pilot's overall approach, including:

- Providing funding for system integrators and implementation activities, although the short-term nature of this funding also raised some challenges (as discussed below)
- The DFV pilot's flexible and collaborative implementation approach, with PHNs adapting their activity delivery around the needs and preferences of their local general practices
- The partnership approach which brought the primary care and DFV sectors together to affect system change
- The focus on working with whole practices (rather than individual GPs).

System integrators were also a key DFV pilot facilitator, with their expertise, persistence, passion and commitment to building trust and relationships with general practices frequently mentioned in stakeholder interviews. Interviewees also discussed how co-locating system integrators (in DFV services or general practices) enabled more integrated and collaborative care for DFV victim-survivors and how the PHNs' involvement helped substantially with giving the DFV pilot credibility and engaging GPs.

DFV pilot implementation was hampered by pre-existing primary care attitudes towards DFV and the time-poor nature of modern general practice (which was exacerbated by the COVID-19 pandemic and other natural disasters), issues of staff recruitment and retention, and by the relatively short implementation timeframe of the DFV pilot. Some PHNs reported a reluctance to encourage system integrators to take a more direct or involved role with practices due to concerns they would be unable to continue funding such a role when the pilot concluded. The latter challenge has now been overcome by the announcement that the DFV pilot has received additional funding for another four years, during which its reach and scope will be expanded.

In summary, the DFV pilot's progress has been achieved through varying approaches and activity combinations across the six participating PHNs, in response to local contexts, needs and primary care sector capacity and preferences. At this stage, there is not enough evidence to understand whether the different PHN models (or components of them) are more or less effective than others. However, the tailored place-based approach is considered a key factor in the DFV pilot's success to date and the following components have emerged as particularly valuable across multiple PHNs:

- Funding the system integrator role to work towards building relationships and actively engaging general practices
- Engaging DFV services to deliver the system integrator roles as a first step towards enhancing relationships and collaboration between the primary care and DFV sectors
- Delivering DFV-related training to whole practices (including administrative and allied health staff), rather than to individual GPs
- Providing relevant resources and practical tools as these helped solidify training outcomes and facilitate primary care sector practice changes
- Regular face-to-face contact with general practices (possibly through co-location of system integrators) to reinforce training outcomes and keep DFV on general practices' radar
- Providing some form of incentive (financial and/or continuing professional development (CPD) points) to encourage general practices to engage with DFV pilot activities.

Based on these key learnings and the detailed findings presented throughout this report, we make the following recommendations to enhance the ongoing implementation of the DFV initiative:

<p>1. Maintain the flexible implementation approach but consider establishing a common branding and key messages/ components for the ongoing DFV initiative</p>	<p>Learnings from the DFV pilot provide a solid foundation that can inform future implementation activities for the ongoing DFV initiative, which would benefit from a common branding and key messages or components across all participating PHNs. This would enable more consistent promotion and evaluation of the future implementation. However, there will still be an ongoing need for flexibility, collaboration and co-design (especially in new sites) to ensure they remain relevant to diverse communities.</p>
<p>2. Maintain the system integrator role and PHN involvement</p>	<p>The system integrators were critical in the general practice engagement and wide-ranging outcomes achieved by the DFV pilot and should remain a core element in the ongoing DFV initiative – to maintain already-established relationships and foster new ones. The PHN involvement was also important given their pre-existing relationships with GPs and their role in supporting general practice. PHNs and system integrators should consider forging relationships with peak bodies to get onto conference agendas to promote the DFV initiative and messages to a broader audience.</p>
<p>3. Prioritise face-to-face engagement with general practices</p>	<p>The increased use of face-to-face contact with general practices in this phase of the DFV pilot (compared to the reliance on other methods during the COVID-19 pandemic) facilitated relationship building and increased engagement with DFV pilot activities, including training, resources and system integrators. PHNs could consider co-locating their system integrators within DFV services and/or general practices as this was found beneficial in the PHNs trying it during the DFV pilot.</p>
<p>4. Continue to provide DFV training and explore additional training avenues</p>	<p>The DFV pilot has achieved considerably improved capacity among participating general practices but there are still many more practices to be engaged and upskilled, especially in relation to awareness of DFV as a health issue. Already-trained practices could also benefit from additional and/or refresher trainings in the future. PHNs and Health could also consider advocating for the inclusion of DFV training in RACGP professional development and relevant undergraduate and/or postgraduate health professional courses. Ideally, there should be coordination between the various government departments and other entities providing DFV-related training (e.g., Monash University’s pilot course on recognising and responding to sexual violence).</p>
<p>5. Explore options for incentivising general practice engagement</p>	<p>Given the primary challenge faced in implementation was engaging general practices, Health and PHNs should continue to explore options for incentivising and encouraging engagement. For example, three PHNs (HNECCPHN, NWMPHN and WVPHN) have used behavioural contracting techniques through the Practice Incentives Program (PIP) Quality Improvement (QI) Incentive to support general practice engagement with the DFV pilot.</p>

<p>6. Increase the focus on diverse community groups experiencing DFV</p>	<p>In response to stakeholder feedback in the interim report, some PHNs continued to tailor their approaches to meet the needs of priority population groups, such as Aboriginal and Torres Strait Islander, CALD, LGBTIQ+ and children. However, in a reflective workshop in late 2022, all PHNs identified a need for an increased focus on this going forward²². PHNs and Health should consider options that enable the model to support these diverse groups. This might include PHN collaboration on the evidence base and shared training, resources and support (learning from the work already undertaken in some PHNs). Health could also consider supporting training packages that take diversity and intersectionality into account. Where possible, Health should align these activities with <i>The National Plan to End Violence against Women and Children 2022-2032</i>.</p>
<p>7. Continue evaluating the DFV pilot and explore options for facilitating improvements in data systems and collection</p>	<p>The data challenges identified in the interim evaluation report remain, that is regarding collecting and accessing consistent and secure primary care administrative data that demonstrate the role they play in supporting DFV victim-survivors and the outcomes achieved in relation to integration with the DFV sector. Health should explore options for facilitating improvements in data systems and collection, to support the development of secure, integrated reporting systems that are embedded within primary care and specialist DFV services, and allow transparent access to de-identified information such as primary care referrals to specialist DFV services. The evaluator of the next phase should also refine the tools and processes developed for this evaluation to reduce the burden on PHNs and DFV services and facilitate access to real-time reporting.</p>

²² *Outcomes and Next Steps - PHN DFV Trial Workshop 13-14 Oct 2022.*

Appendices

Appendix A: Monitoring data collection tools

General Practice Training Tracker

Date	Practice code	Training Type	IF OTHER training - <i>please list name of training here</i>	Date of training	Mode of delivery	Pre-training survey distributed	GPs	Nurses	Allied Health staff	Practice Manager	Admin staff	Other	Any comments on the training - highlights and/or challenges

GP Engagement Tracker

		1. HOW AND BY WHO? <i>Select from drop-down menu</i>		2. WHICH PRACTICE STAFF WERE INVOLVED IN THE ENGAGEMENT? <i>Indicate the number of each staff type, where relevant</i>						3. WHAT HAPPENED IN THE ENGAGEMENT? <i>Indicate the number of each type of engagement, where relevant (please select as many as apply)</i> Please record any FORMAL training in the Training Tracker tab								
Date	Practice code	Contact mode	Who initiated contact?	GPs	Nurses	Allied Health staff	Practice Manager	Admin staff	Other	Relationship building <i>eg: catchups, drop-ins, followups, check-ins</i>	DFV Resource provision	QI activity support	General DFV advice / informal training	Referral Pathway advice <i>ie: NOT patient-specific</i>	Patient-specific DFV advice <i>eg: case consults, suggest referral options</i>	Supported GP to make referral - for individual patients	Safety Action Meeting (SAM) proposed	Other <i>Please specify (free text)</i>

Appendix B: Updated tracker guide (April 2021)

Meaningful engagements – Definitions for “What happened in the engagement?”

Response option	Definition
Relationship building	Includes: regular catchups/check-in or maintaining communication with practice; drop-in or follow-up visits; introducing system integrators to practices and staff (and providing their contact info); circulating general information of interest
DFV resource provision	Includes providing DFV-related information or flyers
QI activity support	Includes communication or tasks specific to quality improvement activities. Excludes related administrative activities (such as organising meetings, etc)
General DFV advice/ Informal training	Includes broader advice or information about DFV or instances where support or guidance was provided on DVSTAT/MARAM, mandatory reporting
Patient-specific DFV advice	Includes case-specific DFV advice, such as: case consultations; secondary consultations; action plans; safety plans; individual referral recommendations; post-referral feedback
General referral pathway advice	Instances broader advice where important contact numbers for DFV services and support services (e.g., service directories) were provided
Supporting GPs make referrals	Instances where system integrator have provided referrals forms and assisted GPs to complete these in relation to individual patients
Safety Action Meeting proposed	Instances where a Safety Action Meeting was proposed for an individual patient
Other	Other items not covered by the above codes. Free text option

Meaningful engagements – Definitions for “Did engagement result in any referrals/recommendations?”

Response option	Definition
Directly initiated referral by GP	Instances where GP has made a patient referral to DFV services and includes instances where DFV Navigators support GP in relation to referrals to services
Directly initiated referral by DFV Navigator	Instances where GPs refer to the DFV Navigator (where applicable in PHNs), and DFV Navigators making patient referrals to other services. <i>If this option is selected, provide additional details in the “Direct Local Linker referrals” spreadsheet</i>
YES - referral recommendation	Instances where DFV Navigator advised GP of recommended referral options

Appendix C: PHN Progress Report template

PHN DFV Pilot – Implementation Progress Update

This template is a living document which aims to capture key information about **how the DFV pilot was implemented in your PHN over the life of the initiative**. It includes our understanding of your progress and plans to date, based on your previous progress reports and interviews conducted during our interim evaluation. Please review and edit the existing information as needed and update all the yellow-highlighted sections. Add new rows for new roles/activities

SYSTEM INTEGRATION ROLE(S) – please include only those people PAID through Pilot funds

As reported in [CURRENT PERIOD] Progress Report				Any changes as at [CURRENT PERIOD]
Position (Organisation)	Role	FTE / Timeframe	Start date	

TRAINING/CAPACITY BUILDING ACTIVITIES – please include ALL activities (planned, underway & completed)

Name of training/capacity development activity	Brief description of training/activity	Delivery partner	Training Implementation Timeframe Start & finish	Frequency of delivery	Target Audience(s)

SYSTEM INFLUENCING ACTIVITIES – please include ALL activities (planned, underway & completed)

Name of activity	Brief description of training/activity	Stage of implementation (planned/ in progress/ complete)	Reflection about activity usefulness in terms of affecting system change Rating: 0= Not at all useful5= OK ... 10=Extremely useful AND please add a brief comment

IMPLEMENTATION HIGHLIGHTS – indicate highlights for this reporting period

IMPLEMENTATION CHALLENGES – indicate any challenges encountered for this reporting period, including any actions taken to address them

Appendix D: Pre-/Post-training surveys

Pre-training survey (health professionals)

Domestic and Family Violence Pilot: PRE-Training Survey

HEALTH PROFESSIONALS

Welcome to the Outcomes Survey for the Primary Health Network Domestic and Family Violence (DFV) Pilot currently underway across New South Wales, Queensland and Victoria. It will help us understand what people think about the DFV pilot, how helpful it is and how it could be better.

To access this survey online, scan this QR code



To help us link your responses across the two surveys, please answer these three questions. They can't be used to identify you.

1. What is your mother's maiden name?	
2. In which month were you born?	
3. What was the name of your first pet?	

The following questions ask about your background.

4. What is your MAIN profession? <i>Please select only ONE</i>	<input type="checkbox"/> Aboriginal & Torres Strait Islander Health Worker	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> GP	<input type="checkbox"/> Nurse	<input type="checkbox"/> Occupational Therapist
	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Physiotherapist	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Social Worker	<input type="checkbox"/> Speech Therapist
	<input type="checkbox"/> Other – <i>please specify:</i> _____				

5. How long have you been practising?	<input type="checkbox"/> Less than 5 years	<input type="checkbox"/> 6-10 years	<input type="checkbox"/> 11-20 years	<input type="checkbox"/> More than 20 years
----------------------------------------------	--------------------------------------------	-------------------------------------	--------------------------------------	---------------------------------------------

6. In which LGA is your practice based? <i>Please select only ONE</i>	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> Other – <i>please specify:</i> _____
---------------------------------------------------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------------------------------

The next set of questions ask you to think more generally about DFV.

		STRONGLY DISAGREE	DISAGREE	NEITHER/ VARIES	AGREE	STRONGLY AGREE
<p>7. Thinking about your ability to recognise and respond to DFV overall, how much do you agree or disagree with the following statements? Please tick ONE box for each statement</p>	a) I feel confident identifying patients' needs when they experience DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) When I suspect that my patients are experiencing DFV, I know what appropriate questions to ask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) I am able to recognise different kinds of clinical presentations of DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) I feel confident addressing DFV victims' concerns about their children's safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e) During consultations, I am able to pick up on cues given by patients who have been abused by their partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f) I have adequate counselling skills to support DFV victims	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g) I feel confident assessing whether my patients are safe to go home in an abusive situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h) I feel confident dealing with the uncertainty of the patient's situation when supporting those experiencing DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i) I do not have adequate knowledge of DFV issues to help patients being abused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	j) I am confident that I can locate resources (such as community agencies, referral services) for patients who experience DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	k) I feel comfortable asking patients who I have known for some time about DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	l) I am alert to the possibility that my patients may have experienced DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	m) I am hesitant to ask patients about DFV at their first visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	n) I am willing to arrange a follow-up appointment to provide support to patients experiencing DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	o) I am concerned about my patients as fellow human beings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	p) I want to be there for patients who have been abused by their partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	q) DFV is a private relationship issue between partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	r) It is totally up to the patient to initiate the discussion about DFV in a consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	s) I regard DFV as an issue related to the violation of human rights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	t) Pointing out the unacceptability of DFV can help patients put things into perspective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	u) I find myself getting emotional when dealing with DFV issues in my practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	v) Listening to patients' experiences of DFV makes me feel overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	w) I am concerned about being emotionally traumatised by discussing DFV issues with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	x) I know how to deal with my own emotions when encountering DFV issues in my practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	y) I feel awkward discussing DFV issues with my patients if their partners are also my patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	z) I feel shocked when my patients disclose DFV to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	aa) The gender of a GP matters to patients when discussing DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bb) I feel that I have let my patients down if I just listen to their problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	cc) I feel powerless to alleviate the suffering of my patients who experience DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	dd) I have learned not to take on patients' DFV issues to the point where they can get me down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		STRONGLY DISAGREE	DISAGREE	NEITHER/VARIES	AGREE	STRONGLY AGREE
•	•					
	ee) I trust DFV services will appropriately support my patients following referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ff) I am confident that I will be kept informed about outcomes of referrals so I can continue to provide the best care for my patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions ask you to think about the DFV-related training.

8. Which of the following DFV trainings are you enrolled to attend? [INSERT TRAINING NAME] [INSERT TRAINING NAME] Other – *please specify*: _____

9. When are you scheduled to attend this training?
 • Please give the exact date (or dates), if possible.

10. Have you received any *other* training for DFV in the last 5 years? Yes No I'm not sure

Finally, a couple of questions to group your answers.

11. Which age group do you fit into? Under 20 years 20s 30s 40s 50s 60+ years

12. Which gender do you identify with? Female Male Non-binary/ Other Prefer not to answer

THANK YOU VERY MUCH – FOR TAKING THE TIME TO ANSWER THESE QUESTIONS

Pre-training survey (administration staff)

Domestic and Family Violence Pilot: PRE-Training Survey

ADMINISTRATION STAFF

Welcome to the Outcomes Survey for the Primary Health Network Domestic and Family Violence (DFV) Pilot initiative currently underway across New South Wales, Queensland and Victoria.

It will help us understand what people think about the training, how helpful it is and how it could be better.

To access this survey online, scan this QR code



To help us link your responses across the two surveys, please answer these three questions. They can't be used to identify you.

1. What is your mother's maiden name?
2. In which month were you born?
3. What was the name of your first pet?

The following questions ask about your background.

4. What is your MAIN profession?
Please select only ONE
- Administration
 Practice Manager
 Receptionist
 Other – please specify: _____
5. In which LGA is your practice based?
Please select only ONE
- [INSERT LGA]
 [INSERT LGA]
 [INSERT LGA]
 [INSERT LGA]
 Other – please specify: _____

The next set of questions ask you to think more generally about DFV.

		STRONGLY DISAGREE	DISAGREE	NEITHER/VARIES	AGREE	STRONGLY AGREE
6. Thinking about your ability to recognise and respond to DFV overall, how much do you agree or disagree with the following statements? • Please tick ONE box for each statement	a) I feel confident identifying patients' needs when they experience DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) When I suspect patients are experiencing DFV, I know the appropriate questions to ask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) I am confident that I can locate information about support services for patients who experience DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) I have a good understanding of DFV and its impact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Thinking about your ability to recognise and respond to DFV overall, how much do you agree or disagree with the following statements? • Please tick ONE box for each statement	a) I understand who to contact if I need advice on how and where to refer patients if they disclose DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) I feel confident appropriately recording DFV in our practice/service's clinical software	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) I understand how to appropriately bill a patient who is experiencing DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) I feel the DFV service sector understands the challenges health professionals face when responding to DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	e) I understand the point of view of patients who have experienced DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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The following questions ask you to think about the DFV-related training.

8. Which of the following DFV trainings are you enrolled to attend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other – <i>please specify</i> : _____
	[INSERT TRAINING NAME]	[INSERT TRAINING NAME]		

9. When are you scheduled to attend this training?	
• Please give the exact date (or dates), if possible.	

10. Have you received any <i>other</i> training for DFV in the <u>last 5 years</u> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	I'm not sure

Finally, a couple of questions to group your answers.

11. Which age group do you fit into?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Under 20 years	20s	30s	40s	50s	60+ years

12. Which gender do you identify with?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Female	Male	Non-binary/ Other	Prefer not to answer

THANK YOU VERY MUCH – FOR TAKING THE TIME TO ANSWER THESE QUESTIONS

Post-training survey (health professionals)

Domestic and Family Violence Pilot: POST-Training Survey HEALTH PROFESSIONALS

Welcome to the Outcomes Survey for the Primary Health Network Domestic and Family Violence (DFV) Pilot currently underway across New South Wales, Queensland and Victoria.

It will help us understand what people think about the DFV pilot, how helpful it is and how it could be better.

To access this survey
online, scan this QR code



To help us link your responses across the two surveys, please answer the following questions. They can't be used to identify you.

1. What is your mother's maiden name?
2. In which month were you born?
3. What was the name of your first pet?

The following questions ask about your background.

4. What is your MAIN profession? <i>Please select only ONE</i>	<input type="checkbox"/> Aboriginal & Torres Strait Islander Health Worker	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> GP	<input type="checkbox"/> Nurse	<input type="checkbox"/> Occupational Therapist
	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Physiotherapist	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Social Worker	<input type="checkbox"/> Speech Pathologist
	<input type="checkbox"/> Other – <i>please specify:</i> _____				
5. How long have you been practising in this profession?	<input type="checkbox"/> Less than 5 years	<input type="checkbox"/> 6-10 years	<input type="checkbox"/> 11-20 years	<input type="checkbox"/> More than 20 years	
6. In which LGA is your practice based? <i>Please select only ONE</i>	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> Other – <i>please specify:</i> _____

The next set of questions ask you to think more generally about DFV.

		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
<p>7. Thinking about your ability to recognise and respond to DFV overall, how much do you agree or disagree with the following statements?</p> <p><i>Please tick ONE box for each statement</i></p>	a) I feel confident identifying patients' needs when they experience DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) When I suspect that my patients are experiencing DFV, I know what appropriate questions to ask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) I am able to recognise different kinds of clinical presentations of DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) I feel confident addressing DFV victims' concerns about their children's safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e) During consultations, I am able to pick up on cues given by patients who have been abused by their partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f) I have adequate counselling skills to support DFV victims	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g) I feel confident assessing whether my patients are safe to go home in an abusive situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h) I feel confident dealing with the uncertainty of the patient's situation when supporting those experiencing DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i) I do not have adequate knowledge of DFV issues to help patients being abused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	j) I am confident that I can locate resources (such as community agencies, referral services) for patients who experience DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	k) I feel comfortable asking patients who I have known for some time about DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	l) I am alert to the possibility that my patients may have experienced DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	m) I am hesitant to ask patients about DFV at their first visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	n) I am willing to arrange a follow-up appointment to provide support to patients experiencing DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	o) I am concerned about my patients as fellow human beings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	p) I want to be there for patients who have been abused by their partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	q) DFV is a private relationship issue between partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	r) It is totally up to the patient to initiate the discussion about DFV in a consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	s) I regard DFV as an issue related to the violation of human rights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	t) Pointing out the unacceptability of DFV can help patients put things into perspective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	u) I find myself getting emotional when dealing with DFV issues in my practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	v) Listening to patients' experiences of DFV makes me feel overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	w) I am concerned about being emotionally traumatised by discussing DFV issues with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	x) I know how to deal with my own emotions when encountering DFV issues in my practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	y) I feel awkward discussing DFV issues with my patients if their partners are also my patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	z) I feel shocked when my patients disclose DFV to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	aa) The gender of a GP matters to patients when discussing DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bb) I feel that I have let my patients down if I just listen to their problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
cc) I feel powerless to alleviate the suffering of my patients who experience DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dd) I have learned not to take on patients' DFV issues to the point where they can get me down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ee) I trust DFV services will appropriately support my patients following referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ff) I am confident that I will be kept informed about outcomes of referrals so I can continue to provide the best care for my patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions ask you to think about the DFV-related training.

8. Which of the following DFV trainings are you enrolled to attend? [INSERT TRAINING NAME] [INSERT TRAINING NAME] Other – *please specify*: _____

9. When did you attend this DFV training?
Please give the exact date (or dates), if possible.

10. Have you received any *other* training for DFV in the last 5 years? Yes No I'm not sure

11. How would you rate your recent DFV training in relation to... : Please CIRCLE your preferred rating for each		EXTREMELY POOR				OK / It VARIES				EXCELLENT			
		0	1	2	3	4	5	6	7	8	9	10	
a) The quality of the training		0	1	2	3	4	5	6	7	8	9	10	
b) The relevance of the training for your role in the practice/service		0	1	2	3	4	5	6	7	8	9	10	

12. To what extent did your recent DFV training help with improving the following? Please CIRCLE your preferred rating for each		NOT AT ALL				SOMEWHAT				VERY MUCH SO			
		0	1	2	3	4	5	6	7	8	9	10	
a) Your ability to adopt clear and concise referral pathways between your practice/service and local DFV services		0	1	2	3	4	5	6	7	8	9	10	
b) Your ability to reflect on your attitudes towards DFV		0	1	2	3	4	5	6	7	8	9	10	
c) Your confidence accessing up to date evidence regarding DFV		0	1	2	3	4	5	6	7	8	9	10	
d) Your understanding of the prevalence of DFV		0	1	2	3	4	5	6	7	8	9	10	
e) Your awareness of the barriers to disclosing and/or leaving DFV situations		0	1	2	3	4	5	6	7	8	9	10	
f) Your ability to recognise the signs of DFV		0	1	2	3	4	5	6	7	8	9	10	
g) Your confidence to respond appropriately to patients experiencing DFV		0	1	2	3	4	5	6	7	8	9	10	

13. What did you find most useful about your recent DFV training?

14. What did you find least useful about your recent DFV training?

15. Will you do anything differently in your practice/service as a result of your recent DFV training?
If YES, please provide an example

Finally, the following questions to help us group your answers.

16. Which age group do you fit into?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Under 20 years	20s	30s	40s	50s	60+ years

17. Which gender do you identify with?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female	Male	Non-binary/ Other	Prefer not to answer

THANK YOU VERY MUCH – FOR TAKING THE TIME TO ANSWER THESE QUESTIONS

Post-training survey (administration staff)

Domestic and Family Violence Pilot: POST-Training Survey ADMINISTRATION STAFF

Welcome to the Outcomes Survey for the Primary Health Network Domestic and Family Violence (DFV) Pilot currently underway across New South Wales, Queensland and Victoria.

It will help us understand what people think about the DFV pilot, how helpful it is and how it could be better.

To access this survey online, scan this QR code



To help us link your responses across the two surveys, please answer these three questions. They can't be used to identify you.

1. What is your mother's maiden name?	
2. In which month were you born?	
3. What was the name of your first pet?	

The following questions ask about your background.

4. What is your MAIN profession? <i>Please select only ONE</i>	<input type="checkbox"/> Practice Manager	<input type="checkbox"/> Receptionist	<input type="checkbox"/> Administration	<input type="checkbox"/> Other – <i>please specify:</i> _____
5. How long have you been practising in this profession?	<input type="checkbox"/> Less than 5 years	<input type="checkbox"/> 6-10 years	<input type="checkbox"/> 11-20 years	<input type="checkbox"/> More than 20 years
6. In which LGA is your practice based? • Please select only ONE	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA] <i>Other – please specify:</i> _____

The next set of questions ask you to think more generally about DFV.

		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
7. How much do you agree or disagree with the following statements? • Please tick ONE box for each statement	a) I feel confident identifying patients' needs when they experience DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) When I suspect patients are experiencing DFV, I know the appropriate questions to ask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) I am confident that I can locate information about support services for patients who experience DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) I have a good understanding of DFV and its impact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	8. How much do you agree or disagree with the following statements? • Please tick ONE box for each statement	a) I understand who to contact if I need advice on how and where to refer patients if they disclose DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) I feel confident appropriately recording DFV in our practice/service's clinical software	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

c) I understand how to appropriately bill a patient who is experiencing DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I feel the DFV service sector understands the challenges health professionals face when responding to DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I understand the point of view of patients who have experienced DFV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions ask you to think about the DFV-related training.

9. Which of the following DFV trainings are you enrolled to attend? [INSERT TRAINING NAME] [INSERT TRAINING NAME] Other – *please specify*: _____

10. When did you attend this training?
 • Please give the exact date (or dates), if possible.

11. Have you received any *other* training for DFV in the last 5 years? Yes No I'm not sure

12. How would you rate your recent DFV training in relation to... : Please CIRCLE your preferred rating for each		EXTREMELY POOR				OK / IT VARIES				EXCELLENT		
		0	1	2	3	4	5	6	7	8	9	10
a) The quality of the training		0	1	2	3	4	5	6	7	8	9	10
b) The relevance of the training for your role in the practice		0	1	2	3	4	5	6	7	8	9	10

13. To what extent did your recent DFV training help with improving the following? Please CIRCLE your preferred rating for each		NOT AT ALL				SOMEWHAT				VERY MUCH SO			
		0	1	2	3	4	5	6	7	8	9	10	
a) Your ability to reflect on your attitudes towards DFV		0	1	2	3	4	5	6	7	8	9	10	
b) Your confidence accessing up to date evidence regarding DFV		0	1	2	3	4	5	6	7	8	9	10	
c) Your understanding of the prevalence of DFV		0	1	2	3	4	5	6	7	8	9	10	
d) Your awareness of the barriers to disclosing and/or leaving DFV situations		0	1	2	3	4	5	6	7	8	9	10	
e) Your ability to recognise the signs of DFV		0	1	2	3	4	5	6	7	8	9	10	
f) Your confidence to respond appropriately to patients experiencing DFV		0	1	2	3	4	5	6	7	8	9	10	

14. What did you find most useful about your recent DFV training?

15. What did you find least useful about your recent the DFV training?

16. Will you do anything differently in your practice/service as a result of your recent DFV training?
 • If **YES**, please provide an example

Finally, a couple of questions to help us group your answers.

17. Which age group do you fit into?

Under 20 years

20s

30s

40s

50s

60+ years

18. Which gender do you identify with?

Female

Male

Non-binary/ Other

Prefer not to answer

THANK YOU VERY MUCH – FOR TAKING THE TIME TO ANSWER THESE QUESTIONS

Appendix E: Follow-up survey

Survey introduction

<Brief blurb about the DFV pilot initiative>

1. Are you aware of the DFV Pilot initiative?
 - Yes
 - No → **END SURVEY**
2. Have you been involved with the DFV Pilot Initiative in any of the following ways? **SELECT AS MANY AS APPLY**
 - Attended DFV-related training events organised by your local PHN (e.g., Recognise Respond Refer)
 - Accessed DFV-related resources distributed by your local PHN (e.g., XX)
 - Participated in DFV-related quality improvement or capacity building activities in your practice/service (e.g., XX)
 - Received support from your local DFV support worker (e.g., DV Navigator, DV Local Link, DFV Link, DFV Linker or Family Violence Connector) for advice or support (e.g.: with referral pathways, case consultations)
 - No, I have had no involvement → **END SURVEY**
3. In which PHN is your practice/service based?

<input type="checkbox"/> Brisbane South PHN	<input type="checkbox"/> Central & Eastern Sydney PHN
<input type="checkbox"/> Hunter New England & Central Coast PHN	<input type="checkbox"/> Nepean Blue Mountains PHN
<input type="checkbox"/> North West Melbourne PHN	<input type="checkbox"/> Western Victoria PHN
4. In which of the LGAs is your practice/service based?

<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]	<input type="checkbox"/> [INSERT LGA]
---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------
5. Which best describes your practice/service?

<input type="checkbox"/> Solo GP	<input type="checkbox"/> Multi-practice GP (2-5 GPs)
<input type="checkbox"/> Multi-practice GP (6-10 GPs)	<input type="checkbox"/> Multi-practice GP (11+ GPs)
<input type="checkbox"/> Allied health service	<input type="checkbox"/> Other, please specify: _____
6. Which best describes your MAIN role within your practice/service?

<input type="checkbox"/> Administrative – e.g., receptionist	<input type="checkbox"/> Practice Manager
<input type="checkbox"/> GP	<input type="checkbox"/> Nurse
<input type="checkbox"/> Allied Health Practitioner – e.g., OT, Speech Pathologist, Physiotherapist, Social Worker, Chiropractor, Psychologist	
<input type="checkbox"/> Other practitioner role, please specify: _____	
7. How long have you been practising in this role (in any practice/service)?

<input type="checkbox"/> Less than 5 years	<input type="checkbox"/> 5-10 years
<input type="checkbox"/> 11-20 years	<input type="checkbox"/> More than 20 years

Training attendance and feedback

(ONLY APPEARS IF “Attended DFV-related training events” IS SELECTED IN QUESTION 2)

8. Which of the following DFV-related trainings did you attend? **SELECT AS MANY AS APPLY**

<input type="checkbox"/> [INSERT TRAININGS]	<input type="checkbox"/> Other (please specify)
---------------------------------------------	-------------------------------------------------
9. How would you rate this DFV-related training in relation to...
PLEASE SELECT ONE ANSWER FOR EACH SUPPORT – APPEARS FOR EACH RESPONSE OPTION SELECTED IN Q8

	Terrible					OK					Excellent				
a) The quality of training	0	1	2	3	4	5	6	7	8	9	10				
b) It's relevance for your role in the practice/service	0	1	2	3	4	5	6	7	8	9	10				

10. Have you been able to apply this DFV-related training in your work?

<input type="checkbox"/> No, I haven't had the opportunity to	→ GO TO QUESTION 12
<input type="checkbox"/> No, I wasn't comfortable to	→ GO TO QUESTION 12
<input type="checkbox"/> Yes, once or twice	→ GO TO QUESTION 11
<input type="checkbox"/> Yes, a few times	→ GO TO QUESTION 11
<input type="checkbox"/> Yes, many times	→ GO TO QUESTION 11
11. Could you please give a brief example of how you've applied the DFV-related training in your practice.

Resource use and feedback

(ONLY APPEARS IF “Accessed DFV-related resources” IS SELECTED IN QUESTION 2)

12. Which of the following DFV-related resources have you used? **SELECT AS MANY AS APPLY**

- Resource 1 Resource 2
 Resource 3 Add more as needed

13. How useful have you found these resources in your work?

DRAG THE RED BUTTON TO YOUR PREFERRED RATING FOR EACH RESOURCE (SHOWS THOSE SELECTED IN Q12)

	Not at all				Somewhat				Extremely		
a) Resource 1	0	1	2	3	4	5	6	7	8	9	10
b) Resource 2	0	1	2	3	4	5	6	7	8	9	10
c) Resource 3	0	1	2	3	4	5	6	7	8	9	10
d) Add more as needed	0	1	2	3	4	5	6	7	8	9	10

Quality improvement and capacity building activity participation and feedback

(ONLY APPEARS IF “Participated in DFV-related quality improvement or capacity building activities” IS SELECTED IN QUESTION 2)

14. Which of the following DFV-related quality improvement or capacity building activities did you participate in? **SELECT AS MANY AS APPLY**

- QI/CB activity 1 QI/CB activity 2
 QI/CB activity 3 Add more as needed

15. How useful have you found these quality improvement or capacity building activities in your work?

DRAG THE RED BUTTON TO YOUR PREFERRED RATING FOR EACH ACTIVITY (SHOWS THOSE SELECTED IN Q14)

	Not at all				Somewhat				Extremely		
a) QI/CB activity 1	0	1	2	3	4	5	6	7	8	9	10
b) QI/CB activity 2	0	1	2	3	4	5	6	7	8	9	10
c) QI/CB activity 3	0	1	2	3	4	5	6	7	8	9	10
d) Add more as needed	0	1	2	3	4	5	6	7	8	9	10

System integrator access and feedback

(ONLY APPEARS IF “Received support from local DFV support worker” IS SELECTED IN QUESTION 2)

The following questions ask about your experience of the dedicated DFV support worker recruited to support health professionals in relation to DFV as part of this DFV Pilot Initiative (you may know them as a DV Navigator, DV Local Link, DFV Link, DFV Linker or Family Violence Connector).

16. In the last year, how often have you used the following DFV support worker functions?

SELECT ONE ANSWER FOR EACH STATEMENT

	Never	1-2 times	3-5 times	10+ times
a) General advice about supporting patients experiencing DFV (HEALTH PROFESSIONALS ONLY)	0	1	2	3
b) Advice about specific patients who were at risk, or experiencing DFV (e.g., case consultations) (HEALTH PROFESSIONALS ONLY)	0	1	2	3
c) Support with referring patients experiencing DFV to relevant support services (HEALTH PROFESSIONALS ONLY)	0	1	2	3
d) Referred patients directly to DFV support worker	0	1	2	3
e) Advice about planning & implementing better DFV policies & practices	0	1	2	3
f) Support with DFV-related quality improvement activities	0	1	2	3
g) Support to develop clear & concise referral processes for clients impacted by DFV	0	1	2	3
h) Building better working relationships with local DFV services	0	1	2	3

17. How would you rate this DFV-related training in relation to... *SELECT ONE ANSWER FOR EACH STATEMENT*

	Terrible			OK				Excellent			
a) The quality of support you've received	0	1	2	3	4	5	6	7	8	9	10
b) The timeliness of the support you've received	0	1	2	3	4	5	6	7	8	9	10

18. How much do you agree with the following statements about your local DFV support worker?

SELECT ONE ANSWER FOR EACH STATEMENT

	Not at all			Somewhat				Very much so			
a) I feel comfortable referring my patients to them (HEALTH PROFESSIONALS ONLY)	0	1	2	3	4	5	6	7	8	9	10
b) They have supported me to make appropriate referrals for patients disclosing DFV (HEALTH PROFESSIONALS ONLY)	0	1	2	3	4	5	6	7	8	9	10
c) I am confident in their ability to make appropriate referrals for my patients (HEALTH PROFS ONLY)	0	1	2	3	4	5	6	7	8	9	10
d) They keep me informed about outcomes of referrals so I can continue to provide the best care for my patients (HEALTH PROFESSIONALS ONLY)	0	1	2	3	4	5	6	7	8	9	10
e) They understand the challenges health professionals face when responding to DFV	0	1	2	3	4	5	6	7	8	9	10
f) I feel supported by them in the work I do	0	1	2	3	4	5	6	7	8	9	10
g) Having access to them has been a big relief	0	1	2	3	4	5	6	7	8	9	10
h) They have helped our practice/service respond to DFV	0	1	2	3	4	5	6	7	8	9	10
i) They help with managing the vicarious trauma associated with this work	0	1	2	3	4	5	6	7	8	9	10

DFV Pilot impact on capacity

Thinking about the DFV Pilot Initiative as a whole (including the resources, training, quality improvement and capacity building activities, as well as the local DFV support worker)

19. To what extent do you think the DFV Pilot Initiative has helped with improving the following?

SELECT ONE ANSWER FOR EACH STATEMENT

	Not at all			Somewhat				Very much so			
a) Your understanding of DFV and its impacts	0	1	2	3	4	5	6	7	8	9	10
b) Your ability to recognise the signs of DFV	0	1	2	3	4	5	6	7	8	9	10
c) Your awareness of the barriers to disclosing and/or leaving DFV situations	0	1	2	3	4	5	6	7	8	9	10
d) Knowing what to ask when you suspect patients are experiencing DFV (HEALTH PROFS ONLY)	0	1	2	3	4	5	6	7	8	9	10
e) Your confidence to identify the needs of patients experiencing DFV (HEALTH PROFS ONLY)	0	1	2	3	4	5	6	7	8	9	10
f) Your awareness of local services that can support people experiencing DFV	0	1	2	3	4	5	6	7	8	9	10
g) Your understanding of the role of specialist DFV services in supporting people experiencing DFV	0	1	2	3	4	5	6	7	8	9	10
h) Your relationship with local DFV and other support services	0	1	2	3	4	5	6	7	8	9	10
i) Your ability to develop clear, concise referral pathways between your practice/service and local DFV services (HEALTH PROFS ONLY)	0	1	2	3	4	5	6	7	8	9	10
j) Your skills and knowledge of DFV risk assessment & management (HEALTH PROFS ONLY)	0	1	2	3	4	5	6	7	8	9	10
k) Your awareness of population groups at increased risk of DFV	0	1	2	3	4	5	6	7	8	9	10
l) The ease with which patients experiencing DFV can access support	0	1	2	3	4	5	6	7	8	9	10

20. To what extent have the following DFV Pilot Initiative components contributed to improving your capacity to recognise and respond to DFV? **SELECT ONE ANSWER FOR EACH STATEMENT**

	Not at all	Maybe a little	Minor contribution	Moderate contribution	Major contribution
a) Your recent DFV training (<i>ONLY APPEARS IF SELECTED IN Q2</i>)	0	1	2	3	4
b) The DFV-related resources you've accessed (<i>ONLY APPEARS IF SELECTED IN Q2</i>)	0	1	2	3	4
c) The DFV-related quality improvement activities you've participated in (<i>ONLY APPEARS IF SELECTED IN Q2</i>)	0	1	2	3	4
d) The other DFV-related capacity building activities you've engaged with (<i>ONLY APPEARS IF SELECTED IN Q2</i>)	0	1	2	3	4
e) Support you've received from your local DFV support worker (<i>ONLY APPEARS IF SELECTED IN Q2</i>)	0	1	2	3	4
f) Other factors (please specify):	0	1	2	3	4

21. What has been the biggest impact on your ability to recognise and respond to DFV?

22. Do you have any suggestions for how the DFV Pilot initiative could be improved or any other comments about additional supports needed?

Respondent characteristics

Finally a few questions to help us group your answers.

23. Which age group do you fit into?

- Less than 20 years 20-29 years 30-39 years
 40-49 years 50-59 years 60 years or older
 Prefer not to answer

24. Which gender do you identify with?

- Female Male Non-binary, Other Prefer not to answer

25. Do you speak a language other than English at home?

- No, only English
 Yes, please specify: _____
 Prefer not to answer

Thank you

We thank you for your time spent taking this survey. Your response has been recorded.

Appendix F: Interview Discussion Guides

PHN Operational Staff

Theme	Question	Prompt
Role	1. Can you tell me about your role in relation to implementing the initiative?	What were your responsibilities, day-to-day activities like? What factors helped or hindered you in doing your role?
Process evaluation	2. Can you describe how the initiative is being implemented in your PHN?	What activities have been implemented? What resources have you used?
	3. What do you see as the key barriers and enablers for implementation?	What worked less well? Why? What worked well? Why?
System integrator – reflections	4. In your opinion, how effective do you feel the system integration role has been?	how have they engaged with general practices?
	5. What do you see as the key barriers and enablers for the system integration role?	What worked well? Why? What worked less well? Why?
<i>I'd like to know more about what you think some of the impacts the initiative has had...</i>		
Outcomes – Overall	6. What do you think has been the most significant change overall as a result of this initiative?	Why? Were there any factors that were key to achieving this?
	7. Have there been any other outcomes that have been achieved to date (expected or unexpected)?	For example, an improvement/ increase in: <ul style="list-style-type: none"> - GP referrals to local specialist DFV services? - Greater collaboration between primary care and DFV services - Understanding or trust among GP practices of the role of specialist DFV services in supporting people who experience DFV? - Understanding among DFV services of the role of primary care in supporting people who experience DFV - GP confidence to support people who experience DFV? - Capacity of general practices to support priority populations such as Aboriginal and Torres Strait Islander, CALD, refugee/migrant women, people with a disability, LGBTIQ+?
	8. Thinking about your previous answer, which activities do you think has contributed most to these changes?	What action has helped create change? What activities have stakeholders been most responsive to?
	9. Are there any other intended outcomes that haven't yet been realised?	Why? Were there any barriers to achieving this?
Sustainability	10. In your opinion, what parts of the initiative are most likely to have a long-term benefit or be sustainable?	Any activities that will continue beyond the initiative?
	11. What do you think are the enablers of ensuring the sustainability of the initiative?	For example: secure funding? Adequate resources? System integrator role?
	12. Based on your experience so far, do you have any recommendations for how the model could be improved in terms of delivering an initiative of this sort?	Do you have any suggestions for future delivery of the initiative?
Final comments	13. Do you have any last comments about the initiative?	

System Integrator

Theme	Question	Prompt
Role	1. How long have you been in your current position as a [system integration role – insert name from key]?	Have you been in this role since the start of the initiative?
	2. Can you tell me about your role?	What do your day-to-day activities look like?
System integrator – reflections	3. How have you found the experience of working in this [system integration role – insert name from key] role?	What went particularly well? Anything you found particularly challenging? Could your role be improved for the future?
I'd like to know more about the engagements you've had with other stakeholder groups involved in the initiative...		
GP and practice staff – reflections	4a. Firstly, did you have any engagement with GPs and practice staff? <i>If not already covered:</i> What types of support do you provide to GPs and practice staff? (e.g., networking meetings, CoPs, advocacy, development of training/courses), what was the level of engagement like	How did they engage with you (and vice versa)? How often did they engage with you (and vice versa)?
	4b. What do you see as the key enablers and barriers to engaging with GPs/practice staff?	Was there anything that helped with engagement? Or anything that made it more difficult? How could this be improved?
• DFV services – reflections	5a. Now thinking about your engagement with specialist DFV services, can you tell me how your experience has been? Clarify how it worked with the DFV organisations they work with, versus other DFV services	How did they engage with you (and vice versa)? How often did they engage with you (and vice versa)?
	5b. What do you see as the key enablers and barriers to engaging with specialist DFV services?	Was there anything that helped with engagement? Or anything that made it more difficult? How could this be improved?
I'd like to know more about what you think some of the impacts the initiative has had...		
• Outcomes	6. What do you think has been the most significant change overall as a result of this initiative?	Why? Were there any factors that were key to achieving this? Do you think [system integration role – insert name from key] have played a key part in this change?
	7. Have there been any other outcomes that have been achieved to date (expected or unexpected)?	For example, an improvement/ increase in: <ul style="list-style-type: none"> - GP referrals to local specialist DFV services? - Greater collaboration between primary care and DFV services - Understanding or trust among GP practices of the role of specialist DFV services in supporting people who experience DFV? - Understanding among DFV services of the role of primary care in supporting people who experience DFV - GP confidence to support people who experience DFV? - Capacity of general practices to support priority populations such as Aboriginal and Torres Strait Islander,

Theme	Question	Prompt
		CALD, refugee/migrant women, people with a disability, LGBTIQ+?
	8. Thinking about your previous answer, which activities do you think has contributed most to these changes?	What action has helped create change? What activities have stakeholders been most responsive to?
	9. Are there any other intended outcomes that haven't yet been realised?	Why? Were there any barriers to achieving this?
Sustainability	10. In your opinion, what parts of the initiative are most likely to have a long-term benefit or be sustainable?	Any activities that will continue beyond the initiative?
	11. What do you think are the enablers of ensuring the sustainability of the initiative?	For example: secure funding? Adequate resources? System integrator role?
	12. Based on your experience so far, do you have any recommendations for how the model could be improved in terms of delivering an initiative of this sort?	Do you have any suggestions for future delivery of the initiative?
Final comments	13. Do you have any last comments about the initiative?	

DFV Service Staff

Theme	Question	Prompt
Role	1. Can you tell me about your role in the service?	What do you do?
	2. What type of support does your service generally provide to victim survivors?	
<i>I'd like to know more about the engagements you've had with other stakeholder groups involved in the initiative...</i>		
System integrator – reflections	3. How has your experience with the [system integration role – insert name from key] role been?	What has worked well? Any challenges?
	4. Could the function of the [system integration role – insert name from key] role be improved?	If yes, how?
GP and practice staff – reflections	5. Have you had any engagement with GPs and practice staff?	How did they engage with you (and vice versa)? How often did they engage with you (and vice versa)?
	6. What do you see as the key enablers and barriers to engaging with GPs/practice staff?	Was there anything that helped with engagement? Or anything that made it more difficult? How could this be improved?
	7. Do you think your understanding of the role of primary care in supporting people who experience DFV has changed since the initiative?	Are you more aware of the processes involved for a GP?
<i>I'd like to know more about what you think some of the impacts the initiative has had...</i>		
System influencing activities – reflections	8a. Do you think there has been an increase in the number of referrals from GPs to your service since the initiative started?	If yes, how many (per month)? If no, why not?
	8b. <i>If yes to 8a...</i> Has this increase in referrals from GPs had an impact on your service?	If so, how? For example, has your workload increased?

Theme	Question	Prompt
	8c. <i>If yes to 8a...</i> Do you feel that your service is adequately resourced to manage the presenting caseload of victim-survivors?	What could be improved? What resources are needed to successfully manage the caseload?
	9. As part of routine practice, does your service report back to GPs about the outcome of their referrals?	If yes, how has this process been? If no, why?
Outcomes	10. What do you think has been the most significant change overall as a result of this initiative?	Why? Were there any factors that were key to achieving this? For example strengthening partnerships between primary care the DFV sector
	11. Have there been any other outcomes that have been achieved to date (expected or unexpected)?	For example, an improvement/ increase in: <ul style="list-style-type: none"> - GP referrals to local specialist DFV services? - Greater collaboration between primary care and DFV services - Understanding or trust among GP practices of the role of specialist DFV services in supporting people who experience DFV? - Understanding among DFV services of the role of primary care in supporting people who experience DFV - GP confidence to support people who experience DFV? - Capacity of general practices to support priority populations such as Aboriginal and Torres Strait Islander, CALD, refugee/migrant women, people with a disability, LGBTIQ+?
Sustainability	12. In your opinion, what parts of the initiative are most likely to have a long-term benefit or be sustainable?	Any activities that will continue beyond the initiative?
	13. What do you think are the enablers of ensuring the sustainability of the initiative?	For example: secure funding? Adequate resources? System integrator role?
Final comments	14. Do you have any last comments about the initiative?	

Other Key Stakeholders

Theme	Question	Prompt
Role	1. Can you tell me about your role in relation to the initiative?	What were your responsibilities? How were you engaged to be involved?
	2. How has your experience been during the initiative, working in this role?	What went particularly well? Anything you found particularly challenging? Could your role be improved for the future?
<i>I'd like to know more about what you think some of the impacts the initiative has had...</i>		
Outcomes – Overall	3. What do you think has been the most significant change overall as a result of this initiative?	Why? Were there any factors that were key to achieving this?
	4. Have there been any other outcomes that have been achieved to date (expected or unexpected)?	For example, an improvement/ increase in: <ul style="list-style-type: none"> - GP referrals to local specialist DFV services? - Greater collaboration between primary care and DFV services? - Understanding or trust among GP practices of the role of specialist DFV services in supporting people who experience DFV?

Theme	Question	Prompt
		<ul style="list-style-type: none"> - Understanding among DFV services of the role of primary care in supporting people who experience DFV? - GP confidence to support people who experience DFV? - Capacity of general practices to support priority populations such as Aboriginal and Torres Strait Islander, CALD, refugee/migrant women, people with a disability, LGBTIQ+?
	5. Thinking about your previous answer, what parts or components of the initiative do you think has contributed most to these changes? <i>For example, the training? The [insert system integrator name] role?</i>	What action has helped create change? What activities have stakeholders been most responsive to?
	6. Are there any other intended outcomes that haven't yet been realised?	Why? Were there any barriers to achieving this?
Sustainability	7. In your opinion, what parts of the initiative are most likely to have a long-term benefit or be sustainable?	Any activities that will continue beyond the initiative?
	8. What do you think are the enablers of ensuring the sustainability of the initiative?	For example: secure funding? Adequate resources? System integrator role?
	9. Based on your experience so far, do you have any recommendations for how the model could be improved in terms of delivering an initiative of this sort?	Do you have any suggestions for future delivery of the initiative?
Final comments	10. Do you have any last comments about the initiative?	

Appendix G: Detailed description of target groups and reach per PHN

PHN	Included primary care providers	Criteria for referral service	Priority population focus	Geographical coverage
BSPHN	<ul style="list-style-type: none"> General practices Aboriginal and Torres Strait Islander Community Controlled Health Services <p>Current RRR model originally designed with general practices for general practices. Design process undertaken with First Nations community before expanding to ATSICCHS in region. Clear need to expand to other primary health care providers, but there needs to be additional funding to support this expansion. Design process required to adapt to other primary care providers. Some operate in substantially different context than general practice (e.g. pharmacy) and considered design process required to determine safe and appropriate adaption</p>	<ul style="list-style-type: none"> Referrals accepted from all general practices and Aboriginal & Torres Strait Islander Community Controlled Health Services across PHN region for people who have or are experiencing DFV and their families. If patient lives out of catchment for the DFV service they will provide warm referral to their appropriate local service Currently don't take referrals for people using violence but can provide case consultations to medical centre staff about these patients and advise on referral options. 	<ul style="list-style-type: none"> Design work undertaken to determine if current model meets needs of DFV victim-survivors who identify as First Nations, culturally and/or linguistically diverse, LGBTIQ+ and/or having a disability. Resulted in development of training for general practices to improve responses to diverse communities, now being implemented, as well as measures to strengthen partnerships and referral pathways between local LGBTIQ+ and disability support services and the DFV Local Link teams. DFV services already have strong partnerships and established referral pathways with local First Nations and CALD support services along with existing First Nations DFV workers internally so these are utilised to ensure people are referred on to the most appropriate service for their needs. Explored having First Nations DFV Local Link but found that most appropriate option would be to support local Aboriginal and Torres Strait Islander Community Controlled Health Services with advocacy to state government for funding for DFV specialist roles in their services which are more holistic and culturally appropriate for First Nations community than version of DFV Local Link. Also, more sustainable and integrated with QLD DFV service system. Diversity in DFV Local Link roles is promoted and one of current DFV Local Links identifies as First Nations. 	Whole region

PHN	Included primary care providers	Criteria for referral service	Priority population focus	Geographical coverage
CESPHN	All primary care providers	<ul style="list-style-type: none"> The Navigator can receive referrals for women and non-binary people affected by DFV from staff from any general practice or allied health service. While the Navigator can provide some referral information about male victims and people who use violence, they will not be able to take referrals directly for these patients. 	<ul style="list-style-type: none"> Next steps in the DFV pilot is to look at priority populations Currently we have been able to provide specific training content on CALD communities. We plan to work with organisations to provide specialised training on working with patients with a disability, older people experiencing abuse and LGBTIQ+ patients. Discussions have begun between CESPHN, NBMPHN and HNECCPHN to develop training on working with First Nations patients affected by DFV with subject matter experts and community. 	Whole region
NBMPHN	All primary care providers RRR program taken from BSPHN model and adopted to incorporate the local region.	<ul style="list-style-type: none"> The Linker can receive referrals for women and non-binary people affected by DFV from staff from any general practice or allied health service. While the Linker can provide some referral information about male victims and people who use violence, they will not be able to take referrals directly for these patients 	<ul style="list-style-type: none"> Next steps in the program is to explore partnerships with subject matters experts focusing on priority groups which will complement the existing short webinars the PHN already have (First Nations; Older People, Children, Male victims; Disability, LGBTIQ+ and CALD). Discussions have begun between CESPHN, NBMPHN and HNECCPHN to develop training on working with First Nations patients affected by DFV with subject matter experts and community. 	Whole region
NWMPHN	All primary care providers	<ul style="list-style-type: none"> Referrals accepted from all general practices within PHN region for people who have or are experiencing DFV and their families. 	<ul style="list-style-type: none"> Five multidisciplinary family violence communities of practice were established, and five sessions were run in the North, Centre and West of Melbourne, connecting with a mix of professions from primary care, hospitals, mental health services, AOD, Aboriginal health, crisis services, community health, legal services, LGBTIQ+ services, specialised family violence services and lived experience speakers 	Whole region

PHN	Included primary care providers	Criteria for referral service	Priority population focus	Geographical coverage
HNECCPHN	Phase 1: General Practice and Aboriginal Medical Centres	<ul style="list-style-type: none"> Referrals accepted from all General Practices and Aboriginal Medical Services across PHN region for people who have or are experiencing DFV and their families. 	<ul style="list-style-type: none"> Design work completed for a First Nation's Men's Behaviour Change program in Armidale to be facilitated by Armidale Aboriginal Medical Service and Local DFV service. First Nation's Manual completed for AMS and local DFV service to implement. 2 x Aboriginal DFV Local Link's to provide cultural safety and capacity building in DFV training with General Practice. Ezidi Refugee DFV Project. Developed with the Armidale Community. 4 x animated videos produced spoken in the Ezidi language that explain DFV in Australia, the law, Healthy Relationships and Confidentiality. Health professionals can use these videos in consultations with this priority population group. 	Armidale, Central Coast and Tamworth.
	Phase 2: All primary care providers	<ul style="list-style-type: none"> Referrals accepted from all Primary Health Care providers and Aboriginal Medical Services Currently don't take referrals for people using violence but can provide case consultations to medical centre staff about these patients and advise on referral options. 	<ul style="list-style-type: none"> Discussions have begun between CESP HN, NBMPHN and HNECCPHN to develop training on working with First Nations patients affected by DFV with subject matter experts and community. The State funded Local Coordination Point employs Aboriginal Focused Workers. DFV Local Link will refer to the Aboriginal Focused Workers for a specialist response. 	Whole region
WVPHN	Phase 1: General Practice staff, non-clinical and clinical staff			Whole region
	Currently rolling out the A-LIVES program an adapted model to Pathways to Safety.	FV Connectors are available for secondary consultations for the General Practice staff. Referrals pathways to the Orange Door or Safe Steps after hours are encouraged and pathways are provided through the training	<ul style="list-style-type: none"> Currently in discussion to appoint a First Nations Consultant to undertake co design work that will enable the training package to be developed and delivered in a culturally safe way. Work internally with our SPIDAH Team to develop resources that are in easy English for people living with an intellectual disability. 	Whole region

Appendix H: Detailed description of training and capacity building activities

Provider	FTE	Overarching training model
BSPHN Two of the local DFV services. Did previously have Queensland Centre for DFV Research as	1 FTE total:	<ul style="list-style-type: none"> Tiered training approach, aiming to reach as many practices as possible with the foundational training and build on this with engaged practices/practitioners through follow up training, ongoing engagement and informal education via DFV Local Link

Provider	FTE	Overarching training model
provider but transitioned to sit within DFV Local Link services so it could be embedded into system integration work.	<ul style="list-style-type: none"> 0.5 FTE in Brisbane south region 0.5 FTE for Redlands, Logan and Beaudesert regions (1.0FTE role with Team Leader responsibilities for DFV Local Link team) 	<ul style="list-style-type: none"> Foundational training delivery model designed to overcome as many of the barriers to uptake for practices as possible to maximise uptake: - Short training – 1-2hrs - In practice at time most convenient to staff - Clear and actionable messaging to support application to practice - DFV Local Link attends training to build relationship and increase trust of referral service - RACGP points for participating GPs DFV Local Link in place to support application of learning from training and build confidence of general practice staff over time through ongoing contact. Case consultations, referral feedback, shared care of patients, debriefings, co-locations and practice visits are all opportunities for further learning. Training promoted primarily by DFV Local Links and the trainer, who do proactive outreach to general practices about the training and referral & support service • BSPHN also promote training via existing PHN communication channels
GP Community of Practice: Australian Society of Psychological Medicine provides administration and facilitator	N/A	<ul style="list-style-type: none"> The GP Community of Practice (CoP) aims to bring together General Practitioners doing the pivotal work of supporting patients impacted by DFV, to reflect and collaborate on case discussions, share knowledge, and support one another to navigate the challenges of responding to DFV in primary care. The Australian Society for Psychological Medicine (ASPM) facilitates the CoP, in partnership with BSPHN. Attendance of five sessions is eligible for 40 RACGP points. Facilitated by Dr Johanna Lynch, a trauma-informed GP Psychotherapist (also BSPHN GP Clinical Advisor for RRR), and a DFV Local Link joins each session to support case discussions and learning.
CESPHN	1 FTE	<ul style="list-style-type: none"> The DFV Educator is situated in the PHN and facilitates all practice training. Subject matter experts are contracted to facilitate certain training sessions and webinars
HNECCPHN	Facilitated by DFV Local Links and a GP	<ul style="list-style-type: none"> Practice training is customised to meet the needs/wishes of the practice. We recommend at least 2 hours for an introduction to responding to DFV in primary care, but will provide training for whatever timeframe is requested by the practice. We also offer training over multiple sessions, follow-up sessions, additional topics, can customise content based on the practice's wishes. We offer the training online and face-to-face and can offer training at the CESPHN office where a practice doesn't have the facilities to host. Where sole practitioners wish for training, we may put together a small group of practitioners, but we try to keep it within their profession, e.g. psychologists together Webinars are offered as complementary training on specific topics. We recommend practitioners have attended the introduction practice training prior to attending
	Phase 1: Safer Families: The Readiness Program	<ul style="list-style-type: none"> The Readiness Program: 2 x 1.5-hour sessions. 1st Session, whole of practice. 2nd Session, clinical staff only. 2nd Session had live patient simulation. Attracted 40 CPD points Communities of Practice: 2 x CoP held. Delivered by Safer Families.
	Phase 2: Local GP	<ul style="list-style-type: none"> Training can be customised to meet the needs of the Primary Care provider. HNECCPHN recommends 2 x 1-hour sessions for General Practice. This is delivered by a GP and is attended by the DFV Local Link, in practice. Evening webinars for Allied Health Short Lunch and Learn webinars, looking to explore a DFV Symposium for the region for Primary Care
NBMPHN	1 FTE	<ul style="list-style-type: none"> The Introduction to DFV was developed by BSPHN but NBMPHN adopted the model to localise it. Resources were also sought from person with lived experience, local DFV services, steering committee, GP advisory group and resources taken from DVNSW, RACGP, 1800RESPECT and DVSM.

Provider	FTE	Overarching training model
NWMPHN	Pathways to Safety Readiness Program	N/A
WVPHN	FV Connectors	

- Training is delivered online and in person at days and times that suit the participant. For example, we originally offered on line training in the morning, lunch time and evening but changed all times to evening as there was low participation at the other times.
- Face to face training is delivered at the practice with a minimum of 3 participants at a day and time that suits them. DFV Linker is also in attendance who provide examples of support (case study) and overview of their DFV service.

- NWMPHN commission University of Melbourne as the education and training provider
- Whole of practice training
- Aim to help staff understand how to recognise FV, respond and provide access to practical resources tailored to their area, enabling patients to feel safe and supported. Program provided an opportunity for practices to discuss issues around strengthening the response to FV in an individualised way with a GP facilitator and FV support worker.
- Allows for a whole of practice discussion on the role of the practice in responding to those experiencing FV and how might the practice facilitate a more effective response.
- Use of role play with GPs & nurses provide an opportunity for participants to try out different way of providing care and communication styles and techniques.
- An opportunity to discuss clinical protocols and procedures and access to DFV resources.

- Deliver A-LIVES training to General Practices (Whole of Practice Approach) – 2 sessions 1x45min non-clinical 1x2hr clinical
- Conduct 4 visits face to face or online to the general practice over a 2-month period to develop resources that are localised, review and assist with policies and procedures
 - 1st visit: Give detailed information regarding the training program; review practice deliverables
 - 2nd visit: 45 min lunch time non-clinical training session
 - 3rd visit: 2hr evening training session for clinical staff
 - 4th visit: Review practice checklist with staff, identify action items and plan how these will be completed; conduct case discussions and secondary consultation if requested
 - 5th visit: Provide additional training and resources requested (e.g., at practice meeting); conduct case discussions and secondary consultations if requested
 - 6th visit: Follow up on incentive payment; finalise referral pathways and ensure practice has all materials that is needed to move forward.

Appendix I: Detailed description of resources to support system influencing activities

PHN	Resource	Provider	Details
BSPHN	Quality Improvement measures	DFV Local Link services - the three local DFV services that cover region	<ul style="list-style-type: none"> DFV Local Links and trainers provide advice and support to practices to establish organisational policies and procedures to better meet the needs of patients impacted by DFV QI toolkit in development for release from 2023-24 financial year. Will be rolled out via partnership between PHN and DFV services.
	Embedded referral form	Developed jointly by all three DFV providers and BSPHN	<ul style="list-style-type: none"> DFV Local Link referral form that can be embedded in practice software Available from BSPHN website or can be sent out by DFV Local Link
	Secure messaging for referrals	Medical Objects – purchased by DFV Local Link providers	<ul style="list-style-type: none"> Each DFV Local Link has Medical Objects account so they can securely receive referrals and send back referral outcome letters
	Posters	Developed by DFV Local Links	<ul style="list-style-type: none"> To be put up in waiting rooms and bathrooms that indicate that general practice is safe place to disclose DFV
	SpotOn HealthPathways – DFV, Perpetrators of DFV & DFV Support Services	GP Clinical Editor funded by Metro South Hospital & Health Service and BSPHN with subject matter expert input	<ul style="list-style-type: none"> Online tool for general practices that provides information on assessment and management for use in consults. Current pathway from 2018 is in review and due to be published by end of 2022. Will be adapted for use across QLD
	Merchandise with discrete DFV Local Link contact details	Developed by DFV Local Links	<ul style="list-style-type: none"> Products that practice staff can give to patients to take away that discretely includes DFV Local Link number (e.g. box of tampons with sticker inside, lip balm with phone number in barcode) to reduce risk of perpetrator finding out they have sought support.
	Additional educational resources for general practice staff	Developed by DFV Local Links and trainers	<ul style="list-style-type: none"> Resources for practice staff to reference: safety planning, information sharing, power & control wheel, gender equality and inequality wheels, DFV service structure, diverse groups & DFV, people using violence, vicarious trauma and compassion fatigue, DFV mythbuster cards
CESPHN	Posters	CESPHN DFV Educator	Developed by NSW PHN partners and made available to CESPHN to rebrand.
	Flyers	CESPHN DFV Educator	Targeted towards GPs and AHPs to promote the program
	Website	CESPHN	Targeted towards GPs and AHPs to promote the program
	DFVA Plan (Domestic Family Violence and Abuse Plan)	NSW PHNs	An evidence-based risk assessment, response and referral document inclusive of domestic family violence action plan. This will be used by GPs and AHPs to refer patients to external services. The risk assessment questions are based on existing NSW DV assessment tool, the DVSAT (Domestic Violence Safety Assessment Tool). Training to use the DFVA Plan will be implemented in 2023.

PHN	Resource	Provider	Details
HNECC PHN	Quality Improvement measures	Developed by the PHN and supported by DFV Local Links	<ul style="list-style-type: none"> DFV Local Links and trainers provide advice and support to practices to establish organisational policies and procedures to better meet the needs of patients impacted by DFV DFV Primary Care Online and Interactive Toolkit for release from 2023-24 financial year.
	Primary Care DFV Action Plan	Developed by HNECC PHN with support from CES and NBM PHNs.	<p>To make a referral the DFV Local Link, clinicians upload the DFV GP Action Plan into their clinical software. The DFV Action Plan has been designed specifically for general practice to:</p> <ul style="list-style-type: none"> Identify patients who require an immediate crisis response Create a safety plan LINK for support for patient triage and support Record and Review
	Secure referral messaging	Medical Objects	DFV Local Links has MO accounts so they can securely receive referrals and send back referral outcome letters
	Posters	Developed by DFV Local Links and PHN in Phase 1	To be put up in waiting rooms and bathrooms that indicate that general practice is safe place to disclose DFV
	Phase 2 Pilot Awareness, Education and Action campaign.	In partnership with HNECC PHN and Brandcraft.	<ul style="list-style-type: none"> Key messaging to assist with a campaign/strategy to build awareness, education and action for the Primary Health Care Community over the next four years with the aim of further bringing DFV into the mainstream medical model / raising awareness that DFV is a serious public health issue. The Communication strategy will also promote the Primary Care response within their scope of practice e.g., Spot the signs, Start the Conversation and LINK for support.
	DFV Ezidi Videos	Developed by PHN, Armidale Local Link, General Practice, Ezidi Community, TAFE, Police, Refugee support services	<ul style="list-style-type: none"> 4 x animated videos that explain DFV in the Australian context: <ul style="list-style-type: none"> DFV in Australia Healthy Relationships Confidentiality & Duty of Care Apprehended Violence Orders Videos are designed to be used by health professionals to raise awareness and provide support to the Ezidi refugee population who are experiencing or using violence in the home.
First Nation's Men's Behaviour Change Program	Co-Design process led by the PHN with the First Nations community, AMS and DFV service sector, Armidale Local Link.	Men's Behaviour Change Manual/Program developed for implementation by local Aboriginal Medical Service in partnership with local DFV sector to provide a culturally safe Men's Behaviour Change Program. The model has been designed for all Primary Care clinicians working with First Nation's families to refer into / access for support when working with men who use violence.	
NBMPHN	Brochures and Posters	Developed by NBMPHN	Resources to be put up in waiting rooms, staff rooms and bathrooms (includes QR code)
	Brochures, Posters and Resources Packs	Developed by DFV Linkers organisations.	Resources to be put up in waiting rooms, staff rooms and bathrooms
	Quality Improvement DFV Tool Kit	Developed by NBMPHN	Tool kit to be delivered by DFV linkers to primary care to provide information pertaining to DFV.
	Embedded referral forms for BP & MD	Developed by NBMPHN	To enable secure referral pathways from primary care to DFV service.
	GP DFV Action Plan	Developed by CESPHN	Easy to use plan to enable primary care better identify patients impacted by DFV and ascertain the level of risk.

PHN	Resource	Provider	Details
NWMPHN	Quality Improvement activities	Developed by NWMPHN and SEMs	Resource for all practices to implement self-directed QI activities based on the activities tested and trailed within the pathways to safety program. Available as a sustainable resource for practices to download
	HealthPathways	Developed by HealthPathways & clinical SEMs (GPs, FV specialists, sector SEMs)	Development/updating of 16 assessment, management and referral pathways Promotion of HealthPathways development and updates
	Communication and awareness campaign	Developed by NWMPHN & SEMs	<ul style="list-style-type: none"> • Development of videos and media – ‘starting the conversation about FV’ • Social media • E-newsletter • Dedicated PHN webpage with resources for clinicians, information about FV info sharing scheme and child info sharing scheme • General practice case-studies
WVPHN	Review policies and procedures	FVC	FVC will look at current policies and procedures and off assistance on improvement
	Develop a resources folder	FVC	FVC will provide a folder of resources for each room within the general practice for quick reference.

Appendix J: Detailed description of system influencing activities implemented by each PHN

PHN	Activity	Lead	Details
BSPHN	Integrated Service Response and High-Risk Teams	DFV service providers	<ul style="list-style-type: none"> DFV services that are providers for DFV Local Link are also the providers of the QLD Government funded Integrated Service Responses and High-Risk Teams in their local area DFV Local Links are part of the ISR and act as conduit between primary health care DFV Local Links also support the HRT to link with general practices to share information under the QLD Information Sharing Legislation
	Local Level Alliance and Regional Child & Family Committees	DFV service providers	<ul style="list-style-type: none"> Meetings of government and non-government organisations that work with vulnerable families and children DFV Local Links are part of these and act as conduit between primary health care
	QLD State Government Partnerships	BSPHN	<p>BSPHN have established partnerships with the following state government branches with the aim of integrating primary health care into state government DFV reforms:</p> <ul style="list-style-type: none"> QLD Health's Strategy, Policy and Reform Branch who are responsible for implementing DFV reforms across the state health system Department of Justice and Attorney General's Office for Women & Violence Prevention
	QLD PHN DFV Collaborative	BSPHN	<ul style="list-style-type: none"> BSPHN are in the process of establishing this group to commence joint work in 2023. Will include QLD PHNs that opt in as well as state government partners shown above Aim to have state-wide approach to supporting implementation of QLD DFV reforms in primary health care within limitations of other QLD PHN budget and capacity as they do not have specific funding for this area of work
	Metro South Hospital and Health Service partnership	BSPHN	<ul style="list-style-type: none"> BSPHN work with MSHHS on local implementation of supports for health professionals across the health system, primary to tertiary. BSPHN sit on MSHHS DFV Reference Group
	RRR Network	BSPHN	<ul style="list-style-type: none"> Oversight of regional implementation of the RRR program Includes BSPHN, DFV service providers, GP Clinical Advisor and Lived Experience Advisor Other above local and state networks/partnerships are linked into via other means, to inform work on RRR program
CESPHN	CESPHN DFV Assist Advisory Committee		The Advisory Committee is an interdisciplinary collaborative between health professionals and DFV services in our region to address system barriers, support system improvements, share knowledge and information, identify primary care practice improvements and contribute to enhance primary care referral pathways.
	Regional Domestic Violence Networks and Interagency Groups	Various organisations in CESPHN region	CESPHN DFV Educator is linked with multiple interagency groups in our region to keep abreast of trends and concerns for our local population, priority populations and service providers.
HNECC PHN	NSW Safer Pathways Initiative	HNECCPHN	HNECCPHN has partnered with the NSW State Government to provide a dedicated Primary Care response within the NSW Safer Pathway program that supports victim-survivors across NSW. Within Safer Pathway, relevant government and non-government agencies work together to identify DFV victim-survivors and to offer them support to increase their safety.
	Local Level Alliance and Regional Child & Family Committees	DFV Local Links	<ul style="list-style-type: none"> Meetings of government and non-government organisations that work with vulnerable families and children DFV Local Links are part of these and act as conduit between primary health care
	NSW Ministry of Health	HNECC, CESPHN and NBM PHNs	PHN pilots are included in the NSW DFV Health strategy and will continue to work with the NSW Health to improve patient journeys from Primary Care to Acute services and vice versa.
NBMPHN	PHN General Practice Clinical Council, Allied	NBMPHN	PHN General Practice Clinical Council, Allied Health Clinical Council, Primary Care Advisory Committee and Community Advisory Committee

PHN	Activity	Lead	Details
	Health Clinical Council, Primary Care Advisory Committee and Community Advisory Committee		
	RRR Steering Committee	NBMPHN	Steering committee made up of the NBM regions includes: Aboriginal Health; DFV sector; Primary care and person with lived experience. Provide expert advice and guidance on an integrated and coordinated approach to support general practice when recognising, responding and referring people who present with domestic and family violence.
	NSW PHN Collaborative (DFV Pilot sites)	All PHNs	Provide support and collaboration on a state base level. Includes the delivery of webinars and the GP DFV Action Plan
	Safety Action Meetings (SAMs)	Local DFV Services	Steering Committee member attend the local SAMs meetings and provides feedback to committee when relevant.
	Nepean DV Network	Penrith City Council	DFV PHN program lead attends regular meetings where program updates are provided and information on traits/trends within the Nepean DFV sector is shared with primary care via training.
	Hawkesbury Action Network Against Domestic Violence	Women's Cottage (Local DFV Service)	DFV PHN program lead attends regular meetings where program updates are provided and information on traits/trends within the Hawkesbury DFV sector is shared with primary care via training.
	Lithgow Cares	Linc (Local DFV service)	DFV PHN program lead attends regular meetings where program updates are provided and information on traits/trends within the Lithgow DFV sector is shared with primary care via training.
	Coalition Against Violence & Abuse	Blue Mountains Women's Health Centre	DFV PHN program lead attends regular meetings where program updates are provided and information on traits/trends within the Blue Mountains DFV sector is shared with primary care via training.
	General Practices Conference and Education (GPCE) Australian Primary Health Care Nurses Association (APNA)	Consortium between CES, HNE & NBM PHNs	Developed DFV training session which was delivered by a GP at the conference. Secured a stall at both GPCE and APNA where information and resources pertaining to DFV will be provided.
NWMPHN	Engagement with state-wide central intake referral services- Orange Door & Safer Families Centre	NWMPHN	<ul style="list-style-type: none"> • Communication of sitewide referral services to GPs/general practice • Communications & promotion
WVPHN	Co-design	WVPHN	Identify linkages between services, consult people with lived experience, General Practice staff, System Service Navigators and FVC
	Co-design	First Nations Consultant	Co-design with 7 ACCHOS across WVPHN, to develop and implement a training package that is culturally safe.
	Family Violence/Child Wellbeing Systems forum	Orange Door	Workshop delivered by Orange Door to establish workflow and outcomes, referral pathways, allocation and partnership across multiple sectors. Attended by Child Protection, local Health Service, Maternal & Child Health, Brophy, Bethany and Police.
	Service System Navigator meetings	WVPHN	Regular monthly meetings with all Orange Doors reps to familiarise FVC & WVPHN with the local landscapes and to establish where improvement can be made.
	LAPG Meetings – Local Area Planning Group	Wimmera Family Violence Local Area Planning Group	Meets quarterly to discuss local Wimmera FV needs, action plan has been established for 2020-2024

Appendix K: Detailed t-test results for changes in pre-post training survey respondents' DFV capacity

Whole sample – Independent t-tests assuming equal variance

	GRIPS – Self-efficacy domain		GRIPS – Motivational readiness domain		GRIPS – Emotional readiness		Readiness items for administrative staff		Additional capacity items for health professionals		Additional capacity items for administrative staff	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
Mean	2.9898	3.8315	4.1873	4.3589	3.1880	3.4228	3.0086	3.9217	2.8939	3.8906	3.1259	3.7031
Variance	0.3343	0.1957	0.2116	0.2013	0.2142	0.2241	0.6086	0.5968	0.4851	0.4226	0.3456	0.2646
Observations	551	270	547	270	546	268	204	66	128	48	143	64
Pooled Variance	0.2888		0.2082		0.2174		0.6057		0.4682		0.3207	
Hypothesized Mean Difference	0		0		0		0		0		0	
df	819		815		812		268		174		205	
t Stat	-21.0843		-5.0556		-6.7492		-8.2851		-8.6065		-6.7775	
P(T<=t) one-tail	1.81029E-79		2.65012E-07		1.41348E-11		2.85031E-15		2.16937E-15		6.37E-11	
t Critical one-tail	1.6467		1.6467		1.6467		1.6506		1.6537		1.6523	

Matched sample – Paired t-tests

	GRIPS – Self-efficacy domain		GRIPS – Motivational readiness domain		GRIPS – Emotional readiness		Readiness items for administrative staff		Additional capacity items for health professionals		Additional capacity items for administrative staff	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
Mean	2.8880	3.8423	4.3310	4.4894	3.2460	3.4518	2.9063	4.0208	2.9837	3.7609	2.6184	3.7500
Variance	0.3649	0.1944	0.2036	0.1618	0.2356	0.1690	0.5389	0.4384	0.2249	0.3280	0.4518	0.6824
Observations	101	101	101	101	100	100	48	48	23	23	38	38
Pooled Variance	0.4214		0.6593		0.7452		0.0862		0.2256		0.1551	
Hypothesized Mean Difference	0		0		0		0		0		0	
df	100		100		99		47		22		37	
t Stat	-16.5747		-4.4837		-6.2836		-8.1693		-5.6817		-7.1121	
P(T<=t) one-tail	9.55753E-31		9.79799E-06		4.45566E-09		7.12618E-11		5.15E-06		1.00524E-08	
t Critical one-tail	1.6602		1.6602		1.6604		1.6779		1.7171		1.6871	

